
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

☒ **ANNUAL REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934
FOR THE FISCAL YEAR ENDED DECEMBER 31, 2007**

or

☐ **TRANSITION REPORT PURSUANT TO SECTION 13 OR 15(d)
OF THE SECURITIES EXCHANGE ACT OF 1934**

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

Delaware
*(State or other jurisdiction of
incorporation or organization)*

13-4204626
*(I.R.S. Employer
Identification No.)*

200 Oceangate, Suite 100, 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:

Title of Class	
Common Stock, \$0.001 Par Value	New York Stock Exchange

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act. ☐ Yes ☒ No

Indicate by check mark if the registrant is not required to file reports pursuant to Section 13 or Section 15(d) of the Act. ☐ Yes ☒ No

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 a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act. (Check one):

Large accelerated filer ☐ Accelerated filer ☒ Non-accelerated filer ☐ Smaller reporting company ☐
(Do not check if a smaller reporting company)

Indicate by check mark whether the registrant is a shell company (as defined in Rule 12b-2 of the Exchange Act). ☐ Yes ☒ No

The aggregate market value of Common Stock held by non-affiliates of the Registrant as of June 30, 2007, the last business day of our most recently completed second fiscal quarter, was approximately \$394.5 million (based upon the closing price for shares of the Registrant's Common Stock as reported by the New York Stock Exchange, Inc. on June 29, 2007).

As of February 26, 2008, approximately 28,445,000 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 2008 Annual Meeting of Stockholders to be held on May 15, 2008 are incorporated by reference into Part III of this Form 10-K.

MOLINA HEALTHCARE, INC.

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PART I

Item 1: *Business*

Overview

We are a multi-state managed care organization participating exclusively in government-sponsored health care programs for low-income persons, such as the Medicaid program and the State Children's Health Insurance Program, or SCHIP. Commencing in January 2006, we also began to serve a small number of members who are dually eligible under both the Medicaid and Medicare programs. We conduct our business primarily through nine licensed health plans in the states of California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those nine states, each of which is licensed as a health maintenance organization, or HMO. Our revenues are derived primarily from premium revenues paid to our HMOs by the relevant state Medicaid authority. Increasingly, we also derive revenues from the federal Centers for Medicare and Medicaid Services, or CMS, in connection with our Medicare services.

The payments made to our HMOs generally represent an agreed upon amount per member per month, or a "capitation" amount, which is paid regardless of whether the member utilizes any medical services in that month or whether the member utilizes medical services in excess of the capitation amount. Each of our HMOs (with the exception of our Utah plan whose Medicaid business is not capitated) is thus financially "at risk" for the medical care of its members. Each HMO arranges for health care services for its members by contracting with health care providers in the relevant communities or states, including contracting with primary care physicians, specialist physicians, physician groups, hospitals, and other medical care providers. Our California HMO also operates 19 of its own primary care community clinics. Various core administrative functions of our health plans — primarily claims processing, information systems, and finance — are centralized at our corporate parent in Long Beach, California. As of December 31, 2007, approximately 1,149,000 members were enrolled in our nine health plans.

Dr. C. David Molina founded our company in 1980 under the name "Molina Medical Centers" as a provider organization serving the Medicaid population in Southern California through a network of primary care clinics. Since then, we have increased our membership through the start-up development of new health plan operations, through the acquisition of existing health plans, and through internal or organic growth. In 1997, we established our Utah health plan as a start-up operation. In 1999, we incorporated in California as the parent company of our California and Utah health plan subsidiaries under the name "American Family Care, Inc." In late 1999, we acquired our Michigan and Washington health plans. In March 2000, we changed our name to Molina Healthcare, Inc. In June 2003, we reincorporated from California to Delaware, and in July 2003 we completed our initial public offering of common stock and listed our shares for trading on the New York Stock Exchange under the trading symbol, MOH. In July 2004, we acquired our New Mexico health plan. Our start-up health plan in Ohio began operations in December 2005. On January 1, 2006, our health plans in California, Michigan, Utah, and Washington began operating Medicare Advantage Special Needs Plans in their respective states. On May 15, 2006, we acquired Cape Health Plan in Michigan, merging it into our Michigan HMO effective December 31, 2006. Our start-up health plan in Texas began operations in September 2006. In June 2007, we organized a health plan in Nevada which serves only Medicare members. On November 1, 2007, we acquired Alliance For Community Health LLC, d/b/a Mercy CarePlus ("Mercy CarePlus"), an HMO serving approximately 68,000 members in Missouri as of December 31, 2007. We previously operated an HMO in Indiana which ceased serving members effective December 31, 2006 after its state Medicaid contract was not renewed. On January 1, 2008, our health plans in California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington began enrolling members in our new Medicare Advantage plans with prescription drug coverage, or MA-PD plans. Also in January 2008, our health plans in New Mexico and Texas began operating Medicare Advantage Special Needs Plans.

Our members have distinct social and medical needs and come from diverse cultural, ethnic, and linguistic backgrounds. From our inception, we have focused exclusively on serving low-income individuals enrolled in government-sponsored healthcare programs. Our success has resulted from our extensive experience with meeting the needs of our members, including our over 27 years of experience in operating community-based primary care clinics, our cultural and linguistic expertise, our education and outreach programs, our expertise in working with government agencies, and our focus on operational and administrative efficiencies.

Our principal executive offices are located at 200 Oceangate, Suite 100, Long Beach, California 90802, and our telephone number is (562) 435-3666. Our website is www.molinahealthcare.com. Information contained on our website or linked to our website is not incorporated by reference into, or as part of, this annual report. Unless the context otherwise requires, references to “Molina Healthcare,” the “Company,” “we,” “our,” and “us” herein refer to Molina Healthcare, Inc. and its subsidiaries. Our annual reports on Form 10-K, quarterly reports on Form 10-Q, current reports on Form 8-K, and all amendments to these reports, are available free of charge on our website, www.molinahealthcare.com, as soon as reasonably practicable after such reports are electronically filed with or furnished to the Securities and Exchange Commission, or SEC. Information regarding our officers, directors, and copies of our Code of Business Conduct and Ethics, Corporate Governance Guidelines, and our Audit, Compensation, and Corporate Governance and Nominating Committee Charters, are also available on our website. Such information is also available in print upon the request of any stockholder to our Investor Relations Department at the address of our executive offices set forth above.

Our Industry

The Medicaid and SCHIP Programs. Established in 1965, the Medicaid program is an entitlement program funded jointly by the federal and state governments and administered by the states. The Medicaid program provides health care benefits to low-income families and individuals. Each state establishes its own eligibility standards, benefit packages, payment rates, and program administration within federal guidelines. The most common state-administered Medicaid program is the Temporary Assistance for Needy Families program, or TANF (often pronounced “TAN-if”). TANF is the successor to the Aid to Families with Dependent Children program, or AFDC, and most enrolled members are mothers and their children. Another common state-administered Medicaid program is for the aged, blind, and disabled, or ABD Medicaid members, who do not qualify under other Medicaid coverage categories.

In addition, the State Children’s Health Insurance Program, known widely by the acronym, SCHIP, is a matching program that provides health care coverage to children whose families earn too much to qualify for Medicaid coverage, but not enough to afford commercial health insurance. States have the option of administering SCHIP through their Medicaid programs.

The state and federal governments jointly finance Medicaid and SCHIP through a matching program in which the federal government pays a percentage based on the average per capita income in each state. Typically, this federal 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. Nevertheless, budgetary constraints at both the federal and state levels may limit the benefits paid and the number of members served by Medicaid.

Medicaid Managed Care. Under traditional fee-for-service Medicaid programs, health care services are made available to beneficiaries in an uncoordinated manner. These beneficiaries 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, because providers are paid on a fee-for-service basis where additional services rendered result in additional revenues, they lack incentives to monitor utilization and control costs.

In an effort to improve quality and provide more uniform and more cost-effective care, many states have implemented Medicaid managed care programs. Such programs seek to improve access to coordinated health care services, including preventive care, and to control health care costs. Under Medicaid managed care programs, a health plan receives a predetermined payment per enrollee or member (commonly referred to as “capitation”) for the covered health care services. The health plan is thus financially “at risk” for its members’ medical services. The health plan, in turn, arranges for the provision of the covered health care services by contracting with a network of providers, including both physicians and hospitals, who agree to provide the covered services to the health plan’s members. The health plan also monitors quality of care and implements preventive programs, thereby striving to improve access to care while more effectively controlling costs.

Over the past decade, the federal government has expanded the ability of state Medicaid agencies to explore and, in many cases, to mandate the use of managed care for Medicaid beneficiaries. If Medicaid managed care is not

mandatory, individuals entitled to Medicaid may choose either the fee-for-service Medicaid program or a managed care plan, if available. All states in which we operate have mandatory Medicaid managed care programs.

Medicare Advantage Special Needs Plans. Consistent with our historical mission of serving low-income and medically underserved families and individuals, on January 1, 2006, our health plans in California, Michigan, Utah, and Washington began operating Medicare Advantage Special Needs Plans in their respective states. The Medicare Modernization Act of 2003 created a new type of Medicare Advantage coordinated care plan focused on individuals with special needs, such as those Medicare beneficiaries who are also eligible for Medicaid, are institutionalized, or have severe or disabling chronic conditions. The plans organized to provide services to these “special needs individuals” are called Special Needs Plans, or SNPs. The Molina Healthcare SNPs operate under the trade name, “Molina Medicare Options Plus,” and currently focus on serving only the dual eligible population — that is, those beneficiaries eligible for both Medicare and Medicaid such as low-income seniors and people with disabilities. We use our Medicare Advantage SNPs as a platform for ongoing discussions with state and federal regulators regarding the integration of Medicare and Medicaid benefits in order to provide a single point of access and accountability for care and services. Total enrollment in our SNPs at December 31, 2007 was approximately 5,000 members. On January 1, 2008, our New Mexico and Texas health plans also began operating SNPs. Our 2007 premium revenues from Medicare across all health plans represented approximately 2.0% of our total premium revenues.

Medicare Advantage Prescription Drug Plans. On January 1, 2008, our health plans in California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington also began enrolling members in our new Medicare Advantage Prescription Drug plans, or MA-PD plans. The Molina MA-PD plans operate under the trade name, “Molina Medicare Options.”

Other Government Programs for Low Income Individuals. In certain instances, states have elected to provide medical benefits to individuals and families who do not qualify for Medicaid. Such programs are often administered in a manner similar to Medicaid and SCHIP, but without federal matching funds. At December 31, 2007, our Washington HMO served approximately 26,000 such members under one such program, that state’s “Basic Health Plan.”

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. These families and individuals 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. We believe we are well-positioned to capitalize on the growth opportunities in serving these members. Our approach to managed care is based on the following key attributes:

Experience. For over 27 years we have focused on serving Medicaid beneficiaries as both a health plan and as a provider. We have developed and forged strong relationships with the constituents whom we serve — members, providers, and government agencies. Our ability to deliver quality care and to establish and maintain provider networks, as well as our administrative efficiency, has allowed us to compete successfully for government contracts. We have a strong record of obtaining and renewing contracts and have developed significant expertise as a government contractor.

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

Proven Expansion Capability. We have successfully replicated our business model through the acquisition of health plans, the start-up development of new operations, and the transition of members from other health plans. The integration of our New Mexico acquisition demonstrated our ability to integrate stand-alone acquisitions. The establishment of our health plans in Utah, Ohio, and Texas reflects our ability to replicate our business model in new

states, while contract acquisitions in California, Michigan, and Washington have demonstrated our ability to acquire and successfully integrate existing health plan operations into our business model.

Flexible Care Delivery Systems. Our systems for delivery of health care services are diverse and readily adaptable to different markets and changing conditions. We arrange health care services through contracts with providers that include independent physicians and medical groups, hospitals, ancillary providers and, in California, our own clinics. Our systems support multiple contracting models, such as fee-for-service, capitation, per diem, case rates, and diagnostic related groups, or DRGs. 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 members we serve.

We operate 19 company-owned primary care clinics in California. Our clinics require low capital expenditures and minimal start-up time. We believe that our clinics serve a useful role in providing certain communities with access to primary care and providing us with insights into physician practice patterns, first-hand knowledge of the needs of our members, and a platform to pilot new programs.

Cultural and Linguistic Expertise. We have over 27 years of experience developing targeted health care programs for culturally diverse Medicaid members, and believe we are well-qualified to successfully serve these 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 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.

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 brand drugs.

Our Strategy

Our objective is to be an innovative health care leader providing quality care and accessible services in an efficient and caring manner to Medicaid, SCHIP, Medicare, and other low-income members. To achieve this objective, we intend to:

Focus On Serving Low-Income Families And Individuals. We believe that the Medicaid and low-income Medicare population, which is characterized by significant ethnic diversity, requires unique services to meet its health care needs. Our more than 27 years of experience in serving this population has provided us significant expertise in meeting the unique needs of our members.

Increase Our Membership. We have grown our membership through a combination of acquisitions, start-up health plans, serving new populations, and internal or organic 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 continue to seek to grow our membership by expanding within existing markets and entering new strategic 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, extending our services to new populations, maintaining positive provider relationships, and integrating members from other health plans.
- *Enter new strategic markets.* We intend to enter new markets by acquiring existing businesses or building our own operations. We will focus our expansion on markets with competitive provider communities, supportive regulatory environments, significant size and, where possible, mandated Medicaid managed care enrollment.

Provide quality cost-effective care. We will use our information systems, strong provider networks, and first-hand provider experience to further develop and utilize effective medical management and other programs that address the distinct needs of our members. While improving the quality of care, these programs also facilitate the cost-effective delivery of that care. To document our commitment to quality, each Molina Healthcare health plan has adopted goals: (1) to achieve or continue accreditation by the National Committee for Quality Assurance, or NCQA, and (2) to achieve scores under the Healthcare Effectiveness Data and Information Set (HEDIS) at the 75th percentile for Medicaid plans. It is our goal to be the health plan of choice, recognized for the quality and accessibility of our services. Low-income families and individuals covered by government programs have traditionally faced long-standing barriers to accessing care that include language, culture, and literacy. We want to be known for our ability to help others overcome these barriers. Among physicians, hospitals, and other providers, we want to be known for prompt and accurate payment of claims and sound medical decisions.

Leverage operational efficiencies. Our centralized administrative infrastructure, flexible information systems, and dedication to controlling administrative costs provide economies of scale. We believe our administrative infrastructure has significant expansion capacity, allowing us to integrate new members from expansion within existing markets and entry into new markets.

Our Health Plans

As of December 31, 2007, our health plans were located in California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. An overview of our health plans and their principal governmental program contracts with the relevant state authority as of December 31, 2007 is provided below:

State	Expiration Date	
California	6-30-09	Subcontract with Health Net for services to Medi-Cal members under Health Net's Los Angeles County Two-Plan Model Medi-Cal contract with the California Department of Health Services (DHS).
California	12-31-08	Medi-Cal contract for Sacramento Geographic Managed Care Program with California Department of Health Services (DHS).
California	3-31-09	Two Plan Model Medi-Cal contract for Riverside and San Bernardino Counties (Inland Empire) with California Department of Health Services (DHS).
California	12-31-08	Medi-Cal contract for San Diego Geographic Managed Care Program with California Department of Health Services (DHS).
California	6-30-08	Healthy Families contract (California's SCHIP program) with California Managed Risk Medical Insurance Board (MRMIB).
Michigan	9-30-08	Medicaid contract with State of Michigan.
Missouri	6-30-09	Medicaid contract with the Missouri Department of Social Services.
New Mexico	6-30-08	Salud! Medicaid Managed Care Program contract (including SCHIP) with New Mexico Human Services Department (HSD).
Ohio	6-30-08	Medicaid contract with Ohio Department of Job and Family Services (ODJFS).
Texas	8-31-08	Medicaid contract with Texas Health and Human Services Commission (HHSC).
Utah	6-30-08	Medicaid contract with Utah Department of Health.
Washington	12-31-08	Basic Health Plan and Basic Health Plus Programs contract with Washington State Health Care Authority (HCA).
Washington	12-31-08	Healthy Options Program (including Medicaid and SCHIP) contract with State of Washington Department of Social and Health Services.

In addition to the foregoing, our health plans in California, Michigan, New Mexico, Texas, Utah, and Washington have entered into a standardized form of contract with CMS with respect to their operation of a MA SNP, and our health plans in California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington have also entered into a standardized form of contract with CMS with respect to their operations of an MA-PD plan. Our 2007

premium revenues from Medicare across all health plans represented approximately 2.0% of our total premium revenues.

Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. For example, our Indiana plan's contract with the state of Indiana expired without being renewed effective December 31, 2006. The Salud! Medicaid Managed Care contract of our New Mexico plan is currently the subject of a new Request for Proposal, or RFP, and the New Mexico plan is currently awaiting the results of its submission to the New Mexico Human Services Department.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and pharmacy benefits. We are usually paid a negotiated amount per member per month, with the amount varying from contract to contract. Generally, that amount is higher in states where we are required to offer more extensive health benefits. We are also paid an additional amount for each newborn delivery in Michigan, New Mexico, Texas, Ohio, and Washington. Since July 1, 2002, our Utah health plan has been reimbursed by the state for all medical costs incurred by Utah Medicaid members plus a 9% administrative fee. In general, either party may terminate our state contracts with or without cause upon 30 days to nine months prior written notice. In addition, most of these contracts contain renewal options that are exercisable by the state.

California. Molina Healthcare of California, our California HMO, had enrollment of 296,000 total members at December 31, 2007. 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 the counties of Los Angeles, Riverside, San Bernardino, San Diego, Sacramento, and Yolo. Our Medi-Cal members in Los Angeles County are served pursuant to a subcontract we have entered into with Health Net, with Health Net in turn contracting with the state.

Michigan. Molina Healthcare of Michigan, Inc., our Michigan HMO, is the largest Medicaid managed care health plan in the state, with 209,000 members at December 31, 2007. Our Michigan HMO serves 41 counties throughout Michigan, including the Detroit metropolitan area.

Missouri. On November 1, 2007, Molina Healthcare, Inc. acquired Mercy CarePlus, a licensed Medicaid managed care plan based in St. Louis, Missouri. Our Missouri health plan operates in 57 counties of the state, with 68,000 members at December 31, 2007.

Nevada. On Nevada HMO became operational on June 1, 2007. As of December 31, 2007, our Nevada HMO served approximately 500 Medicare members. Our Nevada HMO has no Medicaid enrollment.

New Mexico. As of December 31, 2007, our New Mexico HMO served 73,000 members. Our New Mexico HMO serves members in all of New Mexico's 33 counties.

Ohio. As of December 31, 2007, our Ohio HMO served 136,000 members. Our Ohio HMO operates in 50 counties of the state.

Texas. As of December 31, 2007, our Texas HMO served 29,000 members. Our Texas HMO serves STAR and CHIP members in 6 counties and STAR PLUS members in 13 counties. STAR stands for State of Texas Access Reform, and is Texas' Medicaid managed care program. STAR PLUS is the Texas Medicaid managed care program serving the aged, blind and disabled and includes a long-term care component.

Utah. As of December 31, 2007, Molina Healthcare of Utah, Inc., our Utah HMO, served 55,000 members (including 1,900 Medicare Advantage SNP members). Our Utah HMO serves Medicaid members in 25 of the state's 29 counties, including the Salt Lake City metropolitan area, and SCHIP members in all 29 counties.

Washington. Molina Healthcare of Washington, Inc., our Washington HMO, is the largest Medicaid managed care health plan in the state, with 283,000 members at December 31, 2007. We serve members in 32 of the state's 39 counties.

Provider Networks

We arrange health care services for our members through contracts with providers that include independent physicians and groups, hospitals, ancillary providers, and our own clinics. 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, 2007:

	California	Michigan	Missouri	Nevada	New Mexico	Ohio	Texas	Utah	Washington	Total
Primary care physicians	2,620	1,933	1,966	807	1,493	1,666	1,321	989	2,548	15,343
Specialists	6,403	3,364	2,376	1,525	6,915	9,460	3,326	1,172	5,809	40,350
Hospitals	80	60	61	17	55	115	40	33	83	544

Physicians. We contract with both primary care physicians and specialists, many of whom are organized into medical groups or 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, usually upon referral from a primary care physician, and are usually compensated on a fee-for-service basis. When we contract with groups of physicians on a capitated basis, we monitor their solvency.

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, or DRGs, capitation, and case rates.

Primary Care Clinics. Our California HMO operates 19 company-owned primary care clinics in California staffed by our physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members live, 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.

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. The underlying challenge we face is to coordinate health care so that our members receive timely and appropriate care from the right provider at the appropriate cost. In support of this goal, and to ensure medical management consistency among our various state health plans, we continuously refine and upgrade our medical management efforts at both the corporate and subsidiary levels.

We seek to ensure quality care for our members on a cost-effective basis through the use of certain key medical management and cost control tools. These tools include utilization management, case and health management, and provider network and contract management.

Utilization Management. We continuously review utilization patterns with the intent to optimize quality of care and ensure that only appropriate services are rendered in the most cost-effective manner. Utilization management, along with our other tools of medical management and cost control, is supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We use a predictive modeling capability that supports a proactive case and health management approach both for us and our affiliated physicians. We also use provider profiling to supply network physicians with information and tools to assist them in making appropriate, cost-effective referrals for specialty and hospital care. Provider profiling seeks to accomplish this aim by furnishing physicians and facilities with information about their own performance relative to national standards and relevant peer groups.

Case and Health Management. We seek to encourage quality, cost-effective care through a variety of case and health management programs, including disease management programs, educational programs, and pharmacy management programs.

Disease Management Programs. We develop specialized disease management programs that address the particular health care needs of our members. *motherhood matters!*sm is a comprehensive program designed to improve pregnancy outcomes and enhance member satisfaction. *breathe with ease!*sm is a multi-disciplinary disease management program that provides intensive health education resources and case management services to assist physicians caring for asthmatic members between the ages of three and fifteen. *Healthy Living with Diabetes*sm is a diabetes disease management program. “*Heart Health Living*” is a cardiovascular disease management program for members who have suffered from congestive heart failure, angina, heart attack, or high blood pressure.

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 information to guide them through various episodes of care. This information, which is available in appropriate languages, is designed to educate parents on the use of primary care physicians, emergency rooms, and nurse call centers.

Pharmacy Management 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.

Provider Network and Contract Management. The quality, depth, and scope of our provider network are essential if we are to ensure quality, cost-effective care for our members. In partnering with quality, cost-effective providers, we utilize clinical and financial information derived by our medical informatics function, as well as the experience we have gained in serving Medicaid members to gain insight into the needs of both our members and our providers. As we grow in size, we seek to strengthen our ties with high-quality, cost-effective providers by offering them greater patient volume.

Plan Administration and Operations

Management Information Systems. With the exception of our recently acquired Missouri health plan which will be transitioned at a later date, 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 scalable. We believe the software is flexible, easy to use, and allows us to accommodate anticipated 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 the integration of new plans and acquisitions.

We have designed our corporate website with a focus on ease of use and visual appeal. For example, our website has a secure ePortal which allows providers, members, and trading partners to access individualized data. The ePortal allows the following self-services:

- *Provider Self Services.* Providers have the ability to access information regarding their members and claims. Key functionalities include Check Member Eligibility, View Claim, and View/ Submit Authorizations.
- *Member Self Services.* Members can access information regarding their personal data, and can perform the following key functionalities: View Benefits, Request New ID Card, Print Temporary ID Card, and Request Change of Address/ PCP.

- *File Exchange Services.* Various trading partners — such as service partners, providers, vendors, management companies, and individual IPAs — are able to exchange data files (HIPAA or any other proprietary format) with us using the file exchange functionality.

Best Practices. We continuously seek to promote best practices. Our approach to quality is broad, encompassing traditional medical management and the improvement of our internal operations. We have staff assigned full-time to the development and implementation of a uniform, efficient, and quality-based medical care delivery model for our health plans. These employees coordinate and implement Company-wide programs and strategic initiatives such as preparation of the Health Plan Employer Data and Information Set (HEDIS) and accreditation by the National Committee on Quality Assurance, or NCQA. We use measures established by the NCQA in credentialing the physicians in our network. We routinely use peer review to assess the quality of care rendered by providers. At December 31, 2007, five of our nine HMOs were accredited by the NCQA. Our Ohio and Texas HMOs expect to apply for NCQA review later in 2008. Our Missouri plan will undergo NCQA review at a later date, and our Nevada plan will apply for NCQA review as soon as it is eligible.

Claims Processing. With the exception of our Missouri plan, all of the medical claims of our health plans are centrally processed at our processing facility in Long Beach, California.

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.

Disaster Recovery. We have established a disaster recovery and business resumption plan, with back-up operating sites, to be deployed in the case of a major disruptive event such as an earthquake along the San Andreas fault in Southern California.

Competition

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

- *Multi-Product Managed Care Organizations* — National and regional managed care organizations that have Medicaid members in addition to numerous commercial health plan and Medicare members.
- *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 to 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 may present partial barriers to entry into our industry.

We compete for government contracts, renewals of those government contracts, members, and providers. State agencies consider many factors in awarding contracts to health plans. Among such factors are the health plan's provider network, medical management, degree of member satisfaction, timeliness of claims payment, and financial resources. Potential members typically choose a health plan based on a specific provider being a part of the network, the quality of care and services available, accessibility of services, and reputation or name.

recognition of the health plan. We believe factors that providers consider in deciding whether to contract with a health plan include potential member volume, payment methods, timeliness and accuracy of claims payment, and administrative service capabilities.

Regulation

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

In order to operate a health plan in a given state we must apply for and obtain a certificate of authority or license from that state. Our nine operating health plans are licensed to operate as HMOs in each of California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. In those states we are regulated by the agency with responsibility for the oversight of HMOs which, in most cases, is the state department of insurance. In California, however, the agency with responsibility for the oversight of HMOs 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 operating results to the appropriate state regulatory agencies, and to undergo periodic examinations and reviews by the state in which it operates. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. Any acquisition of another plan's members must also be approved by the state, and our ability to invest in certain financial securities may be proscribed by statute.

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

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the federal and state 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 member eligibility standards;
- determines the type, amount, duration, and scope of services;
- sets the rate of payment for health care 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. Other states, such as California, engage in a competitive bidding process. In all cases, we must demonstrate to the satisfaction of the state Medicaid program that we are able to meet the state's operational and financial requirements. These requirements are in addition to those required for a license and are targeted to the specific needs of the Medicaid population. For example:

- We must measure provider access and availability in terms of the time needed to reach the doctor's office using public transportation;

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

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

Once awarded, our contracts generally have terms of one to four years, with renewal options at the discretion of the states. Our health plan subsidiaries have generally been successful in obtaining the renewal by amendment of their contracts in each state prior to the actual expiration of their contracts. However, there can be no assurance that these contracts will continue to be renewed. For example, our Indiana plan's contract with the state of Indiana expired without being renewed effective December 31, 2006. The Salud! Medicaid Managed Care contract of our New Mexico plan is currently the subject of a new Request for Proposal, or RFP, and the New Mexico plan is currently awaiting the results of its submission to the New Mexico Human Services Department. 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.

HIPAA regulations require that health care providers obtain from CMS a unique 10-digit national provider identifier, or NPI. The providers are required to use the NPI when submitting electronic claims to health plans such as us. The regulations had required providers and plans to use only the NPI in applicable transactions by May 23, 2007. However, on April 18, 2007, CMS issued guidance indicating that it would not impose penalties on covered entities that deploy contingency plans in order to ensure the smooth flow of payments if the entities have made reasonable and diligent efforts to become compliant. Pursuant to CMS's guidance, we implemented an NPI contingency plan in order to help ensure the smooth flow of payments to providers. We anticipate ending this contingency plan by May 22, 2008.

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, we will continue to devote significant resources to support our compliance efforts.

Employees

As of December 31, 2007, we had approximately 2,300 employees. Our employee base is multicultural and reflects the diverse Medicaid and Medicare membership we serve. We believe we have good relations with our employees. None of our employees is represented by a union.

Item 1A: Risk Factors

RISK FACTORS

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully read and consider the following risk factors, as well as other information we include or incorporate by reference in this report and the information in the other reports we file with the Securities and Exchange Commission. If any of the following events actually occur, our business, results of operations, financial condition, cash flows, or prospects could be materially adversely affected. The risks and uncertainties described below are those that we currently believe may materially affect us. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial may also become important factors that may materially affect us.

Our profitability depends on our ability to accurately predict and effectively manage our medical care costs.

Our profitability depends, to a significant degree, on our ability to accurately predict and effectively manage our medical care costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of our premium revenue, has fluctuated, and has also varied across our state health plans. Because the premium payments we receive are generally fixed in advance and we operate with a narrow profit margin, relatively small changes in our medical care cost ratio can create significant changes in our financial results. For example, if our overall medical care ratio for 2007 of 84.5% had been one percentage point higher, or 85.5%, our earnings for the year would have been \$1.50 per diluted share rather than our actual 2007 earnings of \$2.05 per diluted share, a 27% reduction in earnings. Factors that may affect our medical care costs include the level of utilization of healthcare services, increases in hospital costs or pharmaceutical costs, an increased incidence or acuity of high dollar claims related to catastrophic illness for which we do not have adequate reinsurance coverage, increased maternity costs, payment rates that are not actuarially sound, changes in state eligibility certification methodologies, unexpected patterns in the annual flu season, relatively low levels of hospital and specialty provider competition in certain geographic areas, increases in the cost of pharmaceutical products and services, changes in healthcare regulations and practices, epidemics, new medical technologies, and other external factors such as general economic conditions, inflation, interest rate fluctuations, or federal or state budgetary issues. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively manage the costs of providing health care services. The inability to forecast and manage our medical care costs or to establish and maintain a satisfactory medical care cost ratio, either with respect to a particular state health plan or across the consolidated entity, could have a material adverse effect on our business, financial condition, cash flows, or results of operations. For additional information regarding this risk, see “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations — Critical Accounting Policies.”

A failure to accurately estimate incurred but not reported medical care costs may negatively impact our results of operations.

Because of the significant time lag between when medical services are actually rendered by our providers and when we receive, process, and pay a claim for those medical services, we must continually estimate our medical claims liability at particular points in time, and establish claims reserves related to such estimates. Our estimated reserves for such “incurred but not reported,” or IBNR medical care costs, are based on numerous assumptions. We estimate our medical claims liabilities using actuarial methods based on historical data adjusted for claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract

changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our ability to accurately estimate claims for our newer HMOs in Missouri, Ohio, and Texas is impacted by the limited claims payment history of those HMOs. Likewise, our ability to accurately estimate claims for our newer lines of business or populations, such as with respect to Medicare Advantage or aged, blind, or disabled Medicaid members, is likewise impacted by the more limited experience we have had with those populations. The IBNR estimation methods we use and the resulting reserves that we establish are reviewed and updated, and adjustments, if deemed necessary, are reflected in the current period. Given the uncertainties inherent in such estimates, our actual claims liabilities for particular periods could differ significantly from the amounts estimated and reserved. Our actual claims liabilities have varied and will continue to vary from our estimates, particularly in times of significant changes in utilization, medical cost trends, and populations and markets served. If our actual liability for claims payments is higher than estimated, our earnings per share in any particular quarter or annual period could be negatively affected. Our estimates of IBNR may be inadequate in the future, which would negatively affect our results of operations for the relevant time period. Furthermore, if we are unable to accurately estimate IBNR, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results. For additional information regarding this risk, see “Item 7. Management’s Discussion and Analysis of Financial Condition and Results of Operations — Critical Accounting Policies.”

There are numerous risks associated with the growth of our Ohio HMO.

Membership at our Ohio HMO has grown rapidly, and the medical care ratio of our Ohio plan has been substantially higher than that historically experienced by the Company as a whole. In 2007, the medical care ratio of our Ohio plan was 90.4%. For 2008, we have projected that we can lower the medical care ratio of our Ohio plan to approximately 88%. In the event we are unable to do so, our higher than expected medical care ratio in Ohio could negatively impact the financial performance of the Company as a whole. In addition, the lower amount of experience of our Ohio Medicaid and ABD members in accessing managed care, of our local providers in coordinating managed care services for their patients, and our relative lack of experience in operating in that state, may also contribute to a higher than average medical care ratio. In addition, as our Ohio plan continues to grow, we will be required to increase the amount of regulatory capital we contribute to it. In December 2007, we were required to contribute \$32.5 million in additional regulatory capital to our Ohio plan. If we are required to contribute additional capital in the future, our existing cash balances or cash from operations may not be sufficient to cover such payments, in which case we would be required to draw down on our credit facility or obtain additional financing from another source and thereby incur additional indebtedness. In the event we are unable to lower our medical care ratio in Ohio, or if the Ohio plan requires a disproportionate investment of corporate energy and resources or is otherwise unsuccessful, the poor performance of that health plan could detrimentally impact the financial performance of the Company as a whole.

If our government contracts are not renewed or are terminated, or if the RFP bids of our health plans are not successful, our premium revenues could be materially reduced.

Our contracts generally run for periods of from one year to four years, and may be successively extended by amendment for additional periods if the relevant state agency so elects. Our current contracts expire on various dates over the next several years. There is no guarantee that our contracts will be renewed or extended. For example, in the fall of 2006, we were informed that the contract of our Indiana HMO to provide Medicaid services would not be extended beyond its expiration date of December 31, 2006. Moreover, our contracts may be opened for bidding by competing healthcare providers. As an example of that, our New Mexico health plan recently submitted a bid in response to the request for proposals of the New Mexico Medicaid authority for the new Salud! Medicaid managed care contract. In addition, all of our contracts may be terminated for cause if we breach a material provision of the contract or violate relevant laws or regulations. Our contracts with the states are also 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. We may face increased competition as other plans (many with greater financial resources and greater name recognition) attempt to enter our markets through the contracting process. If we are unable to renew, successfully re-bid, or compete for any of our government contracts, or if any of our contracts are terminated or renewed on less favorable terms, our business, financial condition, or results of operations could be adversely affected.

We derive a majority of our premium revenues from operations in a small number of states.

Operations in California, Michigan, New Mexico, Ohio, Utah, and Washington accounted for most of our premium revenues in 2007. If we were unable to continue to operate in any of those states or in any other states in which we have a health plan, or if our current operations in any portion of the states we are in were significantly curtailed, our revenues could decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on a loss of a material contract, legislative actions, changes in Medicaid eligibility methodologies, catastrophic claims, an epidemic or unexpected increase in utilization, general economic conditions, and similar factors in those states. Our inability to continue to operate in any of the states in which we currently operate could adversely affect our results of operations.

A sustained drop in the rate of interest earned on our invested balances could adversely affect our revenues.

Our revenues from invested balances were \$30.1 million in 2007. We have projected that, on average in fiscal year 2008, our invested balances will earn interest at the rate of at least 4%. However, due to the slowing growth in the economy at the beginning of 2008, the Federal Reserve Bank Board has effected a series of cuts to the target federal funds interest rate. These rate cuts lower the interest rate we can achieve on our invested balances. For every one-quarter drop in interest rates, our investment income will be reduced by approximately \$1.8 million. In the event the interest earned on our invested balances throughout 2008 averages less than 4% per annum, our revenues and results of operations could be adversely affected.

If we are unable to achieve our projected growth in Medicare members or our projected medical care ratio with respect to our Medicare program, our results of operations could be adversely affected.

Our business strategy includes increasing enrollment for our members who are dually eligible under both the Medicaid and Medicare programs, as well as increasing the number of our members eligible under Medicare alone. Our experience with the Medicare program and with Medicare members is much more limited than our experience with Medicaid. The administrative processes, programmatic requirements, and regulations pertaining to the Medicare program differ significantly from those of the Medicaid program. Likewise, the Medicare population has many characteristics and behavior patterns which differ from the Medicaid population with which we are familiar. Finally, Medicare providers, provider networks, and provider relations also differ from those of Medicaid.

During 2008, we will continue to invest heavily in the infrastructure necessary to grow our Medicare program. We have projected that we will add 5,000 Medicare members in 2008, and that our medical care ratio with respect to our Medicare members will be approximately 85%. In the event we are unable to enroll as many Medicare members as we project or are unable to maintain a medical care ratio of no greater than 85%, or if we are unable to quickly develop our Medicare expertise and adapt to the differing requirements and needs of the Medicare program and Medicare members, our business strategy may be unsuccessful and our business, financial condition, or results of operations could be adversely affected.

Medicaid and SCHIP funding is subject to political disagreements over budgetary funding and efforts to control governmental spending in order to balance federal and/or state budgets.

Nearly all of our revenues come from federal and state funding of the Medicaid and SCHIP programs. Because these governmental health care programs account for such a large portion of federal and state budgets, efforts to contain overall governmental spending and to achieve a balanced budget often result in significant political pressure being directed at the funding for these programs. The funding of our various Medicaid contracts, or the rate increases we expect to obtain during the course of a year, can thus be put at risk whenever there is a federal or state budget impasse, a budgetary crisis, or political disagreement that is not quickly resolved. For example:

- In the summer of 2007, passage of the 2008 budget for the State of California was months overdue, thereby threatening the funding of our California health plan's contracts with the state. In early 2008, due to a mounting state budget deficit, the California Legislature passed and Governor Arnold Schwarzenegger signed a 10% across-the-board cut to most California government-funded programs, including the reimbursement rates paid to physicians under Medi-Cal as well as Medi-Cal outpatient fees. The cuts are

scheduled to be implemented on July 1, 2008 unless an alternative budget is passed and signed before that date.

- The Michigan state government briefly shut down on October 1, 2007 due to lack of agreement on a significant budget shortfall in that state.
- Funding under the federal SCHIP program, which provided 2.1% of our total premium revenues for the year ended December 31, 2007, is subject to an ongoing political disagreement between the United States Congress and President Bush. While it is unclear when a political compromise might be reached, the SCHIP program has been extended on its existing terms through March 31, 2009.

Overall Medicaid enrollment and costs are projected to continue to increase over the next several years. These increasing costs, combined with an economic slowdown or recession in 2008, will exert additional budgetary pressures on federal and state governments. In the event of a recession, an extended budgetary or political impasse at either the federal or state level, the failure of the California legislature to pass an alternative budget with less draconian cuts to Medi-Cal provider rates, the failure of the states of Michigan, Missouri, or Texas to provide our health plans in those states with their expected rate increases, or the non-renewal of the SCHIP program, the funding of one or more of our contracts could be curtailed or cut off which could have a material adverse effect on our business, financial condition, or results of operations.

Funding under our contracts is also subject to regulatory and programmatic adjustments and reforms for which we may not be appropriately compensated.

The federal government and the governments of the states in which we operate frequently consider legislative and regulatory proposals regarding Medicaid reform and programmatic changes. Such proposals involve, among other things, changes in reimbursement or payment levels based on certain parameters or member characteristics, changes in eligibility for Medicaid, and changes in benefits covered such as pharmacy, behavioral health, or vision. Any of these changes could be made effective retroactively. If our cost increases resulting from these changes are not matched by commensurate increases in our revenue, we would be unable to make offsetting adjustments, such as supplemental premiums or changes in our benefit plans, as would a commercial health plan. For example, as part of its periodic rebasing of diagnostic-related group (DRG) rates to adjust for changes in hospital cost experience, effective August 1, 2007, the state of Washington recalibrated the relative weights used in its DRG reimbursement system for in-patient hospital claims. The changes were intended to be budget neutral, but corresponding increases were not made to the amounts paid to managed care organizations such as our Washington health plan until January 1, 2008. As a result, the Washington DRG rebasing increased our Washington plan's medical care costs for the second half of 2007 without a compensating increase in payments to the Washington plan. Any other such regulatory or programmatic reforms at either the federal or state level could have a material adverse effect on our business, financial condition, or results of operations.

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 over the last several years. For example, on November 1, 2007, we acquired Mercy CarePlus, an HMO in Missouri. Although we cannot predict with certainty our rate of growth as the result of acquisitions, we believe that additional acquisitions of all sizes will be important to our future growth strategy. Many of the other potential purchasers of these assets — particular operators of commercial health plans — have significantly greater financial resources than we do. Also, many of the sellers may insist on selling assets that we do not want, such as commercial lines of business, or may insist on transferring their liabilities to us as part of the sale of their companies or assets. Even if we identify suitable targets, we may be unable to complete acquisitions on terms favorable to us or obtain the necessary financing for these acquisitions. Further, to the extent we complete an acquisition, we may be unable to realize the anticipated benefits from such acquisition because of operational factors or difficulty in integrating the acquisition with our existing business. This may include problems involving the integration of:

- additional employees who are not familiar with our operations or our corporate culture,
- 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,
- internal controls and accounting policies, including those which require the exercise of judgment 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, and
- new regulatory schemes, relationships, practices, and compliance requirements.

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 would be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of that state in which we did not operate previously. We may be unable to obtain the necessary governmental approvals or comply with these regulatory requirements in a timely manner, if at all. For all of the above reasons, we may not be able to consummate our proposed acquisitions as announced from time to time to sustain our pattern of growth or to realize benefits from completed acquisitions.

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

Depending on acquisitions and other opportunities, we expect to continue to grow our membership and to expand into other markets. In fiscal year 2004, we had total premium revenue of \$1,171 million. In fiscal year 2007, we had total premium revenue of \$2,462 million, an increase of 110% over a three-year span. Continued rapid growth could place a significant strain on our management and on other Company 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.

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 managed care organizations. The government agencies administering these laws and regulations have broad latitude in interpreting and applying 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. For instance, some states mandate minimum medical expense levels as a percentage of premium revenues. These laws and regulations, and their interpretations, are subject to frequent change. The interpretation of certain contract provisions by our governmental regulators may also 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 mandated benefits, forcing us to restructure our relationships with providers, or requiring us to implement additional or different programs and systems. Changes in the interpretation of our contracts could also reduce our profitability if we have detrimentally relied on a prior interpretation.

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

government contracts and as a result lose significant numbers of members and amounts of revenue. In addition, government receivables are subject to government audit and negotiation, and government contracts are vulnerable to disagreements with the government. The final amounts we ultimately receive under government contracts may be different from the amounts we initially recognize in our financial statements.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are typically approved for multi-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

Our business depends on our information and medical management systems, and our inability to effectively integrate, manage, and keep secure our information and medical management 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 medical 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 and medical management systems, our operations and ability to produce timely and accurate reports could be adversely affected. In addition, if the licensor or vendor of any software which is integral to our operations were to become insolvent or otherwise fail to support the software sufficiently, 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. Our policy is to 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, upgrade 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 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 members, 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.

If we are unable to maintain good relations with the physicians, hospitals, and other providers with whom we contract, or if we are unable to enter into cost-effective contracts with such providers, our profitability could be adversely affected.

We contract with physicians, hospitals, and other providers as a means to assure access to health care services for our members, to manage health care costs and utilization, and to better monitor the quality of care being delivered. In any particular market, providers could refuse to contract with us, demand higher payments, or take other actions which could result in higher health care costs, disruption to provider access for current members, a decline in our growth rate, or difficulty in meeting regulatory or accreditation requirements.

In some markets, certain providers, particularly hospitals, physician/hospital organizations, and some specialists, may have significant market positions or even monopolies. If these providers refuse to contract with us or utilize their market position to negotiate favorable contracts which are disadvantageous to us, our profitability in those areas could be adversely affected.

Some providers that render services to our members are not contracted with our plans. In those cases, there is no pre-established understanding between the provider and our plan about the amount of compensation that is due to the provider. In some states, the amount of compensation is defined by law or regulation, but in most instances it is either not defined or it is established by a standard that is not clearly translatable into dollar terms. In such instances, providers may believe they are underpaid for their services and may either litigate or arbitrate their dispute with our plan. The uncertainty of the amount to pay and the possibility of subsequent adjustment of the payment could adversely affect our financial position or results of operations.

Failure to attain profitability in any new start-up operations or in connection with our expansion into Medicare could negatively affect our results of operations.

Start-up costs associated with a new business can be substantial. For example, in order to obtain a certificate of authority to operate as a health maintenance organization in most jurisdictions, we must first establish a provider network, have infrastructure and required systems in place, and demonstrate our ability to obtain a state contract and process claims. Often we are also required to contribute significant capital in order to fund mandated net worth requirements, performance bonds or escrows, or contingency guaranties. If we were unsuccessful in obtaining the certificate of authority, winning the bid to provide services, or attracting members in sufficient numbers to cover our costs, any new business of ours would fail. We also could be required by the state to continue to provide services for some period of time without sufficient revenue to cover our ongoing costs or to recover our significant start-up costs.

Even if we are successful in establishing a profitable HMO in a new state, increasing membership, revenues, and medical costs will trigger increased mandated net worth requirements which could substantially exceed the net income generated by the HMO. Rapid growth in an existing state will also create increased net worth requirements. In such circumstances we may not be able to fund on a timely basis or at all the increased net worth requirements with our available cash resources. The expenses associated with starting up a health plan in a new state or expanding a health plan in an existing state could have a significant adverse impact on our business, financial condition, or results of operations.

Likewise, our expansion into Medicare involves substantial start-up costs for which there may be minimal associated revenue. For example, we must hire sales personnel and establish a rigorous and comprehensive compliance program. The expenses associated with our expansion into Medicare could have a significant impact on our business, financial condition and results of operations.

High profile qui tam matters and negative publicity regarding Medicaid managed care and Medicare Advantage may lead to programmatic changes, intensified regulatory scrutiny, or “guilt by association.”

Certain of our competitors have recently been involved in high profile qui tam or “whistleblower” actions which have resulted in significant volatility in the price of their stock. Because of the limited number of health care companies competing in our market space, these whistleblower actions and investigations, and the resulting negative publicity, could become associated with or imputed to the Company, regardless of the Company’s actual regulatory compliance. Such an association, as well as any perception of a recurring pattern of abuse among the health plan participants in these government programs and the diminished reputation of the managed care sector as a whole, could result in public distrust, political pressure for programmatic changes, intensified scrutiny by regulators, increased stock volatility due to speculative trading, and heightened barriers to new managed care markets and contracts, all of which could have a material adverse effect on our business, financial condition, or results of operations.

If a state fails to renew its federal waiver application for mandated Medicaid enrollment into managed care or such application is denied, our membership in that state will likely decrease.

States may only mandate Medicaid enrollment into managed care under federal waivers or demonstrations. Waivers and programs under demonstrations are approved for two-year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew its mandated program or the federal government denies the state's application for renewal, our business would suffer as a result of a likely decrease in membership.

We face claims related to litigation which could result in substantial monetary damages.

We are subject to a variety of legal actions, including medical malpractice actions, provider disputes, employment related disputes, and breach of contract actions. In the event we incur liability materially in excess of the amount for which we have insurance coverage, our profitability would suffer. In addition, our providers involved in medical care decisions are exposed to the risk of medical malpractice claims. Providers at the 19 primary care clinics we operate in California are employees of our California health plan. As a direct employer of physicians and ancillary medical personnel and as an operator of primary care clinics, our California plan is subject to liability for negligent acts, omissions, or injuries occurring at one of its clinics or caused by one of its employees. We maintain medical malpractice insurance for our clinics in the amount of \$1 million per occurrence, and an annual aggregate limit of \$3 million, errors and omissions insurance in the amount of \$10 million per occurrence and in aggregate for each policy year, and such other lines of coverage as we believe are reasonable in light of our experience to date. However, given the significant amount of some medical malpractice awards and settlements, 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.

Furthermore, claimants often sue managed care organizations for improper denials of or delays in care, and in some instances improper authorizations of care. Also, Congress and several state legislatures have considered 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.

We cannot predict the outcome of any lawsuit with certainty. While we currently have insurance coverage for some of the potential liabilities relating to litigation, other such liabilities may not be covered by insurance, the insurers could dispute coverage, or the amount of insurance could be insufficient to cover the damages awarded. In addition, insurance coverage for all or certain types of liability may become unavailable or prohibitively expensive in the future or the deductible on any such insurance coverage could be set at a level which would result in us effectively self-insuring cases against us.

Although we have established reserves for litigation as we believe appropriate, we cannot assure you that our recorded reserves will be adequate to cover such costs. Therefore, the litigation to which we are subject could have a material adverse effect on our financial condition, results of operations, or cash flows and could prompt us to change our operating procedures.

The Medicaid citizenship documentation requirements may adversely impact the enrollment levels of our health plans.

The United States Department of Health and Human Services requires persons applying for Medicaid to document their citizenship. The documentation requirement is outlined in Section 6036 of the Deficit Reduction Act of 2005 and is intended to ensure that Medicaid beneficiaries are United States citizens without imposing undue burdens on them or the states. The rule requires actual documentary evidence before Medicaid eligibility is granted or renewed. The provision requires that a person provide both evidence of citizenship and identity. In many cases, a

single document will be enough to establish both citizenship and identity, such as a passport. However, if secondary documentation is used, such as a birth certificate, the individual will also need evidence of his or her identity. Affidavits can only be used in rare circumstances. Additional types of documentation, such as school records, may be used for children. Once citizenship has been proven, it need not be documented again with each eligibility renewal unless later evidence raises a question.

Each state must implement its own process for assuring compliance with documentation of citizenship in order to obtain federal matching funds, and effective compliance is part of Medicaid program integrity monitoring. In particular, audit processes track the extent to which a state relies on lower categories of documentation, and on affidavits, with the expectation that such categories would be used relatively infrequently and less over time, as state processes and beneficiary documentation improves.

Because this rule is relatively new and states have varied their compliance processes since its implementation, it is unclear what the full impact will be on the enrollment levels of our various state HMOs. The rule could result in the disenrollment of a material number of our members, thereby decreasing our premium revenues. As a result, this proof of citizenship requirement could have a material adverse effect on our business, financial condition, or results of operations.

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 the financial resources available to a health plan. Many other organizations with which we compete, including large commercial plans, have substantially greater financial and other resources than we do. For these reasons, we may be unable to grow our membership, or may lose members to other health plans.

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

In order to provide liquidity, we have a \$200 million senior secured credit facility that matures in May 2012. As of December 31, 2007, we had no outstanding indebtedness under our credit facility. Our credit facility imposes numerous 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. As a result of the restrictions and covenants imposed under our credit facility, our growth strategy may be negatively impacted by our inability to act with complete flexibility, or our inability to use our credit facility in the manner intended.

If we are in default at a time when funds under the credit facility are required to finance an acquisition, or if a proposed acquisition does not satisfy the pro forma financial requirements under our credit facility, we may be unable to use the credit facility in the manner intended. In addition, if we were to draw down on our credit facility, or incur other additional debt in the future, it could have an adverse effect on our business and future operations. For example, it could:

- require us to dedicate a substantial portion of cash flow from operations to pay principal and interest on our debt, which would reduce funds available to fund future working capital, capital expenditures, and other general operating requirements;
- increase our vulnerability to general adverse economic and industry conditions or a downturn in our business; and
- place us at a competitive disadvantage compared to our competitors that have less debt.

Our ability to obtain any financing, whether through the issuance of new debt securities or otherwise, and the terms of any such financing are dependent on, among other things, our financial condition, financial market

conditions within our industry and generally, credit ratings, and numerous other factors. There can be no assurance that we will be able to refinance our credit facility and obtain financing on acceptable terms or within an acceptable time frame, if at all. If we are unable to obtain financing on terms and within a time frame acceptable to us it could, in addition to other negative effects, have a material adverse effect on our operations, financial condition, ability to compete or ability to comply with regulatory requirements.

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

Our operations are highly dependent on the efforts of our executive officers. 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.

A pandemic, such as a worldwide outbreak of a new influenza virus, could materially and adversely affect our ability to control health care costs.

An outbreak of a pandemic disease, such as the H5N1 avian flu, could materially and adversely affect our business and operating results. The impact of a flu pandemic on the United States would likely be substantial. Estimates of the contagion and mortality rate of any mutated avian flu virus that can be transmitted from human to human are highly speculative. A significant global outbreak of avian flu among humans could have a material adverse effect on our results of operations and financial condition as a result of increased inpatient and outpatient hospital costs and the cost of anti-viral medication to treat the virus.

Because our corporate headquarters and claims processing facilities are located in Southern California, our business operations may be significantly disrupted as a result of a major earthquake.

Our corporate headquarters, centralized claims processing, finance, and information technology support functions are located in Long Beach, California. Southern California is located along the San Andreas fault and is thus exposed to a statistically greater risk of a major earthquake than most other parts of the country. If a major earthquake were to strike the Los Angeles and Long Beach area, our claims processing and other corporate functions could be significantly impaired for a substantial period of time. Although we have established a disaster recovery and business resumption plan with back-up operating sites to be deployed in the case of such a major disruptive event, there can be no assurances that the business operations of all our health plans, including those that are remote from any such event, would not be substantially impacted by a major earthquake.

Our results of 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 tax receipts 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.

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

We are a corporate parent holding company and hold most of our assets at, and conduct most of our operations through, direct and indirect subsidiaries. As a holding company, our results of operations depend on the results of

operations of our subsidiaries. Moreover, we are dependent on dividends or other intercompany transfers of funds from our subsidiaries to meet our debt service and other obligations. The ability of our subsidiaries to pay dividends or make other payments or advances to us will depend on their operating results and will be subject to applicable laws and restrictions contained in agreements governing the debt of such subsidiaries. In addition, our health plan 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, New Mexico, Ohio, Texas, 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, 2007, 2006, and 2005 without approval of the regulatory authorities were approximately \$18.7 million, \$6.9 million, and \$4.3 million, respectively. 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 under our credit facility and/or our senior convertible notes.

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

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

Failure to maintain effective internal controls over financial reporting could have a material adverse effect on our business, operating results, and stock price.

The Sarbanes-Oxley Act of 2002 requires, among other things, that we maintain effective internal control over financial reporting. In particular, we must perform system and process evaluation and testing of our internal controls over financial reporting to allow management to report on, and our independent registered public accounting firm to attest to, our internal controls over our financial reporting as required by Section 404 of the Sarbanes-Oxley Act of 2002. Our future testing, or the subsequent testing by our independent registered public accounting firm, may reveal deficiencies in our internal controls over financial reporting that are deemed to be material weaknesses. Our compliance with Section 404 will continue to require that we incur substantial accounting expense and expend significant management time and effort. Moreover, if we are not able to continue to comply with the requirements of Section 404 in a timely manner, or if we or our independent registered public accounting firm identifies deficiencies in our internal control over financial reporting that are deemed to be material weaknesses, the market price of our stock could decline and we could be subject to sanctions or investigations by the NYSE, SEC or other regulatory authorities, which would require additional financial and management resources.

Volatility of our stock price could adversely affect stockholders.

Since our initial public offering in July 2003, the sales price of our common stock has ranged from a low of \$20.00 to a high of \$53.23. A number of factors will continue to influence the market price of our common stock, including:

- state and federal budget decreases,
- adverse publicity regarding health maintenance organizations and other managed care organizations,

- government action regarding member eligibility,
- changes in government payment levels,
- a change in control of the Presidency or of Congress from one party to the other,
- 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 in the healthcare industry,
- the termination of our Medicaid or SCHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,
- regulatory or legislative change, and
- general economic conditions, including inflation, interest rates, and unemployment rates.

Our stock may not trade at the same levels as the stock of other health care companies and the market in general may not sustain its current prices. Also, if the trading market for our stock does not continue to develop, securities analysts may not initiate or maintain research coverage of our company and our shares, and this could further depress the market for our shares.

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

Our executive officers and directors, in the aggregate, beneficially own approximately 20% of our capital stock, and members of the Molina family (some of whom are also officers or directors), in the aggregate, beneficially own approximately 53% 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 by themselves or together with our officers and directors, have the ability to significantly influence all matters submitted to stockholders for approval, including the election and removal of directors, amendments to our charter, and any merger, consolidation, or sale of substantially all of our assets. A significant concentration of share ownership can also adversely affect the trading price for our common stock because investors often discount the value of stock in companies that have controlling stockholders. Furthermore, the concentration of ownership in our company could delay, defer, or prevent a merger or consolidation, takeover, or other business combination that could be favorable to our stockholders. Finally, the interests and objectives of our controlling stockholders may be different from those of our company or our other stockholders, and our controlling stockholders may vote their common stock in a manner that may adversely affect our other stockholders.

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

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

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

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

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

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

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

From time to time in press releases and otherwise, we may publish earnings guidance, forecasts, or other forward-looking statements regarding our future results, including estimated revenues, net earnings, and other operating and financial metrics. Any forecast of our future performance reflects numerous assumptions. These assumptions are subject to significant uncertainties, and as a matter of course, any number of them may prove to be incorrect. For example, our earnings guidance issued on January 18, 2007 assumed that the membership of our Ohio HMO would grow during 2007 to approximately 160,000 members, an assumption which proved to be inaccurate (actual membership in Ohio grew to 136,000 at December 31, 2007). Further, the achievement of any forecast depends on numerous risks and other factors, including those described in this report, many of which are beyond our control. As a result, we cannot assure that our performance will be consistent with any management forecasts or that the variation from such forecasts will not be material and adverse. You are cautioned not to base your entire analysis of our business and prospects upon isolated predictions, but instead are encouraged to utilize the entire publicly available mix of historical and forward-looking information, as well as other available information affecting us and our services, when evaluating our prospective results of operations.

We do not anticipate paying any cash dividends in the foreseeable future.

We have not declared or paid any dividends since our initial public offering in July 2003, and 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 deduct interest on our convertible notes for U.S. federal income tax purposes may be reduced or eliminated and as a result our after-tax cash flow could be adversely affected.

In October 2007, we completed our offering of \$200 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014. Under Section 279 of the Internal Revenue Code, deductions otherwise allowable to a corporation for interest may be reduced or eliminated in the case of corporate acquisition indebtedness, which is generally defined to include subordinated convertible debt issued to provide consideration for the acquisition of stock or a substantial portion of the assets of another corporation, if either (i) the acquiring corporation has a debt to equity ratio (measured, in part, with reference to tax basis) that exceeds 2 to 1 or (ii) the projected earnings of the corporation (the average annual earnings, determined with certain adjustments, for the three-year period ending on the test date) do not exceed three times the annual interest costs of the corporation. At the present time, based on our current and expected operational metrics for the current taxable year (as specifically calculated for purposes of the debt to equity ratio and projected earnings tests referred to in the preceding sentence), we do not expect our convertible notes to qualify as corporate acquisition indebtedness. However, our actual operational metrics could differ from our expectations and, as a result, our deductions for interest on our convertible notes could be reduced or eliminated if our convertible notes meet the definition of corporate acquisition indebtedness in 2007, the taxable year in which the notes were issued. In addition, our convertible notes could become corporate acquisition indebtedness in a subsequent taxable year if we initially meet the debt to equity ratio and projected earnings tests, but later fail one or both tests in a year during which we issue additional indebtedness for certain corporate acquisitions. If we are not entitled to deduct interest on our convertible notes, our after-tax cash flow could be adversely affected.

Conversion of our senior convertible notes may dilute the ownership interest of existing stockholders.

Our convertible notes are convertible into cash and, under certain circumstances, shares of our common stock. The conversion of some or all of our convertible notes may dilute the ownership interests of existing stockholders. Any sales in the public market of our common stock issuable upon such conversion could adversely affect prevailing market prices of our common stock. In addition, the anticipated conversion of the convertible notes into cash and shares of our common stock could depress the price of our common stock.

The accounting method for convertible debt securities with net share settlement, like our \$200 million senior convertible notes, could change in a manner that may affect our results of operations.

In August 2007, the Financial Accounting Standards Board, or FASB, issued an exposure draft of a proposed FASB Staff Position (the "Proposed FSP") reflecting new rules that would change the accounting for certain convertible debt instruments, including our convertible notes. Under the proposed new rules for convertible debt instruments that may be settled entirely or partially in cash upon conversion, an entity should separately account for the liability and equity components of the instrument in a manner that reflects the issuer's economic interest cost. The effect of the proposed new rules for our convertible note is that the equity component would be included in the paid-in-capital section of stockholders' equity on our balance sheet and the value of the equity component would be treated as original issue discount for purposes of accounting for the debt component of our convertible notes. Higher interest expense would result by recognizing accretion of the discounted carrying value of our convertible notes to their face amount as interest expense over the term of our convertible notes. We believe FASB plans to issue final guidance in the first half of 2008. This Proposed FSP is expected to be effective for fiscal years beginning after December 15, 2008, would not permit early application, and would be applied retrospectively to all periods presented. We are currently evaluating the proposed new rules and cannot quantify the impact at this time. However, if the Proposed FSP is adopted, we expect to have higher interest expense in 2009 due to the interest expense accretion, and prior period interest expense associated with our convertible notes would also reflect higher than previously reported interest expense due to retrospective application.

In addition, for purposes of calculating diluted earnings per share, a convertible debt security providing for net share settlement upon conversion and meeting specified requirements under Emerging Issues Task Force, or EITF, Issue No. 00-19, "Accounting for Derivative Financial Instruments Indexed to, and Potentially Settled in, a Company's Own Stock," is currently accounted for in a manner similar to non-convertible debt, with the stated coupon constituting interest expense and any shares issuable upon conversion of the security accounted for under the treasury stock method. The effect of the treasury stock method is that the shares potentially issuable upon conversion of our convertible notes are not included in the calculation of our earnings per share except to the extent that the conversion value of our convertible notes exceeds their principal amount, in which event, for earnings per share purposes, we would account for the transaction as if we had issued the number of shares of our common stock necessary to settle the conversion. The Proposed FSP does not affect the earnings per share accounting for convertible instruments such as our convertible notes.

Our investments in auction rate securities are subject to risks that may cause losses and have a material adverse effect on our liquidity.

As of December 31, 2007, \$82.1 million of our total \$242.9 million in short-term investments were comprised of municipal note investments with an auction reset feature ("auction rate securities"). These notes are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities; they carry a AAA credit rating. \$74.1 million of the \$82.1 million are secured by student loans which are generally 97% guaranteed by the U.S. Government under the Federal Family Education Loan Program (FFELP). In addition to the U.S. Government guarantee on such student loans, some of the securities also have separate insurance policies guaranteeing both the principal and accrued interest. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals up to 35 days. Recently, auctions for some of these auction rate securities have failed and there is no assurance that auctions on the remaining auction rate securities in our investment portfolio will succeed. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. In the event that there is a failed auction the indenture governing the security requires

the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar short-term instruments. The securities for which auctions have failed will continue to accrue interest at the contractual rate and be auctioned every 7, 28, or 35 days until the auction succeeds, the issuer calls the securities, or they mature. As a result, our ability to liquidate and fully recover the carrying value of our auction rate securities in the near term may be limited or not exist. All of these investments are currently classified as short-term investments. If the credit ratings of the security issuers deteriorate or if normal market conditions do not return in the near future, we may be required to reduce the value of these securities through an impairment charge against net income and reflect them as long-term investments on our balance sheet for the period ending March 31, 2008 or thereafter.

As of February 29, 2008, the Company held \$75.6 million of auction rate securities. \$71.1 million of these securities are secured by student loans which are generally 97% guaranteed by the U.S. Government under FFELP.

SPECIAL NOTE REGARDING FORWARD-LOOKING INFORMATION

This report and the documents we incorporate by reference in this report contain forward-looking statements within the meaning of Section 27A of the Securities Act of 1933, as amended (the “Securities Act”), and Section 21E of the Securities Exchange Act of 1934, as amended (the “Exchange Act”). All statements, other than statements of historical facts, that we include in this report and in the documents we incorporate by reference in this report, may be deemed forward-looking statements for purposes of the Securities Act and the Securities Exchange Act. We use the words “anticipate,” “believe,” “could,” “estimate,” “expect,” “intend,” “may,” “plan,” “project,” “should,” “will,” “would” and similar expressions to identify forward-looking statements, although not all forward-looking statements contain these identifying words. We cannot guarantee that we actually will achieve the plans, intentions, or expectations disclosed in our forward-looking statements and, accordingly, you should not place undue reliance on our forward-looking statements. There are a number of important factors that could cause actual results or events to differ materially from the forward-looking statements that we make, including the factors discussed above and also the factors included in the documents we incorporate by reference in this report. We wish to caution readers that these factors, among others, could cause our actual results to differ materially from those expressed in our forward-looking statements. In addition, those factors should be considered in conjunction with any discussion of our results of operations herein or in other period reports, as well as in conjunction with all of our press releases, presentations to securities analysts or investors, or other communications by us. You should not place undue reliance on any forward-looking statements, which reflect management’s analysis, judgment, belief, or expectation only as of the date thereof. Except as may be required by law, we undertake no obligation to publicly update or revise any forward-looking statements to reflect events or circumstances that arise after the date on which the forward-looking statement was made.

Item 1B: *Unresolved Staff Comments*

None.

Item 2: *Properties*

We lease a total of 53 facilities, including our corporate headquarters at 200 Oceangate in Long Beach, California, and 18 of our 19 California medical clinics. We also own a 32,000 square-foot office building in Long Beach, California, and one of our medical clinics in Pomona, California. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3: *Legal Proceedings*

Malpractice Action. On February 1, 2007, a complaint was filed in the Superior Court of the State of California for the County of Riverside by plaintiff Staci Robyn Ward through her guardian ad litem, Case No. 465374. The complaint purports to allege claims for medical malpractice against several unaffiliated physicians, medical groups, and hospitals, including Molina Medical Centers and one of its physician employees. The plaintiff alleges that the defendants failed to properly diagnose her medical condition which resulted in her severe and permanent disability. On July 22, 2007, the plaintiff passed away. The proceeding is in the early stages, and no prediction can be made as to the outcome.

Starko. Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department (“NMHSD”). In February 2001, the plaintiffs named health maintenance organizations participating in the New Mexico Medicaid program as defendants (the “HMOs”), including Cimarron Health Plan, the predecessor of our New Mexico HMO. Plaintiff asserts that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. On July 10, 2007, the court dismissed all damages claims against Molina Healthcare of New Mexico, leaving only a pending action for injunctive and declaratory relief. On August 15, 2007, the court held a hearing on the motion of Molina Healthcare of New Mexico to dismiss the plaintiffs’ claims for injunctive and declaratory relief. At that hearing, the court dismissed all remaining claims against Molina Healthcare of New Mexico. The plaintiffs have filed an appeal with respect to the court’s dismissal orders and have submitted their opening appellate brief. Molina Healthcare of New Mexico is preparing its responsive appellate brief. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to Molina Healthcare of New Mexico, an indemnification escrow account was established and funded with \$6,000,000 in order to indemnify Molina Healthcare of New Mexico against the costs of such litigation and any eventual liability or settlement costs. Currently, approximately \$4,100,000 remains in the indemnification escrow fund.

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

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

None.

Executive Officers of the Registrant

J. Mario Molina, M.D., 49, has served as President and Chief Executive Officer since succeeding his father and company founder, Dr. C. David Molina, in 1996. He has also served as Chairman of the Board since 1996. Prior to that, he served as Medical Director from 1991 through 1994 and was Vice President responsible for provider contracting and relations, member services, marketing and quality assurance from 1994 to 1996. He earned an M.D. from the University of Southern California and performed his medical internship and residency at the Johns Hopkins Hospital. Dr. Molina is the brother of John C. Molina.

John C. Molina, J.D., 43, has served in the role of Chief Financial Officer since 1995. He also has served as a director since 1994. Mr. Molina has been employed by us for over 27 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Mark L. Andrews, Esq., 50, has served as Chief Legal Officer and General Counsel since 1998. He also has served as a member of the Executive Committee of our company since 1998. Before joining our company, Mr. Andrews was a partner at Wilke, Fleury, Hoffelt, Gould & Birney of Sacramento, California, where he chaired that firm’s health care and employment law departments and represented Molina as outside counsel from 1994 through 1997. Mr. Andrews holds a Juris Doctorate degree from Hastings College of the Law.

Terry P. Bayer, 57, has served as our Chief Operating Officer since November 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 2005. Ms. Bayer has 25 years of healthcare management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Voluntary Hospital Association (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master’s degree in Public Health from the University of

California, Berkeley, and a Bachelor's degree in Communications from Northwestern University. Ms. Bayer is a member of the board of directors of Apria Healthcare Group Inc.

James W. Howatt, 61, has served as our Chief Medical Officer since May 2007. Dr. Howatt formerly served as the chief medical officer of Molina Healthcare of Washington. Prior to joining Molina Healthcare in February 2006, Dr. Howatt was Western Regional Medical Director for Humana, where he was responsible for the coordination and oversight of quality, utilization management, credentialing, and accreditation for Humana's activities west of Kansas City. Previously, he was Vice President and CMO of Humana Arizona, where he was responsible for leading a variety of medical management functions and worked closely with the company's sales division to develop customer-focused benefit structures. Dr. Howatt also served as CMO for Humana TRICARE, where he oversaw a \$2.5 billion health care operation that served three million beneficiaries and comprised a professional network of 40,000 providers, 800 institutions, and 13 medical directors. Dr. Howatt received B.S. and M.D. degrees from the University of California, San Francisco, and also holds a Master of Business Administration degree with an emphasis in Health Management from the University of Phoenix. He interned and completed his residency program in family practice at Ventura County Hospital in Ventura, California. Dr. Howatt is a board-certified family physician and a member of the American College of Managed Care Medicine.

PART II

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

Our common stock has been listed on the New York Stock Exchange under the trading symbol “MOH” since July 2003. The high and low sales prices of our common stock for specified periods are set forth below:

Date Range	High	Low
2007		
First Quarter	\$ 34.76	\$ 28.88
Second Quarter	\$ 34.92	\$ 28.72
Third Quarter	\$ 38.41	\$ 28.15
Fourth Quarter	\$ 41.21	\$ 34.01
2006		
First Quarter	\$ 34.60	\$ 23.30
Second Quarter	\$ 39.78	\$ 30.17
Third Quarter	\$ 39.39	\$ 31.10
Fourth Quarter	\$ 41.25	\$ 32.02

As of February 26, 2008, there were approximately 141 holders of record of our common stock.

We did not declare or pay any dividends in 2007, 2006, or 2005. We currently anticipate that we will retain any future earnings for the development and operation of our business. Accordingly, we do not anticipate declaring or paying any cash dividends in the foreseeable future.

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

Securities Authorized for Issuance Under Equity Compensation Plans (as of December 31, 2007)

Plan Category	Number of Securities 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 Securities Remaining Available for Future Issuance Under Equity Compensation Plans (Excluding Securities Reflected in Column (a)) (c)
Equity compensation plans approved by security holders	733,713(1)	\$ 30.45	3,622,689(2)

- (1) Options to purchase shares of our common stock issued under the 2000 Omnibus Stock and Incentive Plan and the 2002 Equity Incentive Plan. Further grants under the 2000 Omnibus Stock and Incentive Plan have been frozen.
- (2) Includes only shares remaining available to issue under the 2002 Equity Incentive Plan (the “2002 Incentive Plan”) and the 2002 Employee Stock Purchase Plan (the “ESPP”). The 2002 Incentive Plan initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares available for issuance under the 2002 Incentive Plan 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 affirmatively acts to nullify the automatic increase. The 400,000 share increase on January 1, 2008 increased the total number of shares available for issuance under the 2002 Incentive Plan to 3,600,000 shares. The ESPP initially allowed for the issuance of 600,000 shares of common stock. Beginning December 31, 2003, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance is reached, shares eligible for issuance under the ESPP

automatically increase by 1% of total outstanding capital stock. Through the automatic increase effective December 31, 2007, the total number of shares reserved for issuance under the ESPP has increased to approximately 2.0 million shares.

STOCK PERFORMANCE GRAPH

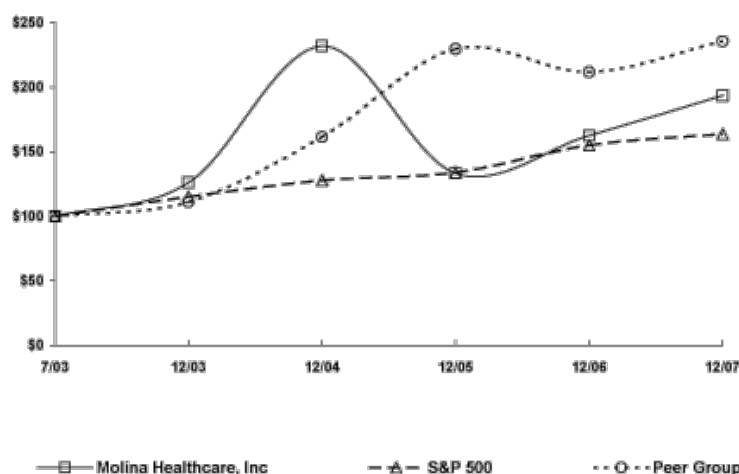
The following discussion shall not be deemed to be “soliciting material” or to be “filed” with the SEC nor shall this information be incorporated by reference into any future filing under the Securities Act or the Exchange Act, except to the extent that the Company specifically incorporates it by reference into a filing.

The following line graph compares the percentage change in the cumulative total return on our common stock against the cumulative total return of the Standard & Poor’s Corporation Composite 500 Index (the “S&P 500”) and a peer group index for the 54-month period from July 2, 2003 (the date of our initial public offering of common stock) to December 31, 2007. The graph assumes an initial investment of \$100 in Molina Healthcare, Inc. common stock and in each of the indices.

The peer group index consists of Amerigroup Corporation (AGP), Centene Corporation (CNC), Coventry Health Care, Inc. (CVH), Health Net, Inc. (HNT), Humana, Inc. (HUM), UnitedHealth Group Incorporated (UNH), and WellPoint, Inc. (WLP).

COMPARISON OF 54 MONTH CUMULATIVE TOTAL RETURN*

Among Molina Healthcare, Inc, The S&P 500 Index
And A Peer Group



* \$100 invested on 7/2/03 in stock or on 6/30/03 in index-including reinvestment of dividends. Fiscal year ending December 31.

Item 6. Selected Financial Data
SELECTED FINANCIAL DATA

We derived the following selected consolidated financial data (other than the data under the caption “Operating Statistics”) for the five years ended December 31, 2007 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. The data under the caption “Operating Statistics” has not been audited.

	Year Ended December 31,				
	2007(1)	2006(2)	2005	2004(3)	2003
Statements of Income Data:					
Revenue:					
Premium revenue	\$ 2,462,369	\$ 1,985,109	\$ 1,639,884	\$ 1,171,038	\$ 791,783
Investment income	30,085	19,886	10,174	4,230	1,761
Total revenue	2,492,454	2,004,995	1,650,058	1,175,268	793,544
Expenses:					
Medical care costs	2,080,083	1,678,652	1,424,872	984,686	657,921
General and administrative expenses	285,295	229,057	163,342	94,150	61,543
Loss contract charge	—	—	939	—	—
Impairment charge on purchased software(4)	782	—	—	—	—
Depreciation and amortization	27,967	21,475	15,125	8,869	6,333
Total expenses	2,394,127	1,929,184	1,604,278	1,087,705	725,797
Operating income	98,327	75,811	45,780	87,563	67,747
Total other income (expense), net	(4,631)	(2,353)	(1,929)	122	(1,334)
Income before income taxes	93,696	73,458	43,851	87,685	66,413
Provision for income taxes	35,366	27,731	16,255	31,912	23,896
Net income	\$ 58,330	\$ 45,727	\$ 27,596	\$ 55,773	\$ 42,517
Net income per share:					
Basic	\$ 2.06	\$ 1.64	\$ 1.00	\$ 2.07	\$ 1.91
Diluted	\$ 2.05	\$ 1.62	\$ 0.98	\$ 2.04	\$ 1.88
Weighted average number of common shares outstanding	28,275,000	27,966,000	27,711,000	26,965,000	22,224,000
Weighted average number of common shares and potential dilutive common shares outstanding	28,419,000	28,164,000	28,023,000	27,342,000	22,629,000
Operating Statistics:					
Medical care ratio(5)	84.5%	84.6%	86.9%	84.1%	83.1%
General and administrative expense ratio(6)	11.5%	11.4%	9.9%	8.0%	7.8%
General and administrative expense ratio, excluding premium taxes	8.2%	8.4%	7.1%	5.9%	6.6%
Members(7)	1,149,000	1,077,000	893,000	788,000	564,000

	As of December 31,				
	2007(1)	2006(2)	2005	2004(3)	2003
Balance Sheet Data:					
Cash and cash equivalents	\$ 459,064	\$ 403,650	\$ 249,203	\$ 228,071	\$ 141,850
Total assets	1,171,305	864,475	659,927	533,859	344,585
Long-term debt (including current maturities)	200,000	45,000	—	1,894	—
Total liabilities	680,827	444,309	297,077	203,237	123,263
Stockholders' equity	490,478	420,166	362,850	330,622	221,322

- (1) The balance sheet and operating results of the MCP (Mercy CarePlus) acquisition have been included since November 1, 2007, the effective date of the acquisition.
- (2) The balance sheet and operating results of the HCLB (Cape Health Plan) acquisition have been included since May 15, 2006, the effective date of the acquisition.
- (3) The balance sheet and operating results of the New Mexico HMO have been included since July 1, 2004, the effective date of the acquisition.
- (4) Amount represents an impairment charge related to commercial software no longer used for operations.
- (5) Medical care ratio represents medical care costs as a percentage of premium revenue. 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 Operation* for further discussion.
- (6) General and administrative expense ratio represents such expenses as a percentage of total revenue.
- (7) Number of members at end of period.

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

The following discussion of our financial condition and results of operations should be read in conjunction with the “Selected Financial Data” and the accompanying consolidated financial statements and the notes to those statements appearing elsewhere in this report. This discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth under Item 1A — Risk Factors, above.

Overview

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, or HMO. Beginning in January 2006, we began to serve a very small number of our dual eligible members under both the Medicaid and the Medicare programs (we served 5,000 Medicare members as of December 31, 2007). We operate our business through health plan subsidiaries in California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. Our financial performance for 2007, 2006 and 2005 is briefly summarized below (dollars in thousands, except per share data):

	Year Ended December 31,		
	2007	2006	2005
Earnings per diluted share	\$ 2.05	\$ 1.62	\$ 0.98
Premium revenue	\$2,462,369	\$1,985,109	\$1,639,884
Operating income	\$ 98,327	\$ 75,811	\$ 45,780
Net income	\$ 58,330	\$ 45,727	\$ 27,596
Medical care ratio	84.5%	84.6%	86.9%
G&A expenses as a percentage of total revenue	11.5%	11.4%	9.9%
Total ending membership	1,149,000	1,077,000	893,000

Revenue

Premium revenue is fixed in advance of the periods covered and is not generally subject to significant accounting estimates. For the year ended December 31, 2007, we received approximately 91.9% 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 for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. The state Medicaid programs periodically adjust premium rates.

The amount of these premiums may vary substantially between states and among various government programs. PMPM premiums for members of the State Children’s Health Insurance Program, or SCHIP, are generally among the Company’s lowest, with rates as low as approximately \$80 PMPM in California and Utah. Premium revenues for Medicaid members are generally higher. Among the Temporary Aid for Needy Families (TANF) Medicaid population — the Medicaid group that includes most mothers and children — PMPM premiums range between approximately \$95 in California to over \$200 in New Mexico and Ohio. Among our Medicaid Aged, Blind or Disabled, or ABD membership, PMPM premiums range from approximately \$370 in California to over \$1,000 in New Mexico and Ohio. Medicare revenue is approximately \$1,200 PMPM. Approximately 3.4% of our premium revenue in the year ended December 31, 2007 was realized under a Medicaid cost-plus reimbursement agreement that our Utah plan has with that state. We also received approximately 4.7% of our premium revenue for the year ended December 31, 2007 in the form of “birth income” — a one-time payment for the delivery of a child — from the Medicaid programs in Michigan, Ohio, Texas, and Washington. Such payments are recognized as revenue in the month the birth occurs. Starting in 2006, our premium revenue also included premiums generated from Medicare, which totaled approximately \$49.3 million for the year ended December 31, 2007. All of our Medicare revenue is paid to us as a fixed PMPM amount.

Certain components of premium revenue are subject to accounting estimates. Chief among these are: 1) that portion of premium revenue paid to our New Mexico health plan by the state of New Mexico that may be refunded to

the state if certain minimum amounts are not expended on defined medical care costs, 2) the additional premium revenue our Utah health plan is entitled to receive from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid, and 3) the profit-sharing agreement between our Texas health plan and the state of Texas, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, according to a tiered rebate schedule.

Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs. During 2007, we recorded adjustments totaling \$6.0 million to reduce premium revenue associated with this requirement. At December 31, 2007, we have recorded a liability of approximately \$12.9 million under our interpretation of the existing terms of this contract provision. Any change to the terms of this provision, including revisions to the definitions of premium revenue or medical care costs, the period of time over which the minimum percentage is measured or the manner of its measurement, or the percentage of revenue required to be spent on the defined medical care costs, may trigger a change in this amount. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to this amount may occur.

The Medicaid contract of our Utah health plan with the state of Utah is paid on a cost plus nine percent basis. In addition, in order to incentivize the plan to save the state money, the contract also entitles the health plan to be paid a percentage of the savings realized as measured against what claims would have been paid on a fee-for-service basis by the state. We had previously estimated the amount that we believe our Utah plan will recover under its savings sharing agreement with the state of Utah. However, as a result of an ongoing disagreement with the state, during 2007 our Utah health plan wrote off the entire receivable, totaling \$4.7 million, \$4.0 million of which was accrued as of December 31, 2006. Nevertheless, our Utah health plan has not waived any of its rights to recovery under the savings sharing provision of the contract, and continues to work with the state in an effort to assure an appropriate determination of amounts due. When additional information is known or agreement is reached with the state regarding the appropriate savings sharing payment amount, we will adjust the amount of savings sharing revenue recorded in our financial statements.

As of December 31, 2007, we have accrued a liability of approximately \$2.3 million pursuant to our profit-sharing agreement with the state of Texas, for the 2006 and 2007 contract years. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimate.

Historically, membership growth has been the primary reason for our increasing revenues, although more recently our revenues have also grown due to the more care intensive benefits associated with our ABD and dual eligible members. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate total number of members by state as of the dates indicated.

	As of December 31,		
	2007	2006	2005
Total Ending Membership by Health Plan:			
California	296,000	300,000	321,000
Michigan	209,000	228,000	144,000
Missouri(1)	68,000	—	—
Nevada(2)	—	—	—
New Mexico	73,000	65,000	60,000
Ohio(3)	136,000	76,000	—
Texas(4)	29,000	19,000	—
Utah	55,000	52,000	59,000
Washington	283,000	281,000	285,000
Subtotal	1,149,000	1,021,000	869,000
Indiana(5)	N/A	56,000	24,000
Total	1,149,000	1,077,000	893,000

	As of December 31,		
	2007	2006	2005
Total Ending Membership by State for our Medicare Advantage Special Needs Plans:			
California	1,115	549	—
Michigan	1,090	152	—
Nevada	520	—	—
Utah	1,860	1,452	—
Washington	507	235	—
Total	<u>5,092</u>	<u>2,388</u>	<u>—</u>
Total Ending Membership by State for our Aged, Blind and Disabled (“ABD”) Population:			
California	11,837	10,717	10,492
Michigan	31,399	33,204	23,101
New Mexico	6,792	6,697	6,665
Ohio(3)	14,887	—	—
Texas(4)	16,018	—	—
Utah	6,795	6,827	7,234
Washington	<u>2,814</u>	<u>2,713</u>	<u>1,864</u>
Total	<u>90,542</u>	<u>60,158</u>	<u>49,356</u>

- (1) Our Missouri health plan was acquired effective November 1, 2007.
- (2) Less than one thousand members. Our Nevada plan serves only Medicare members and commenced operations in June 2007.
- (3) Our Ohio health plan commenced operations in December 2005, serving less than 250 members as of December 31, 2005.
- (4) Our Texas health plan commenced operations in September 2006.
- (5) Our Indiana health plan ceased serving members effective January 1, 2007; it currently has no members.

The following table provides details of member months (defined as the aggregation of each month’s membership for the period) by state for the years ended December 31, 2007, 2006, and 2005:

	2007	2006	2005
Total Member Months by Health Plan:			
California	3,500,000	3,694,000	3,569,000
Michigan	2,597,000	2,365,000	1,811,000
Missouri(1)	136,000	—	—
Nevada(2)	1,000	—	—
New Mexico	803,000	726,000	734,000
Ohio(3)	1,567,000	442,000	—
Texas(4)	335,000	34,000	—
Utah	593,000	689,000	668,000
Washington	<u>3,419,000</u>	<u>3,410,000</u>	<u>3,383,000</u>
Subtotal	12,951,000	11,360,000	10,165,000
Indiana(5)	N/A	499,000	149,000
Total	<u>12,951,000</u>	<u>11,859,000</u>	<u>10,314,000</u>

-
- (1) Our Missouri health plan was acquired effective November 1, 2007.
 - (2) Our Nevada plan serves only Medicare members and commenced operations in June 2007.
 - (3) Our Ohio health plan commenced operations in December 2005, serving less than 250 members as of December 31, 2005.
 - (4) Our Texas health plan commenced operations in September 2006.
 - (5) Our Indiana health plan ceased serving members effective January 1, 2007; it currently has no members.

Expenses

Our operating expenses include expenses related to the provision of medical care services and general and administrative, or G&A, expenses. Our results of operations are impacted by our ability to effectively manage expenses related to health care services and to accurately estimate costs incurred. Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, case rates, and capitation. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.
- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitation basis. Under capitation contracts, we typically pay a fixed PMPM 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. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2007, 2006 and 2005, medically related administrative costs were approximately \$65.4 million, \$52.6 million, and \$44.4 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated (dollars in thousands except PMPM amounts):

	Year Ended December 31,								
	2007			2006			2005		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Medical care costs:									
Fee for service	\$ 1,343,911	\$ 103.77	64.6%	\$ 1,125,031	\$ 94.86	67.0%	\$ 983,608	\$ 95.36	69.0%
Capitation	375,206	28.97	18.0	261,476	22.05	15.6	199,821	19.37	14.0
Pharmacy	270,363	20.88	13.0	209,366	17.65	12.5	176,250	17.09	12.4
Other	90,603	7.00	4.4	82,779	6.98	4.9	65,193	6.32	4.6
Total	<u>\$ 2,080,083</u>	<u>\$ 160.62</u>	<u>100.0%</u>	<u>\$ 1,678,652</u>	<u>\$ 141.54</u>	<u>100.0%</u>	<u>\$ 1,424,872</u>	<u>\$ 138.14</u>	<u>100.0%</u>

Our medical care costs include amounts that have been paid by us through the reporting date as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. See "Critical Accounting Policies" below for a comprehensive discussion of how we estimate such liabilities.

G&A expenses largely consist of wage and benefit costs for our employees, premium taxes, and other administrative expenses. Some G&A services are provided locally, while others are delivered to our health plans from a centralized location. The primary centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally provided functions include member services, plan administration, and provider relations. G&A expenses include premium taxes for each of our health plans in California, Michigan, New Mexico, Ohio, Texas, and Washington.

Results of Operations

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

	Year Ended December 31,		
	2007	2006	2005
Premium revenue	98.8%	99.0%	99.4%
Investment income	1.2	1.0	0.6
Total revenue	<u>100.0%</u>	<u>100.0%</u>	<u>100.0%</u>
Medical care ratio	<u>84.5%</u>	<u>84.6%</u>	<u>86.9%</u>
General and administrative expense ratio, excluding premium taxes	8.2%	8.4%	7.1%
Premium taxes included in general and administrative expenses	3.3	3.0	2.8
Total general and administrative expense ratio	<u>11.5%</u>	<u>11.4%</u>	<u>9.9%</u>
Depreciation and amortization expense ratio	1.1%	1.1%	0.9%
Effective tax rate	37.8%	37.8%	37.1%
Operating income	3.9%	3.8%	2.8%
Net income	2.3%	2.3%	1.7%

Year Ended December 31, 2007 Compared with the Year Ended December 31, 2006

The following table summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2007					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	\$ 378,934	\$ 108.29	\$ 310,226	\$ 88.66	81.9%	\$ 11,338
Indiana	366	—	(3,729)	—	—	—
Michigan	487,032	187.55	409,230	157.59	84.0%	28,493
Missouri	30,730	226.65	26,396	194.69	85.9%	—
Nevada	2,438	1,440.73	2,069	1,222.76	84.9%	—
New Mexico	268,115	333.94	221,567	275.97	82.6%	9,088
Ohio	436,238	278.39	394,451	251.72	90.4%	19,631
Texas	88,453	263.90	68,173	203.40	77.1%	1,598
Utah	116,907	197.19	109,895	185.36	94.0%	—
Washington	652,970	190.96	519,763	152.00	79.6%	10,844
Other	186	—	22,042	—	—	28
	<u>\$2,462,369</u>	\$ 190.13	<u>\$ 2,080,083</u>	\$ 160.62	84.5%	<u>\$ 81,020</u>

	Year Ended December 31, 2006					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	\$ 372,071	\$ 100.74	\$ 328,532	\$ 88.95	88.3%	\$ 11,738
Indiana	82,946	166.29	79,411	159.20	95.7%	—
Michigan	429,835	181.73	335,696	141.93	78.1%	25,982
New Mexico	221,597	305.07	187,460	258.08	84.6%	8,203
Ohio	94,751	214.25	86,249	195.03	91.0%	4,265
Texas	4,508	133.37	4,688	138.70	104.0%	79
Utah	165,507	240.10	151,417	219.66	91.5%	—
Washington	613,750	179.98	484,435	142.06	78.9%	10,506
Other	144	—	20,764	—	—	4
	<u>\$1,985,109</u>	\$ 167.39	<u>\$1,678,652</u>	\$ 141.55	84.6%	<u>\$ 60,777</u>

Net Income

For the year ended December 31, 2007, net income increased to \$58.3 million, or \$2.05 per diluted share, from \$45.7 million, or \$1.62 per diluted share, for the year ended December 31, 2006.

Premium Revenue

For the year ended December 31, 2007, premium revenue was \$2,462.4 million, an increase of \$477.3 million, or 24.0%, over \$1,985.1 million for the year ended December 31, 2006. Medicare premium revenue for 2007 was \$49.3 million compared with \$27.2 million in 2006. Contributing to the \$477.3 million increase in annual premium revenues were the following:

- A \$341.5 million increase at the Ohio health plan principally due to higher enrollment;

- An \$83.9 million increase at the Texas health plan due to higher enrollment. During 2007, the Texas health plan reduced revenue by \$3.1 million to record amounts due back to the state under a profit sharing agreement;
- A \$57.2 million increase at our Michigan health plan principally due to a full year of operations which had included the revenue of the Cape Health Plan, compared to only eight months of operations including Cape Health Plan revenues in 2006 (the acquisition of Cape Health Plan was effective May 1, 2006);
- A \$46.5 million increase at our New Mexico health plan due to higher enrollment and higher premium rates. The New Mexico health plan reduced revenue by \$6.0 million and \$6.9 million in 2007 and 2006, respectively, to meet a contractually required minimum medical care ratio;
- A \$39.2 million increase at our Washington health plan due to higher premium rates and slightly higher membership;
- A \$30.7 million increase as a result of our acquisition of Mercy CarePlus in Missouri effective November 1, 2007; and
- A \$6.9 million increase at our California health plan as increased premium rates offset lower enrollment.

These increases in premium revenues during 2007 were partially offset by:

- An \$82.9 million decrease due to the termination of operations of our Indiana health plan effective January 1, 2007; and
- A \$48.6 million decrease at our Utah health plan due to reduced membership (on a member-month basis), and the write-off of \$4.7 million in savings share receivables.

Investment Income

Investment income for 2007 increased \$10.2 million to \$30.1 million, from \$19.9 million for 2006, as a result of higher invested balances, due in part to the investment of proceeds from our offering of convertible senior notes in the fourth quarter of 2007, and higher investment yields.

Medical Care Costs

Medical care costs as a percentage of premium revenue (the medical care ratio), decreased to 84.5% in the year ended December 31, 2007, from 84.6% in 2006. Contributing to this change were the following:

- The medical care ratio of the California health plan decreased to 81.9% in 2007 from 88.3% in 2006 as a result of the premium increases received during 2007 in San Bernardino/Riverside, San Diego, and Sacramento counties, while PMPM medical costs were essentially flat;
- The medical care ratio of the Michigan health plan increased to 84.0% in 2007 from 78.1% in 2006 due to higher capitation and pharmacy and specialty fee-for-service costs partially offset by lower hospital fee-for-service costs;
- The medical care ratio of the New Mexico health plan decreased to 82.6% in 2007 from 84.6% in 2006. The decrease was the result of higher premium rates and a reduction in the minimum medical care ratio premium adjustment, partially offset by the impact of Medicaid fee schedule increases. Absent the adjustments made to premium revenue in 2007 and 2006, the medical care ratio in New Mexico would have been 80.8% in 2007 and 82.0% in 2006;
- The medical care ratio of the Ohio health plan decreased to 90.4% for 2007 from 91.0% in 2006. The medical care ratio for the Ohio health plan's CFC population decreased to 88.5% in 2007 compared to 91.0% in 2006. During 2007, the Ohio health plan began serving the ABD population for the first time. The medical care ratio for the ABD population for all of 2007 was 94.7%. We expect that the Ohio ABD medical care ratio will decrease in 2008 as a result of the 2.6% rate increase the health plan received under its ABD contract with the state effective January 1, 2008, and the realization of improved utilization as the transition to managed care continues. We estimate that if the 2008 medical care ratio for the CFC population remains at

86.2% for all of 2008, we will need to achieve a medical care ratio of 91.0% for our ABD population to reach our expectation of an 88.0% medical care ratio plan-wide for Ohio. The recent addition of the ABD members (some of whom were not added until late summer of 2007) adds a degree of uncertainty to the medical care cost estimates in Ohio that is not found in our more mature health plans;

- The medical care ratio of the Texas health plan decreased in 2007 primarily due to very low medical costs for the Star Plus membership. As noted above, we recorded a \$3.1 million reduction to revenue in Texas during 2007 to reflect estimated amounts due back to the state under a profit sharing arrangement. We believe that the medical care ratio reported by the Texas health plan in 2007 is not sustainable, and expect the medical care ratio to rise during 2008 to a level consistent with consolidated results;
- The medical care ratio of the Utah health plan increased due to the write-off of \$4.7 million in savings share receivables in the second half of 2007. Medical care costs in Utah decreased on a PMPM basis in 2007 when compared to 2006. Absent the write-off of \$4.7 million in savings share receivable in the second half of 2007 (\$4.0 million of which was accrued as of December 31, 2006), the Utah health plan's medical care ratio would have been 90.4%, an improvement over the 91.5% reported for 2006. Our Utah health plan serves the majority of its membership under a cost-plus contract with the state of Utah;
- The medical care ratio reported at the Washington health plan increased to 79.6% in 2007 from 78.9% in 2006, principally due to higher fee-for-service costs; and
- The termination of our operations in Indiana resulted in a 10 basis-point improvement in our medical care ratio, to 84.5%, in 2007. Absent the impact of the Indiana plan in both years, the medical care ratio in 2007 would have increased 50 basis points to 84.6% from 84.1% in 2006.

General and Administrative Expenses

G&A expenses were \$285.3 million, or 11.5% of total revenue, for the year ended December 31, 2007, compared to \$229.1 million, or 11.4% of total revenue, for 2006. Included in G&A expenses were premium taxes totaling \$81.0 million in 2007 and \$60.8 million in 2006. Premium taxes increased in 2007 due to increased revenues in the states where premium taxes are assessed.

Core G&A expenses (defined as G&A expenses less premium taxes) decreased to 8.2% of total revenue for the year ended December 31, 2007, compared with 8.4% for 2006. Although Core G&A expenses declined slightly in 2007 as a percentage of total revenue, certain categories of expenses increased. These increases included employee incentive compensation, recruitment costs, and our continued investment in the administrative infrastructure necessary to support the Medicare product line. The following table provides details regarding the impact of these increases (dollars in thousands):

	2007		2006	
	Amount	% of Total Revenue	Amount	% of Total Revenue
Medicare-related administrative costs	\$ 9,778	0.4%	\$ 3,237	0.2%
Non Medicare-related administrative costs:				
Employee recruitment expense	2,568	0.1	1,769	0.1
Employee incentive compensation	9,976	0.4	5,102	0.2
All other administrative expense	182,735	7.3	158,172	7.9
Core G&A expenses	<u>\$205,057</u>	<u>8.2%</u>	<u>\$ 168,280</u>	<u>8.4%</u>

Depreciation and Amortization

Depreciation and amortization expense increased \$6.5 million for the year ended December 31, 2007 compared to 2006, primarily due to depreciation expense associated with investments in infrastructure. Of the total increase, amortization expense contributed \$1.3 million, primarily due to the Cape Health Plan acquisition in

Michigan in 2006. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2007	2006
Depreciation expense	\$ 17,118	\$ 11,936
Amortization expense on intangible assets	10,849	9,539
Total depreciation and amortization expense	<u>\$27,967</u>	<u>\$ 21,475</u>

Impairment Charge on Purchased Software

During the second quarter of 2007, we recorded an impairment charge of \$782,000 related to purchased software no longer used for operations. No such charge occurred during the year ended December 31, 2006.

Interest Expense

Interest expense increased to \$4.6 million in 2007 from \$2.4 million in 2006 primarily due to increased borrowings, including the issuance of our convertible senior notes in the fourth quarter of 2007.

Income Taxes

We recognized income tax expense for the year ended December 31, 2007 using an effective tax rate of 37.8%, consistent with the rate used for the year ended December 31, 2006.

Year Ended December 31, 2006 Compared with the Year Ended December 31, 2005

The following summarizes premium revenue, medical care costs, medical care ratio, and premium taxes by health plan for the periods indicated (PMPM amounts are in whole dollars; other dollar amounts are in thousands):

	Year Ended December 31, 2006					
	Premium Revenue		Medical Care Costs		Medical Care	Premium Tax
	Total	PMPM	Total	PMPM	Ratio	Expense
California	\$ 372,071	\$ 100.74	\$ 328,532	\$ 88.95	88.3%	\$ 11,738
Indiana	82,946	166.29	79,411	159.20	95.7%	—
Michigan	429,835	181.73	335,696	141.93	78.1%	25,982
New Mexico	221,597	305.07	187,460	258.08	84.6%	8,203
Ohio	94,751	214.25	86,249	195.03	91.0%	4,265
Texas	4,508	133.37	4,688	138.70	104.0%	79
Utah	165,507	240.10	151,417	219.66	91.5%	—
Washington	613,750	179.98	484,435	142.06	78.9%	10,506
Other	144	—	20,764	—	—	4
	<u>\$1,985,109</u>	\$ 167.39	<u>\$1,678,652</u>	\$ 141.55	84.6%	<u>\$ 60,777</u>

	Year Ended December 31, 2005					
	Premium Revenue		Medical Care Costs		Medical Care Ratio	Premium Tax Expense
	Total	PMPM	Total	PMPM		
California	\$ 340,360	\$ 95.36	\$ 293,485	\$ 82.23	86.2%	\$ 6,401
Indiana	23,373	157.38	23,925	161.09	102.4%	—
Michigan	325,651	179.80	267,111	147.48	82.0%	20,038
New Mexico	241,404	328.84	220,679	300.61	91.4%	9,393
Ohio	38	178.59	66	305.65	171.2%	1
Utah	115,297	172.53	105,298	157.57	91.3%	—
Washington	593,583	175.46	497,853	147.17	83.9%	10,468
Other	178	—	16,455	—	—	—
	<u>\$1,639,884</u>	<u>\$158.99</u>	<u>\$1,424,872</u>	<u>\$ 138.14</u>	<u>86.9%</u>	<u>\$ 46,301</u>

Net Income

For the year ended December 31, 2006, net income increased to \$45.7 million, or \$1.62 per diluted share, from \$27.6 million, or \$0.98 per diluted share, for the year ended December 31, 2005.

Premium Revenue

For the year ended December 31, 2006, premium revenue was \$1,985.1 million, an increase of \$345.2 million, or 21.1%, over \$1,639.9 million for the year ended December 31, 2005. Medicare premium revenue for 2006 was \$27.2 million, with no comparable revenue in 2005. Contributing to the \$345.2 million increase in annual premium revenues were the following:

- A \$114.4 million increase at the Michigan health plan due to the acquisition of Cape Health Plan in Michigan effective May 2006;
- A \$94.8 million increase at the Ohio health plan, which commenced operations in December 2005 with nominal premium revenue in 2005;
- A \$50.2 million increase at the Utah health plan, of which \$20.2 million was attributable to Medicare Advantage revenue;
- A \$31.7 million increase at the California health plan due to increased membership as a result of acquisitions in San Diego county effective June 1, 2005;
- A \$20.2 million increase at the Washington health plan due to improved premium rates; and
- A \$59.6 million increase contributed by the now-terminated Indiana health plan.

These increases in premium revenues during 2006 were partially offset by:

- A \$19.8 million decrease at the New Mexico health plan, which reduced revenue by \$6.9 million in 2006 to meet a contractually required minimum medical care ratio; and
- A \$10.2 million decrease at the Michigan health plan due to a reduction in membership exclusive of the addition of members from the Cape Health Plan acquisition.

Investment Income

Investment income for 2006 was \$19.9 million, compared with \$10.2 million for 2005, an increase of \$9.7 million as a result of higher invested balances and higher investment yields.

Medical Care Costs

Our consolidated medical care ratio decreased to 84.6% in 2006, compared with 86.9% in 2005. Contributing to this change were the following:

- Improved medical care ratios reported in our Michigan (excluding Cape Health Plan), Washington, and New Mexico health plans;
- Partially offsetting the improved medical care ratios in these states was a 207 basis point increase in the medical care ratio in our California health plan in 2006 compared with 2005, due to higher unit costs and limited premium rate increases;
- The Cape Health Plan (acquired effective May 15, 2006) experienced a higher medical care ratio during 2006 than our consolidated average; and
- The medical care ratios for our start-up operations in Ohio, Texas, and Indiana were substantially higher than those experienced by the Company as a whole. Excluding these start-up operations, our medical care ratio decreased 300 basis points to 83.7% for the year ended December 31, 2006 compared with 86.7% in 2005. We believe our medical care cost control initiatives contributed substantially to the year-over-year decrease in our medical care ratio.

General and Administrative Expenses

G&A expenses for 2006 were \$229.1 million compared with \$163.3 million for 2005. G&A expenses as a percentage of total revenue were 11.4% for 2006 compared with 9.9% for 2005. Premium taxes (which are included in G&A) increased to 3.0% of total revenue in 2006 from 2.8% of total revenue in 2005. Increased premium taxes were due to the acquisition of Cape Health Plan in May 2006, the start-up Ohio health plan which commenced operations in December 2005, and the full year effect of premium taxes in California commencing July 1, 2005.

Core G&A increased to 8.4% of total revenue for 2006 from 7.1% of total revenue for 2005. The increase in Core G&A was due to continued investments in infrastructure and workforce to support our medical care cost control initiatives and improve our information technology, the expansion into Ohio and Texas, and the launch of our Medicare Advantage Special Needs Plans. Additionally, effective January 1, 2006, we adopted Statement of Financial Accounting Standards No. 123(R), "Share-Based Payment." This increased our G&A expenses by \$3.2 million, or approximately \$0.07 per diluted share, in 2006.

Depreciation and Amortization

Depreciation and amortization expense for 2006 increased to \$21.5 million from \$15.1 million for 2005. Amortization expense increased \$2.1 million in 2006, primarily due to acquisitions in California and Michigan. Depreciation expense increased \$4.2 million in 2006 due to investments in infrastructure, principally at our corporate offices. The following table presents the components of depreciation and amortization expense (in thousands):

	Year Ended December 31,	
	2006	2005
Depreciation expense	\$ 11,936	\$ 7,695
Amortization expense on intangible assets	9,539	7,430
Total depreciation and amortization expense	<u>\$ 21,475</u>	<u>\$ 15,125</u>

Interest Expense

Interest expense increased to \$2.4 million in 2006 from \$1.5 million in 2005 due to increased borrowings on our credit facility and higher interest rates during 2006.

Other Income (Expense)

No other expense was recorded in 2006. Other expense recorded for the year ended December 31, 2005 of \$0.4 million consisted of a charge for the write-off of costs associated with a registration statement filed during the second quarter of 2005.

Provision for Income Taxes

Income tax expense totaled \$27.7 million in 2006, resulting in an effective tax rate of 37.8%, compared with \$16.3 million in 2005, resulting in an effective tax rate of 37.1%. The increase in our effective tax rate during 2006 was primarily attributable to the accrual of a valuation allowance related to net operating loss carryforwards generated by certain states.

Acquisitions

Effective November 1, 2007, we acquired Mercy CarePlus, a licensed Medicaid managed care plan based in St. Louis, Missouri. The purchase price for the acquisition was \$80.0 million, subject to adjustment based on an analysis after closing of Mercy CarePlus' risk-based capital and incurred but not reported medical costs (IBNR). We also contributed an additional \$7.0 million to the Missouri health plan to fund its statutory net worth requirement. The sellers are entitled to an additional \$5.0 million payment from us in the event the earnings of Mercy CarePlus in the twelve months ending June 30, 2008 are in excess of \$22.0 million. Mercy CarePlus has a contractual agreement to provide healthcare services with the state of Missouri through June 2009 under the state's MC+ Managed Care program. As of December 31, 2007, Mercy CarePlus served approximately 62,000 Medicaid and 6,000 SCHIP members primarily located in the St. Louis metropolitan area.

In May 2006, we acquired HCLB, Inc. ("HCLB"). HCLB is the parent company of Cape Health Plan, Inc. ("Cape"), a Michigan corporation based in Southfield, Michigan. The Cape acquisition has expanded our geographic presence within Michigan. The purchase price was \$44.0 million in cash and the acquisition was deemed effective May 15, 2006 for accounting purposes. Accordingly, the results of operations for Cape are included in the consolidated financial statements for the periods following May 15, 2006. Effective December 31, 2006, we merged Cape into Molina Healthcare of Michigan, Inc., our Michigan health plan.

Liquidity and Capital Resources

We generate cash from premium revenue and investment income. Our primary uses of cash include the payment of expenses related to medical care services and G&A expenses. We generally receive premium revenue in advance of payment of claims for related health care services.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements which prescribe the types of instruments in which our subsidiaries may invest their funds. As of December 31, 2007, a substantial portion of our cash was invested in a portfolio of highly liquid money market securities, and our investments consisted solely of investment-grade debt securities, all of which are classified as current assets. Our investment policies require that all of our investments have final maturities of ten years or less (excluding auction rate securities and variable rate securities, for which interest rates are periodically reset) and that the average maturity be four years or less. Three professional portfolio managers operating under documented investment guidelines manage our investments. The average annualized portfolio yields for the years ended December 31, 2007, 2006, and 2005 were approximately 5.2%, 4.8%, and 3.0%, respectively.

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

Cash provided by operating activities for the year ended December 31, 2007 was \$158.6 million, compared with \$102.3 million for 2006, an increase of \$56.3 million. Cash provided by operating activities described herein does not include the addition of operating assets and liabilities related to our acquisition of Mercy CarePlus, our new Missouri health plan, in 2007. These amounts are reflected in *Net cash paid in purchase transactions* in the accompanying Consolidated Statements of Cash Flows. The 2007 increase in cash provided by operating activities

included the following: 1) increased net income, 2) a nominal change in receivables in 2007, compared with a significant increase in 2006 due to increases of receivables at our Utah, California and Ohio health plans, 3) increased medical claims and benefits payable due to a net increase of \$40.2 million for enrollment growth at our Ohio and Texas health plans, offset by declining enrollment at our Utah health plan, and also offset by a \$21.2 million decrease due to the termination of our Indiana health plan effective December 31, 2006, 4) increased deferred revenue at the Ohio health plan due to the timing of our receipts of premium payments from the state of Ohio, 5) an increase in accounts payable and accrued liabilities due primarily to increases in premium taxes payable, employee incentive compensation accruals and the New Mexico health plan accrual to meet a contractually required minimum medical care ratio, and 6) an increase in income taxes payable due to timing of receipts and payments.

Cash used in investing activities was \$256.3 million for the year ended December 31, 2007, compared with \$3.9 million provided by investing activities for 2006. The primary uses of cash in 2007 were attributable to investment of the proceeds from our issuance of convertible senior notes in the fourth quarter of 2007, and our acquisition of Mercy CarePlus.

Cash provided by financing activities totaled \$153.1 million for the year ended December 31, 2007, compared with \$48.2 million for 2006. The primary source of cash was the receipt of net proceeds from our issuance of convertible senior notes in 2007, offset by the reduction in borrowings and the repayment of amounts owed under our credit facility.

At December 31, 2007, we had working capital of \$407.7 million compared with \$258.6 million at December 31, 2006. At December 31, 2007 and December 31, 2006, cash and cash equivalents were \$459.1 million and \$403.7 million, respectively. At December 31, 2007 and December 31, 2006, investments (all classified as current assets) were \$242.9 million and \$81.5 million, respectively. At December 31, 2007, the parent company (Molina Healthcare, Inc.) had cash and investments of approximately \$98.3 million. We believe that our cash resources and internally generated funds will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Long-Term Debt

Convertible Senior Notes

In October 2007, we completed our offering of \$200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the "Notes"). The sale of the Notes resulted in net proceeds totaling \$193.4 million, from which we repaid the \$20.0 million balance outstanding under our credit facility. In November 2007, we used \$80.0 million of the net proceeds in connection with our acquisition of Mercy CarePlus in Missouri. In December 2007, we used \$41.5 million for contributions to regulatory capital of certain of our health plan subsidiaries, including contributions of \$32.5 million to our Ohio plan, \$7.0 million to our Missouri plan, \$1.5 million to our Texas plan, and \$0.5 million to our Nevada plan. We intend to use the remaining net proceeds of approximately \$52 million to fund future acquisitions and expansion and for general corporate purposes, including working capital. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per \$1,000 principal amount of the Notes. This represents an initial conversion price of approximately \$46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per \$1,000 principal amount of the Notes for each trading day of such period was less than

98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or

- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each \$1,000 principal amount of Notes, as follows:

- An amount in cash (the “principal return”) equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and \$50 (representing 1/20th of \$1,000); and
- A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above \$50.

Credit Facility

In 2005, we entered into an Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the “Credit Facility”). Effective May 2007, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from \$180.0 million to \$200.0 million, maturing in May 2012. The Credit Facility is intended to be used for working capital and general corporate purposes, and subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the amount available under the Credit Facility to up to \$250.0 million.

Borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America’s prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2007, there were no borrowings outstanding under the Credit Facility.

Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our Michigan, New Mexico, Utah, and Washington health plan subsidiaries. The amended Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2007, we were in compliance with all financial covenants in the Credit Facility.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our nine health plan subsidiaries operating in California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are subject to state laws that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and may restrict the timing, payment, and amount of dividends and other distributions that may be paid to Molina Healthcare, Inc. as the sole stockholder of each of our health plans. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans,

advances, or cash dividends totaled \$332.2 million at December 31, 2007, and \$236.8 million at December 31, 2006.

The National Association of Insurance Commissioners, or NAIC, has established model rules which, if adopted by a particular state, set minimum capitalization requirements for health plans and other insurance entities bearing risk for health care coverage. The requirements take the form of risk-based capital, or RBC, rules. These rules, which vary slightly from state to state, have been adopted in Michigan, Nevada, New Mexico, Ohio, Texas, Utah, and Washington. California has not adopted RBC rules and has not given notice of any intention to do so. The RBC rules, if adopted by California, may increase the minimum capital required by that state.

At December 31, 2007, our health plans had aggregate statutory capital and surplus of approximately \$350.9 million, compared to the required minimum aggregate statutory capital and surplus of approximately \$202.5 million. All of our health plans were in compliance with the minimum capital requirements at December 31, 2007. We have the ability and commitment to provide additional working capital to each of our health plans when necessary to ensure that capital and surplus continue to meet regulatory requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements through 2008.

Critical Accounting Policies

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

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates.

The most important element in estimating our medical care costs is our estimate for fee-for-service claims which have been incurred but not paid by us. These fee-for-service costs that have been incurred but have not been paid at the reporting date are collectively referred to as medical costs that are "Incurred But Not Reported," or IBNR. Our IBNR claims reserve, as reported in our balance sheet, represents our best estimate of the total amount of claims we will ultimately pay with respect to claims that we have incurred as of the balance sheet date. We estimate our IBNR monthly using actuarial methods based on a number of factors. Our estimated IBNR liability represented \$264.4 million of our total medical claims and benefits payable of \$311.6 million as of December 31, 2007. Excluding IBNR related to our Utah health plan, where we are reimbursed on a cost-plus basis, our IBNR liability at December 31, 2007 was \$244.9 million.

The factors we consider when estimating our IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. Our assessment of these factors is then translated into an estimate of our IBNR liability at the relevant measuring point through the calculation of a base estimate IBNR, a further reserve for adverse claims development, and an estimate of the administrative costs of settling all claims incurred through the reporting date. The base estimate of IBNR is derived through application of claims payment completion factors and trended per member per month (PMPM) cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based on actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure

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the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date, based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2007 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2007, by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Our Utah health plan is excluded from these calculations, because the majority of the Utah business is conducted under a cost-plus reimbursement contract. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(6)%	\$ 47,818
(4)%	31,879
(2)%	15,939
2%	(15,939)
4%	(31,879)
6%	(47,818)

For the four months of service immediately prior to the reporting date, actual claims paid are not a reliable measure of our ultimate liability, given the inherent delay between the patient/physician encounter and the actual submission of a claim for payment. For these months of service, we estimate our claims liability based on trended PMPM cost estimates. These estimates are designed to reflect recent trends in payments and expense, utilization patterns, authorized services, and other relevant factors. The following table reflects the change in our estimate of claims liability as of December 31, 2007, that would have resulted had we altered our trend factors by the percentages indicated. An increase in the PMPM costs results in an increase in medical claims liabilities. Our Utah HMO is excluded from these calculations, because the majority of the Utah business is conducted under a cost-plus reimbursement contract. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(6)%	\$ (25,564)
(4)%	(17,043)
(2)%	(8,521)
2%	8,521
4%	17,043
6%	25,564

Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNR at December 31, 2007, net income for the year ended December 31, 2007 would increase or decrease by approximately \$5.0 million, or \$0.17 per diluted share, net of tax. Assuming a hypothetical 1% change in PMPM cost estimates from those used in our calculation of IBNR at December 31, 2007, net income for the year ended December 31, 2007 would increase or decrease by approximately \$2.7 million, or \$0.09 per diluted share, net of tax. The corresponding figures for a 5% change in completion factors and PMPM cost estimates would be \$24.8 million, or \$0.87 per diluted share, net of tax, and \$13.3 million, or \$0.47 per diluted share, net of tax, respectively.

It is important to note that any error in the estimate of either completion factors or trended PMPM costs would usually be accompanied by an error in the estimate of the other component, and that an error in one component would almost always compound rather than offset the resulting distortion to net income. When completion factors are *overestimated*, trended PMPM costs tend to be *underestimated*. Both circumstances will create an overstatement of net income. Likewise, when completion factors are *underestimated*, trended PMPM costs tend to be *overestimated*, creating an understatement of net income. In other words, errors in estimates involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities and medical care costs in the same direction. For example, if completion factors were overestimated by 1%, resulting in an overstatement of net

income by approximately \$5 million, it is likely that trended PMPM costs would be underestimated, resulting in an additional overstatement of net income.

After we have established our base IBNR reserve through the application of completion factors and trended PMPM cost estimates, we then compute an additional liability, which also uses actuarial techniques, to account for adverse developments in our claims payments which the base actuarial model is not intended to and does not account for. We refer to this additional liability as the provision for adverse claims development. The provision for adverse claims development is a component of our overall determination of the adequacy of our IBNR. It is intended to capture the adverse development of factors such as the speed of claims payment, the relative magnitude or severity of claims, known outbreaks of disease such as influenza, our entry into new geographical markets, our provision of services to new populations such as the aged, blind and disabled (ABD), changes to state-controlled fee schedules upon which much of our provider payments are based, modifications and upgrades to our claims processing systems and practices, and increasing medical costs. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNR after considering the base actuarial model reserves and the provision for adverse claims development. We also include in our IBNR liability an estimate of the administrative costs of settling all claims incurred through the reporting date. The development of IBNR is a continuous process that we monitor and refine on a monthly basis as additional claims payment information becomes available. As additional information becomes known to us, we adjust our actuarial model accordingly to establish IBNR.

On a monthly basis, we review and update our estimated IBNR liability and the methods used to determine that liability. Any adjustments, if appropriate, are reflected in the period known. While we believe our current estimates are adequate, we have in the past (most recently during the second quarter of 2005) been required to increase significantly our claims reserves for periods previously reported and may be required to do so again in the future. Any significant increases to prior period claims reserves would materially decrease reported earnings for the period in which the adjustment is made.

In our judgment, the estimates for completion factors will likely prove to be more accurate than trended PMPM cost estimates because estimated completion factors are subject to fewer variables in their determination. Specifically, completion factors are developed over long periods of time, and are most likely to be affected by changes in claims receipt and payment experience and by provider billing practices. Trended PMPM cost estimates, while affected by the same factors, will also be influenced by health care service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, outbreaks of disease or increased incidence of illness, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims. As discussed above, however, errors in estimates involving trended PMPM costs will almost always be accompanied by errors in estimates involving completion factors, and vice versa. In such circumstances, errors in estimation involving both completion factors and trended PMPM costs will act to drive estimates of claims liabilities (and therefore medical care costs) in the same direction.

Assuming that base reserves have been adequately set, we believe that amounts ultimately paid out should generally be between 8% and 10% less than the liability recorded at the end of the period as a result of the inclusion in that liability of the allowance for adverse claims development and the accrued cost of settling those claims. However, there can be no assurance that amounts ultimately paid out will not be higher or lower than this 8% to 10% range, as shown by our results in 2007 and 2006 when the amounts ultimately paid out were less than the amount of our established reserves by approximately 19% and 17%, respectively.

As shown in greater detail in the table below, the amounts ultimately paid out on our liabilities recorded at both December 31, 2007 and 2006 were less than what we had expected when we established our reserves. While the specific reasons for the overestimation of our liabilities were different at each of the two reporting dates, in general the overestimations were tied to our assessment of specific circumstances at our various individual health plans which were unique to those reporting periods.

In 2006, overestimation of the claims liability at our Michigan, New Mexico, and Washington health plans at December 31, 2005 led to the recognition of a benefit from prior period claims development, which benefit was partially offset by the underestimation of our claims liability at December 31, 2005 at our California and Indiana health plans.

- In both Michigan and Washington, we overestimated in the second half of 2005 the impact of the upward trend in medical costs observed during the first half of 2005, resulting in an overestimation of the liability of those plans at December 31, 2005.
- In New Mexico, during the second half of the year with respect to medical and drug costs associated with providing care related to behavioral health conditions, we underestimated the impact that the state's assumption of financial responsibility for costs related to the treatment of those behavioral health conditions would have on our claims liability at December 31, 2005, resulting in our overestimating that liability.
- In California, we underestimated costs associated with our members in San Diego County, a market we had first entered only seven months earlier. Additionally, a claims system upgrade during 2005 delayed claims processing and distorted our normal payment pattern for claims. Both of these circumstances led us to underestimate our claim liability at December 31, 2005.
- In Indiana, we underestimated medical costs in a state where we had only begun operations earlier in 2005, leading us to underestimate our claims liability at December 31, 2005.

In 2007, overestimation of the claims liability at our California, New Mexico, and Washington health plans at December 31, 2006, led to the recognition of a benefit from prior period claims development, which benefit was partially offset by the underestimation of our claims liability at December 31, 2006 at our Michigan health plan.

- In California, we underestimated the impact of changes to certain provider contracts implemented during the second half of 2006 which lowered medical costs further than we had anticipated, leading us to overestimate our claims liability at December 31, 2006.
- In Washington, we overestimated the impact of the upward trend in medical costs during the latter half of 2006. Additionally, we lowered claims inventory in December 2006 in anticipation of a claims system upgrade in early 2007. While we attempted to adjust our claims liability estimation procedures for the increased speed of claims payment, we were only partially successful in doing so. Both of these circumstances led us to overestimate our claims liability at December 31, 2006.
- In Michigan, we underestimated the upward trend in medical costs during the latter half of 2006. Additionally, we underestimated the costs associated with the membership we had added as a result of our acquisition of Cape Health Plan in May 2006.

We do not believe that the recognition of a benefit (or detriment) from prior period claims development had a material impact on our consolidated results of operations in either 2007 or 2006.

In estimating our claims liability at December 31, 2007, we adjusted our base calculation to take account of the impact of the following factors which we believe are reasonably likely to change our final claims liability amount:

- The addition during 2007 of a substantial number of aged, blind or disabled (ABD) members to our Ohio health, which members incur higher medical costs than do our members in other categories.
- Our assessment regarding the impact of some overpayments made to certain Ohio providers in 2007 and 2006 and the impact of those overpayments on reported medical cost trends.
- Uncertainties regarding the impact of state-mandated changes to hospital fee schedules implemented in Washington in August 2007.
- Uncertainties regarding the impact of state-mandated changes to the methodology used to pay outpatient claims in Michigan during 2007.

- The addition to our California provider network during 2007 of a hospital that serves high cost patients, as well as changes implemented in September 2007 to our contract with a leading childrens' hospital that provides care to a significant number of our California members.
- The addition in November 2007 of approximately 4,300 members in Sacramento County, California where we have traditionally experienced higher medical costs.
- Changes we made during 2007 to our pharmacy formulary in California in response to competitive pressures.
- Costs associated with our newly acquired membership in Missouri, as well as the impact of any difference between our claims payment policies and those used by the prior management of our Missouri health plan.
- Increases in claims inventory at our California, New Mexico, and Texas health plans during the fourth quarter of 2007.
- Decreases in claims inventory at our Michigan and Washington health plans during the fourth quarter of 2007.

Any absence of adverse claims development (as well as the expensing of the costs to settle claims held at the start of the period through general and administrative expense) will lead to the recognition of a benefit from prior period claims development in the period subsequent to the date of the original estimate. However, that benefit will affect current period earnings only to the extent that the replenishment of the reserve for adverse claims development (and the re-accrual of administrative costs for the settlement of those claims) is less than the benefit recognized from the prior period liability.

We seek to maintain a consistent claims reserving methodology across all periods. Accordingly, any prior period benefit from an unutilized reserve for adverse claims development would likely be offset by the establishment of a new reserve in an approximately equal amount (relative to premium revenue, medical care costs, and medical claims and benefits payable) in the current period, and thus the impact on earnings for the current period would likely be minimal.

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The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2007 and 2006. The negative amounts displayed for “*components of medical care costs related to prior years*” represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The benefit of this prior period development may be offset by the addition of a reserve for adverse claims development when estimating the liability at the end of the period (captured as a “*component of medical care costs related to current year*”). Dollar amounts are in thousands.

	Year Ended December 31,	
	2007	2006
Balances at beginning of period	\$ 290,048	\$ 217,354
Medical claims and benefits payable from business acquired	14,876	21,144
Components of medical care costs related to:		
Current year	2,136,381	1,716,256
Prior years	(56,298)	(37,604)
Total medical care costs	2,080,083	1,678,652
Payments for medical care costs related to:		
Current year	1,851,035	1,443,843
Prior years	222,366	183,259
Total paid	2,073,401	1,627,102
Balances at end of period	\$ 311,606	\$ 290,048
Benefit from prior period as a percentage of premium revenue	2.3%	1.9%
Benefit from prior period as a percentage of balance at beginning of period	19.4%	17.3%
Benefit from prior period as a percentage of total medical care costs	2.7%	2.2%
Days in claims payable	52	57
Number of members at end of period	1,149,000	1,077,000
Number of claims in inventory at end of period(1)	161,395	260,958
Billed charges of claims in inventory at end of period (in thousands)(1)	\$ 211,958	\$ 285,385
Claims in inventory per member at end of period(1)	0.14	0.26

(1) 2006 claims data excludes information for Cape Health Plan membership of approximately 83,000 members. Cape membership was processed on a separate claims platform through September 30, 2007.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2007, our lease obligations for the next five years and thereafter are as follows: \$15.9 million in 2008, \$15.5 million in 2009, \$14.2 million in 2010, \$13.6 million in 2011, \$12.3 million in 2012, and an aggregate of \$49.5 million thereafter.

We are not an obligor to or guarantor of any indebtedness of any other party. We are not a party to off-balance sheet financing arrangements except for operating leases which are disclosed in Note 14 to the accompanying audited consolidated financial statements for the year ended December 31, 2007. We have certain advances to related parties, which are discussed in Note 13 to the accompanying audited consolidated financial statements for the year ended December 31, 2007.

Contractual Obligations

In the table below, we present our contractual obligations as of December 31, 2007. Some of the amounts we have included in this table are based on management's estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	<u>Total</u>	<u>2008</u>	<u>2009-2010</u>	<u>2011-2012</u>	<u>2013 and Beyond</u>
Medical claims and benefits payable	\$ 311,606	\$ 311,606	\$ —	\$ —	\$ —
Long-term debt(1)	200,000	—	—	—	200,000
Operating leases	121,056	15,942	29,658	25,946	49,510
Interest on long-term debt(1)	50,625	7,500	15,000	15,000	13,125
Purchase commitments	23,542	11,290	7,615	3,145	1,492
Total contractual obligations	<u>\$706,829</u>	<u>\$ 346,338</u>	<u>\$ 52,273</u>	<u>\$ 44,091</u>	<u>\$ 264,127</u>

(1) Amounts relate to our October 2007 offering of \$200.0 million aggregate principal amount of 3.75% Convertible Senior Notes due 2014.

In accordance with Financial Accounting Standards Board Interpretation No. 48, *Accounting for Uncertainty in Income Taxes*, we have recorded approximately \$10.3 million of unrecognized tax benefits as liabilities. The above table does not contain this amount because we cannot reasonably estimate when or if such amount may be settled. See Note 11 to the accompanying audited consolidated financial statements for the year ended December 31, 2007 for further information.

Item 7A. Quantitative and Qualitative Disclosures About Market Risk

Quantitative and Qualitative Disclosures About Market Risk

Financial instruments that potentially subject us to concentrations of credit risk consist primarily of cash and cash equivalents, receivables, and restricted investments. We invest a substantial portion of our cash in a portfolio of highly liquid money market securities. Professional portfolio managers operating under documented investment guidelines manage our investments. Restricted investments are invested principally in certificates of deposit and U.S. 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 health plans operate.

As of December 31, 2007, we had cash and cash equivalents of \$459.1 million, investments of \$242.9 million, and restricted investments of \$29.0 million. The cash equivalents consist of highly liquid securities with original or purchase date remaining maturities of up to three months that are readily convertible into known amounts of cash. As of December 31, 2007, our investments consisted solely of investment grade debt securities, all of which were classified as current assets. Our investment policies require that all of our investments have final maturities of ten years or less (excluding auction rate and variable rate securities where interest rates are periodically reset) and that the average maturity be four years or less. The restricted investments consist of interest-bearing deposits and treasury securities required by the respective states in which we operate. Investments and restricted investments are subject to interest rate risk and will decrease in value if market rates increase. All non-restricted investments are reported at fair market value on the balance sheet. All restricted investments are carried at amortized cost, which approximates market value. We have the ability to hold these restricted investments until maturity and, as a result, we would not expect the value of these investments to decline significantly due to a sudden change in market interest rates. Declines in interest rates over time will reduce our investment income.

As of December 31, 2007, \$82.1 million of our total \$242.9 million in short-term investments were comprised of municipal note investments with an auction reset feature ("auction rate securities"). These notes are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities; they carry an AAA credit rating. \$74.1 million of the \$82.1 million are secured by student loans which are

generally 97% guaranteed by the U.S. Government under the Federal Family Education Loan Program (FFELP). In addition to the U.S. Government guarantee on such student loans, some of the securities also have separate insurance policies guaranteeing both the principal and accrued interest. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals up to 35 days. Recently, auctions for some of these auction rate securities have failed and there is no assurance that auctions on the remaining auction rate securities in our investment portfolio will succeed. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. In the event that there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar short-term instruments. The securities for which auctions have failed will continue to accrue interest at the contractual rate and be auctioned every 7, 28, or 35 days until the auction succeeds, the issuer calls the securities, or they mature. As a result, our ability to liquidate and fully recover the carrying value of our auction rate securities in the near term may be limited or not exist. All of these investments are currently classified as short-term investments. If the credit ratings of the security issuers deteriorate or if normal market conditions do not return in the near future, we may be required to reduce the value of these securities through an impairment charge against net income and reflect them as long-term investments on our balance sheet for the period ending March 31, 2008 or thereafter.

As of February 29, 2008, the Company held \$75.6 million of auction rate securities. \$71.1 million of these securities are secured by student loans which are generally 97% guaranteed by the U.S. Government under FFELP.

Inflation

Although the general rate of inflation has remained relatively stable and healthcare cost inflation has stabilized in recent years, the national healthcare cost inflation rate still exceeds the general inflation rate. 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 will mitigate health care cost inflation, 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.

MOLINA HEALTHCARE, INC.

Item 8. *Financial Statements and Supplementary Data*

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REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited the accompanying consolidated balance sheets of Molina Healthcare, Inc. (the Company) as of December 31, 2007 and 2006, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2007. These financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these financial statements based on our audits.

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

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the consolidated financial position of Molina Healthcare, Inc. at December 31, 2007 and 2006, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2007, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 2 to the consolidated financial statements, Molina Healthcare, Inc. changed its method of accounting for Share-Based Payments in accordance with Statement of Financial Accounting Standards No. 123 (revised 2004) on January 1, 2006.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2007, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission and our report dated March 17, 2008 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 17, 2008

MOLINA HEALTHCARE, INC.
CONSOLIDATED BALANCE SHEETS

	December 31,	
	2007	2006
	(Dollars in thousands, except per share data)	
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 459,064	\$ 403,650
Investments	242,855	81,481
Receivables	111,537	110,835
Income tax receivable	—	7,960
Deferred income taxes	8,616	313
Prepaid expenses and other current assets	12,521	9,263
Total current assets	834,593	613,502
Property and equipment, net	49,555	41,903
Intangible assets, net	92,226	85,480
Goodwill	114,997	57,659
Restricted investments	29,019	20,154
Receivable for ceded life and annuity contracts	29,240	32,923
Other assets	21,675	12,854
Total assets	\$1,171,305	\$864,475
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	\$ 311,606	\$ 290,048
Accounts payable and accrued liabilities	69,266	46,725
Deferred revenue	40,104	18,120
Income tax payable	5,946	—
Total current liabilities	426,922	354,893
Long-term debt	200,000	45,000
Liability for ceded life and annuity contracts	29,240	32,923
Deferred income taxes	10,136	6,700
Other long-term liabilities	14,529	4,793
Total liabilities	680,827	444,309
Stockholders' equity:		
Common stock, \$0.001 par value; 80,000,000 shares authorized; issued and outstanding: 28,443,680 shares at December 31, 2007 and 28,119,026 shares at December 31, 2006	28	28
Preferred stock, \$0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Additional paid-in capital	185,808	173,990
Accumulated other comprehensive income (loss)	272	(337)
Retained earnings	324,760	266,875
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	490,478	420,166
Total liabilities and stockholders' equity	\$1,171,305	\$864,475

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF INCOME

	Year Ended December 31,		
	2007	2006	2005
	(Dollars in thousands, except per share data)		
Revenue:			
Premium revenue	\$ 2,462,369	\$ 1,985,109	\$ 1,639,884
Investment income	30,085	19,886	10,174
Total revenue	2,492,454	2,004,995	1,650,058
Expenses:			
Medical care costs	2,080,083	1,678,652	1,424,872
General and administrative expenses	285,295	229,057	163,342
Depreciation and amortization	27,967	21,475	15,125
Impairment charge on purchased software	782	—	—
Loss contract charge	—	—	939
Total expenses	2,394,127	1,929,184	1,604,278
Operating income	98,327	75,811	45,780
Other expense:			
Interest expense	(4,631)	(2,353)	(1,529)
Other, net	—	—	(400)
Total other expense	(4,631)	(2,353)	(1,929)
Income before income taxes	93,696	73,458	43,851
Provision for income taxes	35,366	27,731	16,255
Net income	\$ 58,330	\$ 45,727	\$ 27,596
Net income per share(1):			
Basic	\$ 2.06	\$ 1.64	\$ 1.00
Diluted	\$ 2.05	\$ 1.62	\$ 0.98
Weighted average shares outstanding:			
Basic	28,275,000	27,966,000	27,711,000
Diluted	28,419,000	28,164,000	28,023,000

(1) Potentially dilutive shares issuable pursuant to the Company's 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been antidilutive for the year ended December 31, 2007.

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY

	Common Stock		Additional	Accumulated			
	Outstanding	Amount	Paid-in	Comprehensive	Retained	Treasury	Total
			Capital	Income (Loss)	Earnings	Stock	
	(Dollars in thousands)						
Balance at January 1, 2005	27,602,443	\$ 28	\$ 157,666	\$ (234)	\$ 193,552	\$ (20,390)	\$ 330,622
Comprehensive income:							
Net income	—	—	—	—	27,596	—	27,596
Other comprehensive loss, net of tax:							
Unrealized loss on investments	—	—	—	(395)	—	—	(395)
Total comprehensive income	—	—	—	(395)	27,596	—	27,201
Stock options exercised, employee stock grants and employee stock purchases	189,917	—	3,155	—	—	—	3,155
Tax benefit for exercise of employee stock options	—	—	1,872	—	—	—	1,872
Balance at December 31, 2005	27,792,360	\$ 28	\$ 162,693	\$ (629)	\$ 221,148	\$ (20,390)	\$ 362,850
Comprehensive income:							
Net income	—	—	—	—	45,727	—	45,727
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	292	—	—	292
Total comprehensive income	—	—	—	292	45,727	—	46,019
Stock options exercised, employee stock grants and employee stock purchases	326,666	—	10,070	—	—	—	10,070
Tax benefit for exercise of employee stock options	—	—	1,227	—	—	—	1,227
Balance at December 31, 2006	28,119,026	\$ 28	\$ 173,990	\$ (337)	\$ 266,875	\$ (20,390)	\$ 420,166
Comprehensive income:							
Net income	—	—	—	—	58,330	—	58,330
Other comprehensive income, net of tax:							
Unrealized gain on investments	—	—	—	609	—	—	609
Total comprehensive income	—	—	—	609	58,330	—	58,939
Adjustment to initially apply FIN 48 (see Note 11, "Income Taxes")					(445)		(445)
Stock options exercised, employee stock grants and employee stock purchases	324,654	—	10,965	—	—	—	10,965
Tax benefit for exercise of employee stock options	—	—	853	—	—	—	853
Balance at December 31, 2007	28,443,680	\$ 28	\$ 185,808	\$ 272	\$ 324,760	\$ (20,390)	\$ 490,478

See accompanying notes.

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS

	Year Ended December 31,		
	2007	2006	2005
	(Dollars in thousands)		
Operating activities:			
Net income	\$ 58,330	\$ 45,727	\$ 27,596
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	27,967	21,475	15,125
Amortization of capitalized long-term debt fees	1,042	885	718
Deferred income taxes	(9,057)	(399)	1,705
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	—	—	1,872
Loss on disposal of property and equipment	—	—	297
Stock-based compensation	7,188	5,505	1,283
Changes in operating assets and liabilities, net of effects of acquisitions:			
Receivables	15,007	(38,847)	(5,102)
Prepaid expenses and other current assets	(2,911)	1,369	(1,866)
Medical claims and benefits payable	6,683	51,550	57,144
Deferred revenue	21,984	10,443	803
Accounts payable and accrued liabilities	18,700	5,188	6,665
Income taxes	13,693	(579)	(8,982)
Net cash provided by operating activities	<u>158,626</u>	<u>102,317</u>	<u>97,258</u>
Investing activities:			
Purchases of equipment	(22,299)	(20,297)	(13,960)
Purchases of investments	(264,115)	(148,795)	(63,774)
Sales and maturities of investments	103,718	171,225	48,227
Net cash (paid) acquired in business purchase transactions	(70,172)	5,820	(40,866)
Increase in restricted investments	(8,365)	(912)	(1,706)
Increase in other assets	(4,330)	(3,334)	(983)
Increase in other long-term liabilities	9,290	239	488
Net cash (used in) provided by investing activities	<u>(256,273)</u>	<u>3,946</u>	<u>(72,574)</u>
Financing activities:			
Borrowings under credit facility	—	50,000	3,100
Proceeds from issuance of convertible senior notes	200,000	—	—
Repayments of amounts borrowed under credit facility	(45,000)	(5,000)	(3,100)
Payment of credit facility fees	(551)	(459)	(3,530)
Payment of convertible senior notes fees	(6,498)	—	—
Repayment of mortgage note	—	—	(1,302)
Principal payments on capital lease obligations	—	—	(592)
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	853	1,227	—
Proceeds from exercise of stock options and employee stock plan purchases	4,257	2,416	1,872
Net cash provided by (used in) financing activities	<u>153,061</u>	<u>48,184</u>	<u>(3,552)</u>
Net increase in cash and cash equivalents	55,414	154,447	21,132
Cash and cash equivalents at beginning of year	403,650	249,203	228,071
Cash and cash equivalents at end of year	<u>\$ 459,064</u>	<u>\$ 403,650</u>	<u>\$ 249,203</u>

MOLINA HEALTHCARE, INC.
CONSOLIDATED STATEMENTS OF CASH FLOWS — (Continued)

	Year Ended December 31,		
	2007	2006	2005
	(Dollars in thousands)		
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	\$ 27,734	\$ 27,354	\$ 21,684
Interest	\$ 9,419	\$ 2,260	\$ 1,620
Schedule of non-cash investing and financing activities:			
Change in unrealized gain (loss) on investments	\$ 977	\$ 474	\$ (640)
Deferred income taxes	(368)	(182)	245
Net unrealized gain (loss) on investments	\$ 609	\$ 292	\$ (395)
Accrual of software license fees	\$ —	\$ 2,375	\$ —
Accrual of equipment	\$ 672	\$ 945	\$ —
Impairment charge on purchased software	\$ 782	\$ —	\$ —
Cumulative effect of adoption of Financial Interpretation No. 48, <i>Accounting for Uncertainty in Income Taxes</i>	\$ 445	\$ —	\$ —
Value of stock issued for employee compensation earned in the previous year	\$ —	\$ 2,149	\$ —
Retirement of common stock used for stock-based compensation	\$ (480)	\$ —	\$ —
Details of business purchase transactions:			
Fair value of assets acquired	\$ (106,233)	\$ (86,024)	\$ (43,265)
Less cash acquired	10,843	49,820	2,249
Liabilities assumed	25,218	42,024	150
Net cash (paid) acquired in business purchase transactions	\$ (70,172)	\$ 5,820	\$ (40,866)
Deferred tax asset related to business purchase transactions	\$ 2,747	\$ —	\$ —

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(Dollars in thousands, except per-share data)

1. Basis of Presentation

Organization and Operations

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). Beginning in January 2006, we began to serve a very small number of our dual eligible members under both the Medicaid and the Medicare programs. We operate our business through health plan subsidiaries in California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Utah, and Washington.

Our results of operations include the results of recent acquisitions, including the acquisition of Mercy CarePlus, a Medicaid managed care organization based in St. Louis, Missouri, effective as of November 1, 2007, and the acquisition of Cape Health Plan, Inc. based in Southfield, Michigan, effective as of May 15, 2006.

Our Texas health plan began serving members in September 2006, and our Ohio health plan began serving members in late 2005. Our Indiana health plan ceased serving members effective January 1, 2007 because its Medicaid contract with the State of Indiana expired on December 31, 2006. Our Nevada health plan began serving only Medicare members in June 2007.

Consolidation

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

Use of Estimates

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

2. Significant Accounting Policies

Premium Revenue

Premium revenue is fixed in advance of the periods covered and is not generally subject to significant accounting estimates. For the year ended December 31, 2007, we received approximately 91.9% 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 for which we operate as a subcontractor. These premium revenues are recognized in the month that members are entitled to receive health care services. Premiums collected in advance are deferred. The state Medicaid programs periodically adjust premium rates. The amount of these premiums may vary substantially between states and among various government programs. We received approximately 4.7% of our premium revenue for the year ended December 31, 2007 in the form of "birth income" — a one-time payment for

MOLINA HEALTHCARE, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)**
(Dollars in thousands, except per-share data)

the delivery of a child — from the Medicaid programs in Michigan, Ohio, Texas, and Washington. Such payments are recognized as revenue in the month the birth occurs. Starting in 2006, our premium revenue also included premiums generated from Medicare, which totaled approximately \$49.3 million for the year ended December 31, 2007. All of our Medicare revenue is paid to us as a fixed PMPM amount.

Certain components of premium revenue are subject to accounting estimates. Chief among these are: 1) that portion of premium revenue paid to our New Mexico health plan by the state of New Mexico that may be refunded to the state if certain minimum amounts are not expended on defined medical care costs, 2) the additional premium revenue our Utah health plan is entitled to receive from the state of Utah as an incentive payment for saving the state of Utah money in relation to fee-for-service Medicaid, and 3) the profit-sharing agreement between our Texas health plan and the state of Texas, where we pay a rebate to the state of Texas if our Texas health plan generates pretax income, according to a tiered rebate schedule.

Our contract with the state of New Mexico requires that we spend a minimum percentage of premium revenue on certain explicitly defined medical care costs. During 2007, we recorded adjustments totaling \$6.0 million to reduce premium revenue associated with this requirement. At December 31, 2007, we have recorded a liability of approximately \$12.9 million under our interpretation of the existing terms of this contract provision. Any change to the terms of this provision, including revisions to the definitions of premium revenue or medical care costs, the period of time over which the minimum percentage is measured or the manner of its measurement, or the percentage of revenue required to be spent on the defined medical care costs, may trigger a change in this amount. If the state of New Mexico disagrees with our interpretation of the existing contract terms, an adjustment to this amount may occur.

The Medicaid contract of our Utah health plan with the state of Utah is paid on a cost plus nine percent basis. In addition, in order to incentivize the plan to save the state money, the contract also entitles the health plan to be paid a percentage of the savings realized as measured against what claims would have been paid on a fee-for-service basis by the state. We had previously estimated the amount that we believe our Utah plan will recover under its savings sharing agreement with the state of Utah. However, as a result of an ongoing disagreement with the state, during 2007 our Utah health plan wrote off the entire receivable, totaling \$4.7 million, \$4.0 million of which was accrued as of December 31, 2006. Nevertheless, our Utah health plan has not waived any of its rights to recovery under the savings sharing provision of the contract, and continues to work with the state in an effort to assure an appropriate determination of amounts due. When additional information is known or agreement is reached with the state regarding the appropriate savings sharing payment amount, we will adjust the amount of savings sharing revenue recorded in our financial statements.

As of December 31, 2007, we had accrued a liability of approximately \$2.3 million pursuant to our profit-sharing agreement with the state of Texas, for the 2006 and 2007 contract years. Because the final settlement calculations include a claims run-out period of nearly one year, the amounts recorded, based on our estimates, may be adjusted. We believe that the ultimate settlement will not differ materially from our estimate.

Medical Care Costs

Expenses related to medical care services are captured in the following four categories:

- *Fee-for-service:* Physician providers paid on a fee-for-service basis are paid according to a fee schedule set by the state or by our contracts with these providers. We pay hospitals in a variety of ways, including per diem amounts, diagnostic-related groups or DRGs, percent of billed charges, case rates, and capitation. We also have stop-loss agreements with the hospitals with which we contract. Under all fee-for-service arrangements, we retain the financial responsibility for medical care provided. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. The costs of

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)

drugs administered in a physician or hospital setting that are not billed through our pharmacy benefit managers are included in fee-for-service costs.

- *Capitation:* Many of our primary care physicians and a small portion of our specialists and hospitals are paid on a capitation basis. Under capitation contracts, we typically pay a fixed PMPM 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. Capitation payments are fixed in advance of the periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. The financial risk for pharmacy services for a small portion of our membership is delegated to capitated providers.
- *Pharmacy:* Pharmacy costs include all drug, injectibles, and immunization costs paid through our pharmacy benefit managers. As noted above, drugs and injectibles not paid through our pharmacy benefit managers are included in fee-for-service costs, except in those limited instances where we capitate drug and injectible costs.
- *Other:* Other medical care costs include medically related administrative costs, certain provider incentive costs, reinsurance cost, and other health care expense. Medically related administrative costs include, for example, expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, and a portion of our information technology costs. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2007, 2006, and 2005, medically related administrative costs were approximately \$65.4 million, \$52.6 million, and \$44.4 million, respectively.

The following table provides the details of our consolidated medical care costs for the periods indicated:

	Year Ended December 31,								
	2007			2006			2005		
	Amount	PMPM	% of Total	Amount	PMPM	% of Total	Amount	PMPM	% of Total
Medical care costs:									
Fee for service	\$ 1,343,911	\$ 103.77	64.6%	\$ 1,125,031	\$ 94.86	67.0%	\$ 983,608	\$ 95.36	69.0%
Capitation	375,206	28.97	18.0	261,476	22.05	15.6	199,821	19.37	14.0
Pharmacy	270,363	20.88	13.0	209,366	17.65	12.5	176,250	17.09	12.4
Other	90,603	7.00	4.4	82,779	6.98	4.9	65,193	6.32	4.6
Total	<u>\$ 2,080,083</u>	<u>\$ 160.62</u>	<u>100.0%</u>	<u>\$ 1,678,652</u>	<u>\$ 141.54</u>	<u>100.0%</u>	<u>\$ 1,424,872</u>	<u>\$ 138.14</u>	<u>100.0%</u>

Our medical care costs include amounts that have been paid by us through the reporting date, as well as estimated liabilities for medical care costs incurred but not paid by us as of the reporting date. Such medical care cost liabilities include, among other items, capitation payments owed providers, unpaid pharmacy invoices, and various medically related administrative costs that have been incurred but not paid. We use judgment to determine the appropriate assumptions for determining the required estimates. See Note 9, "Medical Claims and Benefits Payable."

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

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)

Taxes Based on Premiums

Our California (beginning July 1, 2005), Michigan, New Mexico, Ohio, Texas and Washington health plans are assessed a tax based on premium revenue collected. We report these taxes on a gross basis, included in general and administrative expenses. Premium tax expense totaled \$81,020, \$60,777, and \$46,301 in 2007, 2006, and 2005, respectively.

Delegated Provider Insolvency

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

In certain instances, we have required providers to place funds on deposit with us as protection against their potential insolvency. These reserves are frequently in the form of segregated funds received from the provider and held by us or placed in a third-party financial institution. These funds may be used to pay claims that are the financial responsibility of the provider in the event the provider is unable to meet these obligations. Additionally, we have recorded liabilities for estimated losses arising from provider instability or insolvency in excess of provider funds on deposit with us. Such liabilities were not material at December 31, 2007 or 2006.

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.

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 No. (SFAS) 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. All unrealized losses at December 31, 2007 and 2006 were deemed to be temporary as all such losses were the result of increases in interest rates rather than a change in the credit quality of the investments. No losses will be realized if we hold these investments to maturity. The cost of securities sold is determined using the specific-identification method, on an amortized cost basis. 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

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)

other comprehensive income (loss). Since these securities may be readily liquidated, they are classified as current assets without regard to the securities' contractual maturity dates. See Note 4, "Investments."

Receivables

Receivables consist primarily of amounts due from the various states in which we operate. All receivables are subject to potential retroactive adjustment. As the amounts of all receivables are readily determinable and our creditors are state governments, our allowance for doubtful accounts is immaterial. Any amounts determined to be uncollectible are charged to expense when such determination is made. See Note 5, "Receivables."

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. Software developed for internal use is capitalized in accordance with the provision of AICPA Statement of Position No. 98-1, *Accounting for the Costs of Computer Software Developed or Obtained for Internal Use*. Furniture and equipment are depreciated using the straight-line method over estimated useful lives ranging from three to seven years. Software is amortized over its estimated useful life of three years. Leasehold improvements are amortized over the term of the lease or five to 10 years, whichever is shorter. Buildings are depreciated over their estimated useful lives of 31.5 years. See Note 6, "Property and Equipment."

Goodwill and Intangible Assets

Goodwill represents the excess of the purchase price over the fair value of net assets acquired. Identifiable intangible assets (consisting principally of purchased contract rights and provider contracts) are amortized on a straight-line basis over the expected period to be benefited (between one and 15 years). See Note 7, "Goodwill and Intangible Assets."

Under SFAS 142, *Goodwill and Other Intangible Assets*, goodwill and indefinite lived assets are no longer amortized, but are subject to impairment tests on an annual basis or more frequently if impairment indicators exist. Under the guidance of SFAS 142, we used a discounted cash flow methodology to assess the fair values of our reporting units at December 31, 2007 and 2006. If book equity values of our reporting units exceed the fair values, we perform a hypothetical purchase price allocation. Impairment is measured by comparing the goodwill derived from the hypothetical purchase price allocation to the carrying value of the goodwill and indefinite lived asset balance. Based on the results of our impairment testing, no adjustments were required for the years ended December 31, 2007, 2006, and 2005.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the undiscounted expected cash flows associated with that asset. In such circumstances the asset is deemed 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. In the second quarter of 2007, we recorded an impairment charge totaling \$782, related to commercial software no longer used in operations. Other than this 2007 charge, we have determined that no long-lived assets were impaired at December 31, 2007 or 2006.

Restricted Investments

Restricted investments, which consist of certificates of deposit and treasury securities, are designated as held-to-maturity and are carried at amortized cost, which approximates market value. The use of these funds is limited to

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)

specific purposes as required by each state, or as protection against the insolvency of capitated providers. See Note 8, “Restricted Investments.”

Receivable / Liability for Ceded Life and Annuity Contracts

We report an acquired 100% ceded reinsurance arrangement related to the December 2005 purchase of Phoenix National Insurance Company by recording a non-current receivable from the reinsurer with a corresponding non-current liability for ceded life and annuity contracts. The name of Phoenix National Insurance Company has been changed to Molina Healthcare Insurance Company.

Other Assets

Other assets include primarily deferred financing costs associated with long-term debt, certain investments held in connection with our employee deferred compensation program, and an investment in a vision services provider (see Note 13, “Related Party Transactions”). A liability approximately equal to the assets held in connection with our deferred employee compensation program is included in long-term liabilities. During 2007, deferred financing costs increased \$6,498 for the deferral of fees paid in connection with the issuance of our convertible senior notes in October 2007. These fees are being amortized on a straight-line basis over the seven-year term of the convertible senior notes.

Income Taxes, including the Recently Adopted Financial Accounting Standard (FIN 48)

We account for income taxes under SFAS 109, *Accounting for Income Taxes*. Deferred tax assets and liabilities are recorded based on temporary differences between the financial statement basis and the tax basis of assets and liabilities using presently enacted tax rates. On January 1, 2007, we adopted the provisions of Financial Accounting Standards Board (FASB) Interpretation No. (FIN) 48, *Accounting for Uncertainty in Income Taxes*, which clarifies the accounting for uncertainty in income taxes recognized in companies’ financial statements in accordance with SFAS 109. FIN 48 prescribes a recognition threshold and measurement attribute for the financial statement recognition and measurement of a tax position taken or expected to be taken in a tax return. The evaluation of a tax position in accordance with FIN 48 is a two-step process. The first step is recognition to determine whether it is more likely than not that a tax position will be sustained upon examination. The second step is measurement whereby a tax position that meets the more-likely-than-not recognition threshold is measured to determine the amount of benefit to recognize in the financial statements. FIN 48 also provides guidance on derecognition of recognized tax benefits, classification, interest and penalties, accounting in interim periods, disclosure and transition.

As a result of the implementation of FIN 48, we recognized a \$445 increase to liabilities for uncertain tax positions, of which the entire increase was accounted for as an adjustment to the beginning balance of retained earnings as of January 1, 2007. Including the cumulative effect increase, at the beginning of 2007, we had \$4,355 of total gross unrecognized tax benefits including \$384 of accrued interest. Of this total, \$1,524 represents the amount of unrecognized tax benefits that, if recognized, would favorably affect the effective income tax rate in any future period. In May 2007, the FASB issued FASB Staff Position No. (FSP) FIN 48-1, *Definition of Settlement in FASB Interpretation No. 48*, which provides guidance on how a company should determine whether a tax position is effectively settled for the purpose of recognizing previously unrecognized tax benefits. We have applied the provisions of FSP FIN 48-1 in our adoption of FIN 48. See Note 11, “Income Taxes.”

Stock-Based Compensation

At December 31, 2007, we had two stock-based employee compensation plans, both of which are described more fully in Note 15, “Stock Plans.” Until December 31, 2005, we accounted for the plans according to Accounting Principles Board Opinion No. (APB) 25, *Accounting for Stock Issued to Employees*, and related interpretations.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)

Under APB 25, compensation cost for stock options was generally recognized as the excess of the market price of the stock over the exercise price of the option awarded on the grant date, if any. This recognition method is also referred to as the intrinsic value method.

In December 2004, the FASB issued SFAS 123 (revised 2004) (SFAS 123(R)), *Share-Based Payment*. SFAS 123(R) is a revision of SFAS 123, *Accounting for Stock Based Compensation*, and supersedes APB 25. SFAS 123(R) eliminates the use of the intrinsic value recognition method, and requires companies to recognize the cost of employee services received in exchange for awards of equity instruments, based on the grant date fair value of those awards. As of January 1, 2006, we adopted SFAS 123(R) using the modified prospective transition method. Under this transition method, there is compensation cost attributable to the unvested portion of option and restricted stock awards granted prior to January 1, 2006. This cost is being recognized in periods subsequent to the adoption date based on the grant date fair values previously determined for pro forma disclosure purposes under SFAS 123, as illustrated in the table below.

We use the Black-Scholes valuation model to determine the fair value of stock option awards; the fair value of restricted stock awards is determined based on the number of shares granted and the quoted price of our common stock on the grant date, which is consistent with our valuation techniques previously used for options in footnote disclosures required under SFAS 123, as amended by SFAS 148, *Accounting for Stock-Based Compensation — Transition and Disclosure*. We estimate the fair value of all share-based awards on the date of grant. Generally, we recognize compensation expense attributable to stock options and restricted stock awards on a straight-line basis over the related vesting periods. We have adopted the alternative transition method of calculating the excess tax benefits available to absorb any tax deficiencies recognized subsequent to the adoption of SFAS 123(R).

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 using the following weighted-average assumptions: a risk-free interest rate of 4.11%; expected stock price volatility of 53.2%; dividend yield of 0% and expected option lives of 60 months.

	Year Ended December 31, 2005
Net income, as reported	\$ 27,596
Reconciling items (net of related tax effects):	
Deduct: Stock-based employee compensation expense determined under the fair-value based method for stock option and employee stock purchase plan awards	(1,048)
Net income, as adjusted	\$ 26,548
Earnings per share:	
Basic — as reported	\$ 1.00
Basic — as adjusted	\$ 0.96
Diluted — as reported	\$ 0.98
Diluted — as adjusted	\$ 0.95

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)

Earnings Per Share

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

	Year Ended December 31,		
	2007	2006	2005
Shares outstanding at the beginning of the year	28,119,000	27,792,000	27,602,000
Weighted-average number of shares issued	156,000	174,000	109,000
Denominator for basic earnings per share	28,275,000	27,966,000	27,711,000
Dilutive effect of employee stock options and stock grants(1)	144,000	198,000	312,000
Denominator for diluted earnings per share(2)	28,419,000	28,164,000	28,023,000

- (1) Options to purchase common shares are included in the calculation of diluted earnings per share when their exercise prices are at or below the average fair value of the common shares for each of the periods presented.
- (2) Potentially dilutive shares issuable pursuant to the Company's 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been antidilutive for the year ended December 31, 2007.

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 Liquid Asset 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 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 ten years and an average duration of four years. Concentration of credit risk with respect to receivables is limited as the payors consist principally of state governments. Restricted investments are invested principally in certificates of deposit and treasury securities.

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, long-term debt and other liabilities. We consider the carrying amounts of current assets and liabilities to approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization. The carrying amounts of other long-term obligations, including borrowings under our Credit Facility, approximated their fair values based on borrowing rates currently available to us for instruments with similar terms and remaining maturities, as of December 31, 2007 and 2006. Based on quoted market prices the fair value of our convertible senior notes, issued in October 2007, was \$225,634 as of December 31, 2007. The carrying amount of the convertible senior notes totaled \$200,000 as of December 31, 2007.

Risks and Uncertainties

Our profitability depends in large part on accurately predicting and effectively managing medical care costs. We continually review our medical costs in light of our underlying claims experience and revised actuarial data. However, several factors could adversely affect medical care costs. These factors, which include changes in health

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
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care practices, inflation, new technologies, major epidemics, natural disasters, and malpractice litigation, are beyond our control and may have an adverse effect on our ability to accurately predict and effectively control medical care costs. Costs in excess of those anticipated could have a material adverse effect on our financial condition, results of operations, or cash flows.

At December 31, 2007, we operated in nine states, in some instances as a direct contractor with the state, and in others as a subcontractor to another health plan holding a direct contract with the state. We are therefore dependent upon a small number of contracts to support our revenue. The loss of any one of those contracts could have a material adverse effect on our financial position, results of operations, or cash flows. Our ability to arrange for the provision of medical services to our members is dependent upon our ability to develop and maintain adequate provider networks. Our inability to develop or maintain such networks might, in certain circumstances, have a material adverse effect on our financial position, results of operations, or cash flows.

Segment Information

We present segment information externally in the same manner used by management to make operating decisions and assess performance. Each of our subsidiaries arranges for the provision of health care services to Medicaid and similar members in return for compensation from state agencies. They share similar characteristics in the membership they serve, the nature of services provided and the method by which medical care is rendered. The subsidiaries are also subject to similar regulatory environment and long-term economic prospects. As such, we have one reportable segment.

Recent Accounting Pronouncements

In September 2006, the FASB issued SFAS 157, *Fair Value Measurements*, which defines fair value, establishes a framework for measuring fair value in U.S. generally accepted accounting principles, and expands disclosures about fair value measurements. SFAS 157 applies under other accounting pronouncements that require or permit fair value measurements, the FASB having previously concluded in those accounting pronouncements that fair value is the relevant measurement attribute. SFAS 157 is effective for financial statements issued for fiscal years beginning after November 15, 2007, and interim periods within those fiscal years. We do not expect the adoption of SFAS 157 in 2008 to have a material impact on our consolidated financial statements.

In February 2007, the FASB issued SFAS 159, *The Fair Value Option for Financial Assets and Financial Liabilities, Including an Amendment of FASB Statement No. 115*, which is effective for fiscal years beginning after November 15, 2007. SFAS 159 permits entities to measure eligible financial assets, financial liabilities and firm commitments at fair value, on an instrument-by-instrument basis, that are otherwise not permitted to be accounted for at fair value under other U.S. generally accepted accounting principles. The fair value measurement election is irrevocable and subsequent changes in fair value must be recorded in earnings. We do not expect the adoption of SFAS 159 in 2008 to have a material impact on our consolidated financial statements.

In December 2007, the FASB issued SFAS 141(R), *Business Combinations* and SFAS 160, *Noncontrolling Interests in Consolidated Financial Statements*. The standards are intended to improve, simplify, and converge internationally the accounting for business combinations and the reporting of noncontrolling (minority) interests in consolidated financial statements. SFAS 141(R) requires the acquiring entity in a business combination to recognize all (and only) the assets acquired and liabilities assumed in the transaction; establishes the acquisition-date fair value as the measurement objective for all assets acquired and liabilities assumed; and requires the acquirer to disclose to investors and other users all of the information they need to evaluate and understand the nature and financial effect of the business combination. SFAS 141(R) is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. SFAS 141(R) applies prospectively to business combinations for which the acquisition date is on or after the beginning of the first annual reporting period beginning on or after December 15, 2008. Earlier adoption is prohibited.

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SFAS 160 is designed to improve the relevance, comparability, and transparency of financial information provided to investors by requiring all entities to report minority interests in subsidiaries in the same way — as equity in the consolidated financial statements. Moreover, SFAS 160 eliminates the diversity that currently exists in accounting for transactions between an entity and minority interests by requiring they be treated as equity transactions. SFAS 160 is effective for fiscal years, and interim periods within those fiscal years, beginning on or after December 15, 2008. Earlier adoption is prohibited. In addition, SFAS 160 shall be applied prospectively as of the beginning of the fiscal year in which it is initially applied, except for the presentation and disclosure requirements. The presentation and disclosure requirements shall be applied retrospectively for all periods presented. We do not have any material outstanding minority interests in one or more subsidiaries and therefore, SFAS 160 is not applicable to the Company at this time.

Other recent accounting pronouncements issued by the FASB (including its Emerging Issues Task Force), the AICPA, and the SEC did not, or are not believed by management to, have a material impact on our present or future consolidated financial statements.

3. Business Purchase Transactions

In accordance with SFAS 141, *Business Combinations*, the purchase price of the acquisition described below was allocated to the fair value of assets acquired and liabilities assumed, including identifiable intangible assets, and the excess of purchase price over the fair value of net assets acquired was recorded as goodwill.

Effective November 1, 2007, we acquired Mercy CarePlus, a licensed Medicaid managed care plan based in St. Louis, Missouri, to expand our market share within our core Medicaid managed care business. The purchase price for the acquisition was \$80,045, subject to adjustment based upon an analysis after closing of Mercy CarePlus' risk-based capital and incurred but not reported medical costs (IBNR). The sellers are entitled to an additional \$5,000 payment from Molina Healthcare in the event the earnings of Mercy CarePlus in the twelve months ending June 30, 2008 are in excess of \$22,000. Mercy CarePlus has a contractual agreement to provide healthcare services with the state of Missouri through June 2009. The acquisition was funded with available cash and proceeds from our issuance of convertible senior notes in October 2007. Based on our preliminary valuation, the fair values of Mercy CarePlus assets acquired and liabilities assumed as of November 1, 2007 were as follows:

Cash	\$ 10,843
Other current assets	16,057
Property and equipment	213
Other non-current assets	874
Goodwill	60,650
Intangible assets	16,626
Total assets acquired	105,263
Current liabilities	(17,564)
Other long-term liabilities	(7,654)
Total liabilities assumed	(25,218)
Net assets acquired	\$ 80,045

Of the \$16,626 of acquired intangible assets, \$354 was assigned to the tradename with a one-year life, \$8,050 was assigned to the member list with a five-year life, \$6,535 was assigned to the provider network with a ten-year life, and \$1,687 was assigned to payor contracts with a fifteen-year life, for a weighted average amortization period of approximately 7.9 years. The acquired goodwill is not subject to amortization.

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The unaudited pro forma financial information presented below assumes that the acquisition of Mercy CarePlus had occurred as of the beginning of each period presented. This pro forma information includes the results of Mercy CarePlus for the period prior to its acquisition, adjusting for interest expense on the portion of the convertible senior notes proceeds used to fund the acquisition, amortization of intangible assets with definite useful lives, and related income tax effects. The pro forma net income for the year ended December 31, 2007 includes a non-recurring charge recorded by Mercy CarePlus prior to the acquisition totaling \$3,840 (\$2,390, net of tax), related primarily to the termination of certain Mercy CarePlus employment agreements as a result of the acquisition. The pro forma financial information is presented for informational purposes only and may not be indicative of the results of operations had Mercy CarePlus been a wholly owned subsidiary during the years ended December 31, 2007 and 2006, nor is it necessarily indicative of future results of operations.

	Year Ended December 31,	
	2007	2006
Pro forma revenues	\$2,636,825	\$2,130,628
Pro forma net income	\$ 62,487	\$ 51,291
Pro forma earnings per share:		
Basic	\$ 2.21	\$ 1.83
Diluted	\$ 2.20	\$ 1.82

Pro forma earnings per share are based on 28.3 million and 28.0 million weighted average shares for the years ended December 31, 2007 and 2006, respectively. Pro forma earnings per share assuming full dilution is based on 28.4 million and 28.2 million weighted average shares for the years ended December 31, 2007 and 2006, respectively.

Effective November 1, 2007 we purchased certain contract rights from another health plan in Sacramento, California for approximately \$970. As a result of this acquisition, we transitioned approximately 4,300 members into our California health plan. The entire purchase price has been recorded as an identifiable intangible asset and is being amortized over a period of fifteen years.

4. Investments

The following tables summarize our investments as of the dates indicated:

	December 31, 2007			
	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
Municipal securities	\$ 114,123	\$ 10	\$ 36	\$ 114,097
U.S. Government agency securities	42,727	162	18	42,871
U.S. Treasury notes	31,563	510	—	32,073
Certificates of deposit	29,136	—	—	29,136
Corporate bonds	24,556	155	33	24,678
	<u>\$242,105</u>	<u>\$ 837</u>	<u>\$ 87</u>	<u>\$242,855</u>

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
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	December 31, 2006			
	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
U.S. Treasury notes	\$ 41,256	\$ 23	\$ 99	\$ 41,167
U.S. Government agency securities	30,118	1	342	29,790
Municipal securities	8,515	—	10	8,505
Corporate bonds	2,020	—	1	2,019
	<u>\$ 81,909</u>	<u>\$ 24</u>	<u>\$ 452</u>	<u>\$ 81,481</u>

The contractual maturities of our investments as of December 31, 2007 are summarized below.

	Amortized Cost	Estimated Fair Value
Due in one year or less	\$ 90,776	\$ 93,802
Due one year through five years	53,027	50,723
Due after five years through ten years	3,402	3,451
Due after ten years	94,900	94,879
	<u>\$ 242,105</u>	<u>\$ 242,855</u>

Gross realized gains and gross realized losses from sales of available-for-sale securities are calculated under the specific identification method and are included in investment income. Total proceeds from sales of available-for-sale securities were \$13,136, \$12,583 and \$4,689 for the years ended December 31, 2007, 2006 and 2005, respectively. Net realized investment losses for the years ended December 31, 2007, 2006 and 2005 were \$78, \$151 and \$220, respectively.

Unrealized gains and losses at December 31, 2007 and 2006 have been determined to be temporary in nature. The change in market value for these securities is the result of declining or rising interest rates rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience gains or losses. In the event that we dispose of these securities before maturity, we expect that realized gains or losses, if any, will be immaterial. The disclosures required under Emerging Issues Task Force No. (EITF) 03-1, *The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments*, have not been included because our unrealized losses are immaterial at December 31, 2007 and 2006.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
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5. Receivables

Accounts receivable by health plan operating subsidiary were as follows:

	December 31,	
	2007	2006
California	\$ 23,046	\$ 32,404
Michigan	6,419	3,392
Missouri	15,986	—
New Mexico	3,887	2,763
Ohio	28,522	11,611
Utah	23,987	46,570
Washington	8,308	7,447
Other	1,382	6,648
Total receivables	\$ 111,537	\$ 110,835

Substantially all receivables due our California and Missouri health plans at December 31, 2007 were collected in January 2008.

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

As of December 31, 2007, the receivable due our Ohio health plan included approximately \$7,400 of accrued delivery payments due from the state of Ohio and approximately \$19,400 due from a capitated provider group. Our agreement with that group calls for us to pay for certain medical services incurred by the group's members, and then to deduct the amount of such payments from the monthly capitation paid to the group. This receivable also includes an estimate of our liability for claims incurred by members of this group for which we have not made payment. The offsetting liability for the amount of this receivable established for claims incurred but not paid is included in "Medical claims and benefits payable" in our Consolidated Balance Sheets. At December 31, 2007, this receivable comprised approximately \$10,700 paid on behalf of the provider group, which will be deducted from capitation payments in the months of January and February 2008. An additional \$8,700 receivable has been recorded to offset amounts included in "Medical claims and benefits payable" in our Consolidated Balance Sheets that are the responsibility of the capitated provider group. Our Ohio health plan has withheld approximately \$9,000 from capitation payments due this provider group and placed the funds in an escrow account. The Ohio health plan is entitled to the escrow amount if the provider is unable to repay amounts owed to us. The escrow amount is included in "Restricted Investments" in our Consolidated Balance Sheets. Monthly gross capitation paid to the provider group is approximately \$8,300.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
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6. Property and Equipment

A summary of property and equipment is as follows:

	December 31,	
	2007	2006
Land	\$ 3,000	\$ 3,000
Building and improvements	21,928	18,665
Furniture, equipment and automobiles	38,439	32,933
Capitalized computer software costs	34,895	20,571
	<u>98,262</u>	<u>75,169</u>
Less: accumulated depreciation and amortization on building and improvements, furniture, equipment and automobiles	(34,071)	(25,670)
Less: accumulated amortization on capitalized computer software costs	<u>(14,636)</u>	<u>(7,596)</u>
	<u>(48,707)</u>	<u>(33,266)</u>
Property and equipment, net	<u>\$49,555</u>	<u>\$ 41,903</u>

Depreciation expense recognized for building and improvements, furniture, equipment and automobiles was \$8,494, \$7,676, and \$5,909 for the years ended December 31, 2007, 2006, and 2005, respectively. Amortization expense recognized for capitalized computer software costs was \$8,624, \$4,260 and \$1,786 for the years ended December 31, 2007, 2006, and 2005, respectively.

7. Goodwill and Intangible Assets

Other intangible assets are amortized over their useful lives ranging from one to 15 years. The weighted average amortization period for contract rights and licenses is approximately 11.7 years, and for provider network is approximately 9.9 years. Amortization expense on intangible assets recognized for the years ended December 31, 2007, 2006, and 2005 was \$10,849, \$9,539, and \$7,430, respectively. We estimate our intangible asset amortization expense will be \$12,766 in 2008, \$11,117 in 2009, \$11,117 in 2010, \$9,880 in 2011, and \$8,012 in 2012. The following table provides details of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
Intangible assets:			
Contract rights and licenses	\$ 114,342	\$ 34,775	\$79,567
Provider network	14,548	1,889	12,659
Balance at December 31, 2007	<u>\$ 128,890</u>	<u>\$ 36,664</u>	<u>\$92,226</u>
Intangible assets:			
Contract rights and licenses	\$ 103,282	\$ 24,748	\$ 78,534
Provider network	8,013	1,067	6,946
Balance at December 31, 2006	<u>\$111,295</u>	<u>\$ 25,815</u>	<u>\$ 85,480</u>

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

Balance as of December 31, 2006	\$ 57,659
Goodwill related to acquisition of Mercy CarePlus	60,085
Adjustment to goodwill, related primarily to the acquisition of Cape Health Plan, Inc.	(2,747)
Balance at December 31, 2007	<u>\$ 114,997</u>

8. Restricted Investments

Pursuant to the regulations governing our subsidiaries, we maintain statutory deposits and deposits required by state Medicaid authorities. Additionally, we maintain restricted investments as protection against the insolvency of capitated providers. The following table presents the balances of restricted investments by health plan, and by our insurance company:

	December 31,	
	2007	2006
California	\$ 524	\$ 301
Florida	307	—
Indiana	500	536
Michigan	1,000	2,000
Missouri	500	—
Nevada	885	—
New Mexico	8,991	8,571
Ohio	9,370	1,742
Texas	1,491	1,559
Utah	575	550
Washington	154	151
Molina Healthcare Insurance Company	4,722	4,744
Total	<u>\$29,019</u>	<u>\$20,154</u>

9. Medical Claims and Benefits Payable

The following table presents the components of the change in our medical claims and benefits payable for the years ended December 31, 2007 and 2006. The negative amounts displayed for “*components of medical care costs related to prior years*” represent the amount by which our original estimate of claims and benefits payable at the beginning of the period exceeded the actual amount of the liability based on information (principally the payment of claims) developed since that liability was first reported. The benefit of this prior period development may be offset

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by the addition of a reserve for adverse claims development when estimating the liability at the end of the period (captured as “components of medical care costs related to current year”).

	Year Ended December 31,	
	2007	2006
Balances at beginning of period	\$ 290,048	\$ 217,354
Medical claims and benefits payable from business acquired	14,876	21,144
Components of medical care costs related to:		
Current year	2,136,381	1,716,256
Prior years	(56,298)	(37,604)
Total medical care costs	2,080,083	1,678,652
Payments for medical care costs related to:		
Current year	1,851,035	1,443,843
Prior years	222,366	183,259
Total paid	2,073,401	1,627,102
Balances at end of period	\$ 311,606	\$ 290,048

	Year Ended December 31,	
	2007	2006
Benefit from prior period as a percentage of premium revenue	2.3%	1.9%
Benefit from prior period as a percentage of balance at beginning of period	19.4%	17.3%
Benefit from prior period as a percentage of total medical care costs	2.7%	2.2%
Days in claims payable	52	57
Number of members at end of period	1,149,000	1,077,000
Number of claims in inventory at end of period(1)	161,395	260,958
Billed charges of claims in inventory at end of period (in thousands)(1)	\$ 211,958	\$ 285,385
Claims in inventory per member at end of period(1)	0.14	0.26

(1) 2006 claims data excludes information for Cape Health Plan membership of approximately 83,000 members. Cape membership was processed on a separate claims platform through September 30, 2007.

10. Long-Term Debt
Convertible Senior Notes

In October 2007, we completed our offering of \$200,000 aggregate principal amount of 3.75% Convertible Senior Notes due 2014 (the “Notes”). The sale of the Notes resulted in net proceeds totaling \$193,400, from which we repaid the \$20,000 balance outstanding under our credit facility. In November 2007, we used \$80,045 of the net proceeds in connection with our acquisition of Mercy CarePlus in Missouri. In December 2007, we used \$41,500 for contributions to regulatory capital of certain of our health plan subsidiaries, including contributions of \$32,500 to our Ohio plan, \$7,000 to our Missouri plan, \$1,500 to our Texas plan, and \$500 to our Nevada plan. The Notes rank equally in right of payment with our existing and future senior indebtedness.

The Notes are convertible into cash and, under certain circumstances, shares of our common stock. The initial conversion rate is 21.3067 shares of our common stock per one thousand dollar principal amount of the Notes. This

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represents an initial conversion price of approximately \$46.93 per share of our common stock. In addition, if certain corporate transactions that constitute a change of control occur prior to maturity, we will increase the conversion rate in certain circumstances. Prior to July 2014, holders may convert their Notes only under the following circumstances:

- During any fiscal quarter after our fiscal quarter ending December 31, 2007, if the closing sale price per share of our common stock, for each of at least 20 trading days during the period of 30 consecutive trading days ending on the last trading day of the previous fiscal quarter, is greater than or equal to 120% of the conversion price per share of our common stock;
- During the five business day period immediately following any five consecutive trading day period in which the trading price per one thousand dollar principal amount of the Notes for each trading day of such period was less than 98% of the product of the closing price per share of our common stock on such day and the conversion rate in effect on such day; or
- Upon the occurrence of specified corporate transactions or other specified events.

On or after July 1, 2014, holders may convert their Notes at any time prior to the close of business on the scheduled trading day immediately preceding the stated maturity date regardless of whether any of the foregoing conditions is satisfied.

We will deliver cash and shares of our common stock, if any, upon conversion of each \$1,000 principal amount of Notes, as follows:

- An amount in cash (the “principal return”) equal to the sum of, for each of the 20 Volume-Weighted Average Price (VWAP) trading days during the conversion period, the lesser of the daily conversion value for such VWAP trading day and fifty dollars (representing 1/20th of one thousand dollars); and

A number of shares based upon, for each of the 20 VWAP trading days during the conversion period, any excess of the daily conversion value above fifty dollars.

Credit Facility

In 2005, we entered into the Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare Inc., certain lenders, and Bank of America N.A., as Administrative Agent (the “Credit Facility”). Effective May 2007, we entered into a third amendment of the Credit Facility that increased the size of the revolving line of credit from \$180,000 to \$200,000, maturing in May 2012. The Credit Facility is intended to be used for working capital and general corporate purposes, and subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the amount available under the Credit Facility to up to \$250,000.

Borrowings under the Credit Facility are based, at our election, on the London Interbank Offered Rate, or LIBOR, or the base rate plus an applicable margin. The base rate equals the higher of Bank of America’s prime rate or 0.500% above the federal funds rate. We also pay a commitment fee on the total unused commitments of the lenders under the Credit Facility. The applicable margins and commitment fee are based on our ratio of consolidated funded debt to consolidated earnings before interest, taxes, depreciation and amortization, or EBITDA. The applicable margins range between 0.750% and 1.750% for LIBOR loans and between 0.000% and 0.750% for base rate loans. The commitment fee ranges between 0.150% and 0.275%. In addition, we are required to pay a fee for each letter of credit issued under the Credit Facility equal to the applicable margin for LIBOR loans and a customary fronting fee. As of December 31, 2007 and 2006, the amounts outstanding under the Credit Facility were zero and \$45,000, respectively.

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Our obligations under the Credit Facility are secured by a lien on substantially all of our assets and by a pledge of the capital stock of our Michigan, New Mexico, Utah, and Washington health plan subsidiaries. The Credit Facility includes usual and customary covenants for credit facilities of this type, including covenants limiting liens, mergers, asset sales, other fundamental changes, debt, acquisitions, dividends and other distributions, capital expenditures, investments, and a fixed charge coverage ratio. The Credit Facility also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.75 to 1.00 at any time. At December 31, 2007, we were in compliance with all financial covenants in the Credit Facility.

11. Income Taxes

The provision for income taxes consisted of the following:

	Year Ended December 31,		
	2007	2006	2005
Current:			
Federal	\$ 36,171	\$ 24,987	\$ 13,906
State	3,073	3,143	879
Total current	39,244	28,130	14,785
Deferred:			
Federal	(3,630)	(471)	1,404
State	(293)	(578)	66
Total deferred	(3,923)	(1,049)	1,470
Change in valuation allowance	45	650	—
Total provision for income taxes	<u>\$35,366</u>	<u>\$ 27,731</u>	<u>\$16,255</u>

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

	Year Ended December 31,		
	2007	2006	2005
Taxes on income at statutory federal tax rate	\$ 32,794	\$ 25,710	\$ 15,348
State income taxes, net of federal benefit	1,954	2,097	614
Other	618	(76)	293
Reported income tax expense	<u>\$35,366</u>	<u>\$ 27,731</u>	<u>\$16,255</u>

Our effective tax rate is based on expected income, statutory tax rates, and tax planning opportunities available to us in the various jurisdictions in which we operate. Significant management estimates and judgments are required in determining our effective tax rate. We are routinely under audit by federal, state, or local authorities regarding the timing and amount of deductions, nexus of income among various tax jurisdictions, and compliance with federal, state, and local tax laws. We have pursued various strategies to reduce our federal, state and local taxes. As a result, we have reduced our state income tax expense due to California Economic Development Tax Credits.

During 2007, 2006, and 2005, excess tax benefits related to stock option exercises were \$853, \$1,227 and \$1,872, respectively. Such benefits were recorded as a reduction of income taxes payable with an increase in additional paid-in capital.

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Deferred tax assets and liabilities are classified as current or non-current according to the classification of the related asset or liability. Significant components of our deferred tax assets and liabilities as of December 31, 2007 and 2006 were as follows:

	December 31,	
	2007	2006
Accrued expenses	\$ 6,335	\$ 1,388
Reserve liabilities	624	425
State taxes	911	1,005
Other accrued medical costs	863	—
Prepaid expenses	(2,783)	(2,396)
Net operating losses	27	27
Other, net	2,641	(130)
Valuation allowance	(2)	(6)
Deferred tax asset, net of valuation allowance — current	<u>8,616</u>	<u>313</u>
Net operating losses	856	819
State taxes	840	437
Depreciation and amortization	(14,453)	(9,656)
Deferred compensation	3,208	2,329
Other accrued medical costs	103	98
Reserve liabilities	885	—
Other, net	(882)	(83)
Valuation allowance	(693)	(644)
Deferred tax liability — long term	<u>(10,136)</u>	<u>(6,700)</u>
Net deferred income tax liabilities	<u>\$ (1,520)</u>	<u>\$ (6,387)</u>

At December 31, 2007, we had federal and state net operating loss carryforwards of \$499 and \$8,343, respectively. The federal net operating losses begin expiring in 2011 and state net operating losses begin expiring in 2025. The utilization of the net operating losses is subject to certain limitations under federal and state law.

We determined that, as of December 31, 2007, \$695 of deferred tax assets did not satisfy the recognition criteria set forth in SFAS 109. Accordingly, a valuation allowance has been recorded for this amount. This valuation allowance primarily relates to the uncertainty of realizing certain state net operating loss carryforwards. In the future, if we determine that the realization of the net operating losses is more likely than not, the reversal of the related valuation allowance will reduce the provision for income taxes.

During 2007, \$6,659 of net deferred tax liabilities were established for certain acquired intangible assets in connection with the purchase of Mercy CarePlus. Under purchase accounting, the intangible assets were recorded at fair market value. For tax purposes, the intangible assets were recorded at carry-over basis. Therefore, the basis difference was recorded as deferred tax liabilities which increased goodwill.

We adopted the provisions of FIN 48 on January 1, 2007. As a result of the implementation we recognized a \$445 increase to liabilities for uncertain tax positions of which the entire increase was accounted for as an adjustment to the beginning balance of retained earnings. Including the cumulative effect increase, at the beginning of 2007, we had \$4,355 of total gross unrecognized tax benefits, including \$384 of accrued interest. Of this total, \$1,524 (net of federal benefit of state issues) represents the amount of unrecognized tax benefits that, if recognized,

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
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would favorably affect the effective income tax rate in any future period. As of December 31, 2007, we had \$10,278 of total gross unrecognized tax benefits of which \$758 represents the amount of unrecognized tax benefits that, if recognized, could favorably affect the effective income tax rate in any future period. We anticipate a decrease of \$395 to our liability for unrecognized tax benefits within the next twelve-month period.

Our continuing practice is to recognize interest and/or penalties related to income tax matters in income tax expense. As of December 31, 2007 and January 1, 2007, we had accrued cumulative \$638 and \$384, respectively, for the payment of interest and penalties.

A reconciliation of the beginning and ending balances of the total amounts of gross unrecognized tax benefits is as follows:

Gross unrecognized tax benefits at January 1, 2007	\$ 4,355
Increases in tax positions for prior years	3,197
Decreases in tax positions for prior years	(1,527)
Increases in tax positions for current year	4,935
Decreases in tax positions for current year	—
Settlements	(202)
Lapse in statute of limitations	(480)
Gross unrecognized tax benefits at December 31, 2007	<u>\$ 10,278</u>

We are subject to taxation in the United States and various states. With certain exceptions, we are no longer subject to U.S. federal tax examination for tax years before 2004 and state as well as local income tax examination for tax years before 2003.

12. Employee Benefits

We sponsor a defined contribution 401(k) plan that covers substantially all full-time salaried and hourly employees of our company and its subsidiaries. Eligible employees are permitted to contribute up to the maximum amount 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 \$3,553, \$2,540 and \$1,633 in the years ended December 31, 2007, 2006, and 2005, respectively.

We also have a nonqualified deferred compensation plan for certain key employees. Under this plan, eligible participants can defer up to 100% of their base salary and 100% of their bonus to provide tax-deferred growth for retirement. The funds deferred are invested in various mutual funds, through a rabbi trust.

13. Related Party Transactions

We lease two medical clinics from the Molina Family Trust, which each have five five-year renewal options. Rental expense for these leases totaled \$97, \$97, and \$96 for the years ended December 31, 2007, 2006, and 2005, respectively. At December 31, 2007, minimum future lease payments for the clinics consisted of the following:

Year ending December 31,	
2008	\$ 107
2009	107
2010	26
Total minimum lease payments	<u>\$ 240</u>

MOLINA HEALTHCARE, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)**
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We have an equity investment in a medical service provider that provides certain vision services to our members. We account for this investment under the equity method of accounting because we have an ownership interest in the investee in excess of 20%. As of December 31, 2007 and 2006, our carrying amount for this investment totaled \$3,460 and \$1,375, respectively. During the third quarter of 2007, we invested an additional \$2,100 in this medical service provider. Effective July 1, 2007 we paid this provider a \$900 network access fee, which is being amortized over twelve months. For the years ended December 31, 2007, 2006, and 2005, we paid \$10,894, \$7,862 and \$3,440, respectively, for medical service fees to this provider.

In 2006, we assumed an office lease from Millworks Capital Ventures with a remaining term of 52 months. Millworks Capital Ventures is owned by John C. Molina, our Chief Financial Officer, and his wife. The monthly base lease payment is approximately \$18 and is subject to an annual increase. Based on a market report prepared by an independent realtor, we believe the terms and conditions of the assumed lease are at fair market value. We are currently using the office space under the lease for an office expansion. Payments made under this lease totaled \$246 and \$170 for the years ended December 31, 2007 and 2006, respectively.

We are a party to a fee for service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, our Executive Vice President, Research and Development. Amounts paid under the terms of that agreement were \$157 and \$357 for the years ended December 31, 2007 and 2006, respectively. We believe that the claims submitted to us by Pacific Hospital were reimbursed at prevailing market rates. In 2006, we entered into an additional agreement with Pacific Hospital as part of a capitation arrangement. Under this arrangement, we pay Pacific Hospital a fixed monthly fee based on member type. For the years ended December 31, 2007 and 2006, we paid approximately \$4,837 and \$1,652, respectively, to Pacific Hospital for capitation services. We believe that this agreement with Pacific Hospital is based on prevailing market rates for similar services. Also as of December 31, 2007, we had an advance outstanding to this provider totaling \$250, which will be offset to capitation payments in 2008.

14. Commitments and Contingencies***Leases***

We lease office space, clinics, equipment, and automobiles under agreements that expire at various dates through 2018. Future minimum lease payments by year and in the aggregate under all non-cancelable operating leases, including those payments described in Note 13, "Related Party Transactions," consist of the following approximate amounts:

Year ending December 31,

2008	\$ 15,942
2009	15,465
2010	14,193
2011	13,660
2012	12,286
Thereafter	49,510
Total minimum lease payments	<u>\$ 121,056</u>

Rental expense related to these leases totaled \$18,127, \$12,193 and \$9,505 for the years ended December 31, 2007, 2006, and 2005, respectively.

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Employment Agreements

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

In most cases, if termination occurs within two years following a Change of Control, the employee will receive two times their base salary 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.

Legal Proceedings

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

Malpractice Action. On February 1, 2007, a complaint was filed in the Superior Court of the State of California for the County of Riverside by plaintiff Staci Robyn Ward through her guardian ad litem, Case No. 465374. The complaint purports to allege claims for medical malpractice against several unaffiliated physicians, medical groups, and hospitals, including Molina Medical Centers and one of its physician employees. The plaintiff alleges that the defendants failed to properly diagnose her medical condition which has resulted in her severe and permanent disability. On July 22, 2007, the plaintiff passed away. The proceeding is in the early stages, and no prediction can be made as to the outcome.

Starko. Our New Mexico HMO is named as a defendant in a class action lawsuit brought by New Mexico pharmacies and pharmacists, Starko, Inc., et al. v. NMHSD, et al., No. CV-97-06599, Second Judicial District Court, State of New Mexico. The lawsuit was originally filed in August 1997 against the New Mexico Human Services Department ("NMHSD"). In February 2001, the plaintiffs named health maintenance organizations participating in the New Mexico Medicaid program as defendants (the "HMOs"), including Cimarron Health Plan, the predecessor of our New Mexico HMO. Plaintiff asserts that NMHSD and the HMOs failed to pay pharmacy dispensing fees under an alleged New Mexico statutory mandate. Discovery is currently underway. It is not currently possible to assess the amount or range of potential loss or probability of a favorable or unfavorable outcome. On July 10, 2007, the court dismissed all damages claims against Molina Healthcare of New Mexico, leaving only a pending action for injunctive and declaratory relief. On August 15, 2007, the court held a hearing on the motion of Molina Healthcare of New Mexico to dismiss the plaintiffs' claims for injunctive and declaratory relief. At that hearing, the court dismissed all remaining claims against Molina Healthcare of New Mexico. The plaintiffs have filed an appeal with respect to the court's dismissal orders and have submitted their opening appellate brief. Molina Healthcare of New Mexico is preparing its responsive appellate brief. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to the Molina Healthcare of New Mexico HMO, an indemnification escrow account was established and funded with \$6,000 in order to indemnify our Molina

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
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Healthcare of New Mexico HMO against the costs of such litigation and any eventual liability or settlement costs. Currently, approximately \$4,100 remains in the indemnification escrow fund.

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

Professional Liability Insurance

We carry medical malpractice insurance for health care services rendered through our clinics in California. Claims-made coverage under this policy is \$1,000 per occurrence with an annual aggregate limit of \$3,000 for each of the years ended December 31, 2007 and 2006. We also carry claims-made managed care errors and omissions professional liability insurance for our HMO operations. This insurance is subject to a coverage limit of \$10,000 per occurrence and \$10,000 in the aggregate for each policy year.

Provider Claims

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

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

Subscriber Group Claims

The United States Office of Personnel Management (OPM) contacted our New Mexico HMO in June 2005 seeking repayment of approximately \$3,800 in premiums paid by OPM on behalf of Federal employees for the years 1999, 2000, and 2002, plus approximately \$500 in interest. OPM asserted that, during the years in question, it did not receive rate discounts equivalent to the largest discount given by the New Mexico HMO for Similar Sized Subscriber Groups as required by the New Mexico HMO's agreement with OPM. In consultation with its external actuaries, our New Mexico HMO responded to OPM asserting that, based upon its analysis, no funds were owed to OPM. Following further discussions of the parties regarding the three plan years at issue, the parties agreed that our New Mexico HMO owed OPM only \$340 for the plan year of 2002, plus \$69 in accrued interest. The parties agreed that no amounts were owed for the plan years of 1999 or 2000. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to our New Mexico HMO, an indemnification escrow account was established and funded with \$6 million to indemnify our New Mexico HMO against the costs of such liabilities. The escrow account paid the full \$409 amount due to OPM on February 26, 2007.

Regulatory Capital and Dividend Restrictions

Our principal operations are conducted through our health plan subsidiaries operating in California, Michigan, Missouri, Nevada, New Mexico, Ohio, Texas, Washington and Utah. Our health plans are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the

MOLINA HEALTHCARE, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)**
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financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations) which may not be transferable to us in the form of loans, advances or cash dividends was \$332,209 at December 31, 2007, and \$236,800 at December 31, 2006. The National Association of Insurance Commissioners, or NAIC, adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital (RBC) rules. Michigan, Nevada, New Mexico, Ohio, Texas, Washington, and Utah have adopted these rules, which may vary from state to state. California has not yet adopted NAIC risk-based capital requirements for HMOs and has not formally given notice of its intention to do so. Such requirements, if adopted by California, may increase the minimum capital required for that state.

As of December 31, 2007, our health plans had aggregate statutory capital and surplus of approximately \$350,870, compared with the required minimum aggregate statutory capital and surplus of approximately \$202,484. All of our HMOs were in compliance with the minimum capital requirements at December 31, 2007. We have the ability and commitment to provide additional capital to each of our health plans when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

15. Stock Plans

In 2002, we adopted the 2002 Equity Incentive Plan (2002 Incentive 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 Incentive Plan became effective upon our initial public offering of common stock (IPO) in July 2003, and initially allowed for the issuance of 1.6 million shares of common stock. Beginning January 1, 2004, shares eligible for issuance 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 affirmatively acts to nullify the automatic increase. There were 3.6 million shares available for issuance under the 2002 Incentive Plan as of January 1, 2008.

Stock option awards have an exercise price equal to the fair market value of our common stock on the date of grant, generally vest in equal annual installments over periods up to four years from the date of grant, and have a maximum term of ten years from the date of grant. Restricted stock awards are granted with a fair value equal to the market price of our common stock on the date of grant, and generally vest in equal annual installments over periods up to five years from the date of grant.

In July 2002, we adopted the 2002 Employee Stock Purchase Plan (ESPP). The ESPP became effective upon our IPO in July 2003. During each six-month offering period, eligible employees may purchase common shares at 85% of the lower of the fair market value of our common stock on either the first or last trading day of the offering period. Each participant is limited to a maximum purchase of \$25 (as measured by the fair value of the stock acquired) per year through payroll deductions. Under the ESPP, we issued 48,000 and 44,400 shares of our common stock during the years ended December 31, 2007 and 2006, respectively. Beginning January 1, 2004, and each year until the 2.2 million maximum aggregate number of shares reserved for issuance is reached, shares eligible for issuance under the ESPP automatically increase by 1% of total outstanding capital stock. The number of unissued common shares reserved for future grants under the 2002 Plan and the ESPP was 3.6 million and 3.4 million as of December 31, 2007 and 2006, respectively.

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The following table illustrates the components of our stock-based compensation expense as reported in general and administrative expenses in the Consolidated Statements of Income:

	Year Ended December 31,					
	2007		2006		2005	
	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount	Pretax Charges	Net-of-Tax Amount
Stock options and ESPP	\$ 3,437	\$ 2,139	\$ 3,248	\$ 2,020	\$ —	\$ —
Stock grants	3,751	2,335	2,257	1,404	1,283	795
Total	\$7,188	\$ 4,474	\$5,505	\$ 3,424	\$1,283	\$ 795

As of December 31, 2007, there was \$3,973 of unrecognized compensation expense related to non-vested stock options, which we expect to recognize over a weighted-average period of 2.3 years. Also as of December 31, 2007, there was \$7,868 of unrecognized compensation cost related to non-vested restricted stock awards, which we expect to recognize over a weighted-average period of 3.0 years.

The Black-Scholes valuation model was used to estimate the fair value of the options at grant date based on the assumptions noted in the following table. The risk-free interest rate is based on the implied yield currently available on U.S. Treasury zero coupon issues. The expected volatility is primarily based on historical volatility levels along with the implied volatility of exchange-traded options to purchase our common stock. The expected option life of each award granted was calculated using the “simplified method” in accordance with SAB 107. There were no material changes made to the methodology used to determine the assumptions during 2007. The assumptions disclosed below represent a weighted-average of the assumptions used for all of our stock option grants throughout the year.

	Year Ended December 31,		
	2007	2006	2005
Risk-free interest rate	4.5%	4.5%	4.1%
Expected volatility	47.1%	53.1%	53.2%
Expected option life (in years)	6	6	5
Expected dividend yield	0%	0%	0%
Grant date weighted-average fair value	\$16.37	\$16.01	\$21.45

Stock option activity for the year ended December 31, 2007 was as follows:

	Number of Options	Weighted- Average Exercise Price	Weighted- Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Stock options outstanding at December 31, 2006	789,965	\$ 25.78		
Granted	279,100	\$ 32.02		
Exercised	(212,364)	\$ 14.17		
Forfeited	(122,988)	\$ 32.09		
Stock options outstanding at December 31, 2007	733,713	\$ 30.45	7.80	\$ 6,471
Stock options exercisable and expected to vest at December 31, 2007(a)	602,479	\$ 30.23	7.60	\$ 5,483
Stock options exercisable at December 31, 2007	312,079	\$ 29.04	6.53	\$ 3,308

- (a) Stock options exercisable and expected to vest at December 31, 2007 information is based on a forfeiture rate of 14.24%, the rate used to estimate the fair value of stock options granted in the fourth quarter of 2007.

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The following is a summary of information about stock options outstanding and options exercisable at December 31, 2007:

Range of Exercise Prices	Options Outstanding			Options Exercisable	
	Number Outstanding at December 31, 2007	Weighted-Average Remaining Contractual Life (Years)	Weighted-Average Exercise Price	Number Exercisable at December 31, 2007	Weighted-Average Exercise Price
\$ 4.50 - \$27.49	171,170	5.97	\$ 23.21	165,602	\$ 23.11
\$28.66 - \$28.66	207,069	8.09	\$ 28.66	65,631	\$ 28.66
\$29.17 - \$30.85	12,700	8.26	\$ 30.12	3,782	\$ 29.73
\$31.32 - \$48.35	342,774	8.52	\$ 35.17	77,064	\$ 42.08
	<u>733,713</u>	<u>7.80</u>	<u>\$ 30.45</u>	<u>312,079</u>	<u>\$ 29.04</u>

The total intrinsic value of stock options exercised during the years ended December 31, 2007, 2006, and 2005 amounted to \$4,251, \$3,812, and \$6,182, respectively.

Non-vested restricted stock activity for the year ended December 31, 2007 is summarized below.

	Shares	Weighted-Average Grant Date Fair Value
Non-vested balance as of December 31, 2006	101,758	\$ 39.10
Granted	256,750	\$ 32.46
Vested	(78,705)	\$ 35.72
Forfeited	(44,390)	\$ 33.00
Non-vested balance as of December 31, 2007	<u>235,413</u>	<u>\$ 34.14</u>

The total fair value of restricted shares vested during the years ended December 31, 2007, 2006, and 2005 was \$2,612, \$1,993, and \$723, respectively.

16. Stockholders' Equity

As described in Note 15, "Stock Plans," we award shares of restricted stock to employees and others under our equity incentive plan. When these shares vest, employees may choose to settle their associated tax obligation by instructing the Company to withhold the number of shares that will settle the tax obligation based on the current market value of the stock. When we settle tax obligations associated with the vesting of restricted stock awards, we retire the stock used. During 2007, we retired 14,391 shares of common stock, totaling \$480.

In November 2005, we filed a shelf registration statement on Form S-3 with the Securities and Exchange Commission covering the issuance of up to \$300,000 of securities, including common stock or debt securities. In October 2007, we issued \$200,000 in convertible senior notes under this shelf registration statement. See Note 10, "Long-Term Debt." We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

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NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
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17. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2007 and 2006.

	For the Quarter Ended			
	March 31, 2007	June 30, 2007	September 30, 2007	December 31, 2007
Premium revenue	\$556,235	\$607,127	\$ 628,402	\$ 670,605
Operating income	16,595	22,284	28,815	30,633
Income before income taxes	15,470	21,559	28,285	28,382
Net income	9,592	13,314	17,513	17,911
Net income per share(1):				
Basic	\$ 0.34	\$ 0.47	\$ 0.62	\$ 0.63
Diluted	\$ 0.34	\$ 0.47	\$ 0.62	\$ 0.63

	For the Quarter Ended			
	March 31, 2006	June 30, 2006	September 30, 2006	December 31, 2006
Premium revenue	\$449,294	\$479,823	\$ 512,080	\$ 543,912
Operating income	14,154	21,741	20,458	19,458
Income before income taxes	13,740	21,164	19,813	18,741
Net income	8,590	13,152	12,341	11,644
Net income per share:				
Basic	\$ 0.31	\$ 0.47	\$ 0.44	\$ 0.41
Diluted	\$ 0.31	\$ 0.47	\$ 0.44	\$ 0.41

- (1) Potentially dilutive shares issuable pursuant to the Company's 2007 offering of convertible senior notes were not included in the computation of diluted net income per share because to do so would have been antidilutive for the year ended December 31, 2007.

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18. Condensed Financial Information of Registrant

Following are the condensed balance sheets of the Registrant as of December 31, 2007 and 2006, and the statements of income and cash flows for each of the three years in the period ended December 31, 2007.

Condensed Balance Sheets

	December 31,	
	2007	2006
ASSETS		
Current assets:		
Cash and cash equivalents	\$ 36,286	\$ 17,398
Investments	61,970	17,215
Deferred income taxes	4,072	39
Due from affiliates	6,705	9,592
Prepaid and other current assets	9,234	6,739
Total current assets	118,267	50,983
Property and equipment, net	37,448	30,134
Goodwill	1,742	—
Investment in subsidiaries	548,931	391,694
Deferred income taxes	1,583	1,683
Advances to related parties and other assets	19,933	12,350
Total assets	<u>\$ 727,904</u>	<u>\$ 486,844</u>
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Accounts payable and accrued liabilities	\$ 29,222	\$ 17,826
Long-term debt	200,000	45,000
Other long-term liabilities	8,204	3,852
Total liabilities	237,426	66,678
Stockholders' equity:		
Common stock, \$0.001 par value; 80,000,000 shares authorized; issued and outstanding:		
28,443,680 shares at December 31, 2007 and 28,119,026 shares at December 31, 2006	28	28
Preferred stock, \$0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	185,808	173,990
Accumulated other comprehensive gain (loss), net of tax	272	(337)
Retained earnings	324,760	266,875
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	490,478	420,166
Total liabilities and stockholders' equity	<u>\$ 727,904</u>	<u>\$ 486,844</u>

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Condensed Statements of Operations

	Year Ended December 31,		
	2007	2006	2005
Revenue:			
Management fees	\$ 154,071	\$ 120,036	\$ 81,694
Other operating revenue	186	144	139
Investment income	2,915	1,361	1,436
Total revenue	157,172	121,541	83,269
Expenses:			
Medical care costs	22,042	20,764	16,455
General and administrative expenses	114,616	91,347	61,111
Depreciation and amortization	15,101	10,162	6,169
Total expenses	151,759	122,273	83,735
Operating income (loss)	5,413	(732)	(466)
Interest expense	(4,485)	(2,239)	(1,426)
Income (loss) before income taxes and equity in net income of subsidiaries	928	(2,971)	(1,892)
Income tax expense (benefit)	2,333	(610)	502
Net loss before equity in net income of subsidiaries	(1,405)	(2,361)	(2,394)
Equity in net income of subsidiaries	59,735	48,088	29,990
Net income	\$ 58,330	\$ 45,727	\$27,596

MOLINA HEALTHCARE, INC.
NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)
Condensed Statements of Cash Flows

	Year Ended December 31,		
	2007	2006	2005
Operating activities:			
Cash provided by operating activities	\$ 23,500	\$ 24,205	\$ 6,709
Investing activities:			
Net dividends from and capital contributions to subsidiaries	(16,890)	(51,260)	1,110
Purchases of investments	(74,604)	(20,613)	(17,772)
Sales and maturities of investments	29,946	29,181	42,119
Cash paid in business purchase transactions	(80,045)	—	(10,827)
Purchases of equipment	(20,159)	(17,723)	(11,960)
Changes in amounts due to and due from affiliates	2,887	5,684	(7,482)
Change in other assets and liabilities	1,192	(2,996)	(451)
Net cash used in investing activities	(157,673)	(57,727)	(5,263)
Financing activities:			
Borrowings under credit facility	—	50,000	3,100
Proceeds from issuance of convertible senior notes	200,000	—	—
Repayments of amounts borrowed under credit facility	(45,000)	(5,000)	(3,100)
Payment of credit facility fees	(551)	(459)	(3,530)
Payment of convertible senior notes fees	(6,498)	—	—
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	853	1,227	—
Proceeds from exercise of stock options and employee stock purchases	4,257	2,416	1,872
Repayment of mortgage note	—	—	(1,302)
Net cash provided by (used in) financing activities	153,061	48,184	(2,960)
Net increase (decrease) in cash and cash equivalents	18,888	14,662	(1,514)
Cash and cash equivalents at beginning of year	17,398	2,736	4,250
Cash and cash equivalents at end of year	\$ 36,286	\$ 17,398	\$ 2,736
Supplemental cash flow information			
Cash paid (received) during the year for:			
Income taxes	\$ 1,981	\$ (7,721)	\$ 5,918
Interest	9,282	2,154	1,520
Schedule of non-cash investing and financing activities:			
Change in unrealized gain (loss) on investments	\$ 97	\$ 60	\$ (73)
Deferred income taxes	(55)	(40)	46
Net unrealized gain (loss) on investments	\$ 42	\$ 20	\$ (27)
Accrual of software license fees	\$ —	\$ 2,375	\$ —
Retirement of common stock used for stock-based compensation	\$ 480	\$ —	\$ —
Accrual of equipment	\$ 672	\$ 945	\$ —
Cumulative effect of adoption of Financial Interpretation No. 48, <i>Accounting for Uncertainty in Income Taxes</i>	\$ 445	\$ —	\$ —
Value of stock issued for employee compensation earned in the previous year	\$ —	\$ 2,178	\$ —

MOLINA HEALTHCARE, INC.**NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)**
(Dollars in thousands, except per-share data)**Notes to Condensed Financial Information of Registrant****Note A — Basis of Presentation**

Molina Healthcare, Inc. (Registrant) was incorporated on July 24, 2002. Prior to that date, Molina Healthcare of California (formerly known as Molina Medical Centers) operated as a California HMO and as the parent company for Molina Healthcare of Utah, Inc. and Molina Healthcare of Michigan, Inc. In June 2003, 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 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 2007, 2006, and 2005 for these services totaled \$154,071, \$120,036, and \$81,694, 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. Net operating loss 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 2007, 2006, and 2005, the Registrant received dividends from its subsidiaries totaling \$39,000, \$22,500, and \$29,000, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2007, 2006, and 2005, the Registrant made capital contributions to certain subsidiaries totaling \$55,887, 73,760, and \$27,890 respectively, primarily to comply with minimum net worth requirements and to fund contract acquisitions. Such amounts have been recorded as an increase in investment in the respective subsidiaries.

Note D — Related Party Transactions

The Registrant has an equity investment in a medical service provider that provides certain vision services to its members. The Registrant accounts for this investment under the equity method of accounting because it has an ownership interest in the investee in excess of 20%. As of December 31, 2007 and 2006, the Registrant's carrying amount for this investment totaled \$3,460 and \$1,375, respectively. During the third quarter of 2007, an additional \$2,100 was invested in this medical service provider. Effective July 1, 2007 the Registrant paid this provider a \$900 network access fee, which is being amortized over twelve months. For the years ended December 31, 2007, 2006, and 2005, the Registrant paid \$10,894, \$7,862, and \$3,440, respectively, for medical service fees to this provider.

Effective March 1, 2006, the Registrant assumed an office lease from Millworks Capital Ventures with a remaining term of 52 months. Millworks Capital Ventures is owned by John C. Molina, Chief Financial Officer, and his wife. The monthly base lease payment is approximately \$18 and is subject to an annual increase. Based on a market report prepared by an independent realtor, the Registrant believes the terms and conditions of the assumed

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS — (Continued)
(Dollars in thousands, except per-share data)

lease are at fair market value. The Registrant is currently using the office space under the lease for an office expansion. Payments made under this lease totaled \$246 and \$170 for the years ended December 31, 2007 and 2006, respectively.

The Registrant is a party to a fee for service agreement with Pacific Hospital of Long Beach ("Pacific Hospital"). Pacific Hospital is owned by Abrazos Healthcare, Inc., the shares of which are held as community property by the husband of Dr. Martha Bernadett, the Registrant's Executive Vice President, Research and Development. Amounts paid under the terms of that agreement were \$157 and \$357 for the years ended December 31, 2007 and 2006, respectively. The Registrant believes that the claims submitted to it by Pacific Hospital were reimbursed at prevailing market rates. In 2006, the Registrant entered into an additional agreement with Pacific Hospital as part of a capitation arrangement. Under this arrangement, the Registrant pays Pacific Hospital a fixed monthly fee based on member type. For the years ended December 31, 2007 and 2006, the Registrant paid approximately \$4,837 and \$1,652, respectively, to Pacific Hospital for capitation services. The Registrant believes that this agreement with Pacific Hospital is based on prevailing market rates for similar services. Also as of December 31, 2007, the Registrant had an advance outstanding to this provider totaling \$250, which will be offset to capitation payments in 2008.

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

None.

Item 9A. *Controls and Procedures*

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

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

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

Changes in Internal Controls: There were no changes in our internal control over financial reporting during the three months ended December 31, 2007 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management’s Report on Internal Control over Financial Reporting: Management of the Company is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Rule 13a-15(f) under the Securities Exchange Act of 1934. The Company’s internal control over financial reporting is designed to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles in the United States. However, all internal control systems, no matter how well designed, have inherent limitations. Therefore, even those systems determined to be effective can provide only reasonable assurance with respect to financial statement preparation and reporting.

Management assessed the effectiveness of the Company’s internal control over financial reporting as of December 31, 2007. In making this assessment, management used the criteria set forth by the Committee of Sponsoring Organizations of the Treadway Commission (“COSO”) in Internal Control-Integrated Framework. Based on our assessment, management believes that the Company maintained effective internal control over financial reporting as of December 31, 2007, based on those criteria.

Management’s assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Alliance for Community Health, LLC d/b/a Mercy CarePlus (acquired on November 1, 2007), which is included in the 2007 consolidated financial statements of Molina Healthcare, Inc. and constituted \$115.8 million and \$87.9 million of total and net assets, respectively, as of December 31, 2007, and \$30.9 million and \$0.9 million of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control

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over financial reporting of Alliance for Community Health, LLC d/b/a Mercy CarePlus. Our management has not had sufficient time to make an assessment of this subsidiary's internal control over financial reporting.

The effectiveness of the Company's internal control over financial reporting has been audited by Ernst & Young LLP, an independent registered public accounting firm, as stated in their report appearing on the page immediately following, which expresses an unqualified opinion on the effectiveness of the Company's internal control over financial reporting as of December 31, 2007.

Item 9B. *Other Information*

None.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

The Board of Directors and Stockholders
of Molina Healthcare, Inc.

We have audited Molina Healthcare, Inc.'s (the "Company's") internal control over financial reporting as of December 31, 2007, based on criteria established in Internal Control — Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The Company's management is responsible for maintaining effective internal control over financial reporting, and for its assessment of the effectiveness of internal control over financial reporting included in the accompanying management's report on internal control over financial reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

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

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

As indicated in the accompanying management's report on internal control over financial reporting, management's assessment of and conclusion on the effectiveness of internal control over financial reporting did not include the internal controls of Alliance for Community Health, LLC d/b/a Mercy CarePlus (acquired on November 1, 2007), which is included in the 2007 consolidated financial statements of Molina Healthcare, Inc. and constituted \$115.8 million and \$87.9 million of total and net assets, respectively, as of December 31, 2007, and \$30.9 million and \$0.9 million of revenues and net income, respectively, for the year then ended. Our audit of internal control over financial reporting of the Company also did not include an evaluation of the internal control over financial reporting of Alliance for Community Health, LLC d/b/a Mercy CarePlus.

In our opinion, Molina Healthcare, Inc. maintained, in all material respects, effective internal control over financial reporting as of December 31, 2007, based on the COSO criteria.

We have also audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Molina Healthcare, Inc. as of December 31, 2007 and 2006, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2007 and our report dated March 17, 2008 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 17, 2008

PART III

Item 10. Directors, Executive Officers, and Corporate Governance

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2008 Annual Meeting of Stockholders under “Proposal No. 1 — Election of Three Class III Directors.” This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 4 of Part I of this Annual Report on Form 10-K under the caption “Executive Officers,” and will also appear in our Proxy Statement for our 2008 Annual Meeting of Stockholders. Such portion of the Proxy Statement is incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2008 Annual Meeting of Stockholders under “Corporate Governance,” “Corporate Governance and Nominating Committee,” “Corporate Governance Guidelines,” and “Code of Business Conduct and Ethics.” These portions of our Proxy Statement are incorporated herein by reference.

(d) Section 16(a) Beneficial Ownership Reporting Compliance

Section 16(a) of the Exchange Act requires our officers and directors, and persons who own more than 10% of a registered class of our equity securities, to file reports of ownership and changes in ownership with the SEC, and to furnish us with copies of the forms. Purchases and sales of our equity securities by such persons are published on our website at www.molinahealthcare.com. Based on our review of the copies of such reports, on our involvement in assisting our reporting persons with such filings, and on written representations from our reporting persons, we believe that, during 2007, each of our officers, directors, and greater than ten percent stockholders complied with all such filing requirements on a timely basis, with the single exception of one Form 4 for our director Romney which we inadvertently filed one day late.

Item 11. Executive Compensation

The information which will appear in our Proxy Statement for our 2008 Annual Meeting under the captions, “Compensation Committee Interlocks,” “Non-Employee Director Compensation,” and “Compensation Discussion and Analysis,” is incorporated herein by reference. The information which will appear in our Proxy Statement under the caption, “Compensation Committee Report” is not incorporated herein by reference.

Item 12. Security Ownership of Certain Beneficial Owners and Management and Related Stockholder Matters

Information concerning the security ownership of certain beneficial owners and management will appear in our Proxy Statement for our 2008 Annual Meeting of Stockholders under “Information About Stock Ownership.” This portion of the Proxy Statement is incorporated herein by reference. The information required by this item regarding our equity compensation plans is set forth in Part II, Item 5 of this report and incorporated herein by reference.

Item 13. Certain Relationships and Related Transactions, and Director Independence

Information concerning certain relationships and related transactions will appear in our Proxy Statement for our 2008 Annual Meeting of Stockholders under “Related Party Transactions.” Information concerning director independence will appear in our Proxy Statement under “Director Independence.” These portions of our Proxy Statement are incorporated herein by reference.

Item 14. *Principal Accountant Fees and Services*

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2008 Annual Meeting of Stockholders under "Disclosure of Auditor Fees." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. *Exhibits and Financial Statement Schedules*

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

(1) The Company's consolidated financial statements, the notes thereto and the report of the Registered Public Accounting Firm are on pages 49 through 80 of this Annual Report on Form 10-K and are incorporated by reference.

Report of Independent Registered Public Accounting Firm

Consolidated Balance Sheets — At December 31, 2007 and 2006

Consolidated Statements of Operations — Years ended December 31, 2007, 2006, and 2005

Consolidated Statements of Stockholders' Equity — Years ended December 31, 2007, 2006, and 2005

Consolidated Statements of Cash Flows — Years ended December 31, 2007, 2006, and 2005

Notes to Consolidated Financial Statements

(2) Financial Statement Schedules

None.

(3) Exhibits

Reference is made to the accompanying 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 17th day of March, 2008.

MOLINA HEALTHCARE, INC.

By: /s/ Joseph M. Molina, M.D.

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

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

Signature		Date
<u>/s/ Joseph M. Molina, M.D.</u> Joseph M. Molina, M.D.	Chairman of the Board, Chief Executive Officer, and President (Principal Executive Officer)	March 17, 2008
<u>/s/ John C. Molina, J.D.</u> John C. Molina, J.D.	Director, Chief Financial Officer, and Treasurer (Principal Financial Officer)	March 17, 2008
<u>/s/ Joseph W. White, CPA, MBA</u> Joseph W. White, CPA, MBA	Chief Accounting Officer (Principal Accounting Officer)	March 17, 2008
<u>/s/ Charles Z. Fedak, CPA, MBA</u> Charles Z. Fedak, CPA, MBA	Director	March 17, 2008
<u>/s/ Frank E. Murray, M.D.</u> Frank E. Murray, M.D.	Director	March 17, 2008
<u>/s/ Steven Orlando, CPA</u> Steven Orlando, CPA	Director	March 17, 2008
<u>/s/ Sally K. Richardson</u> Sally K. Richardson	Director	March 17, 2008
<u>/s/ Ronna Romney</u> Ronna Romney	Director	March 17, 2008
<u>/s/ John P. Szabo, Jr.</u> John P. Szabo, Jr.	Director	March 17, 2008

INDEX TO EXHIBITS

Number		
3.1	Certificate of Incorporation	Filed as Exhibit 3.2 to registrant's Registration Statement on Form S-1 filed December 30, 2002.
3.2	Amended and Restated Bylaws	Filed as Exhibit 3.4 to registrant's Form S-1/A filed March 11, 2003.
4.1	Indenture dated as of October 11, 2007	Filed as Exhibit 4.1 to registrant's Form 8-K filed October 5, 2007.
4.2	First Supplemental Indenture dated as of October 11, 2007	Filed as Exhibit 4.2 to registrant's Form 8-K filed October 5, 2007.
4.3	Global Form of 3.75% Convertible Senior Note due 2014	Filed as Exhibit 4.3 to registrant's Form 8-K filed October 5, 2007.
10.1	2000 Omnibus Stock and Incentive Plan	Filed as Exhibit 10.12 to registrant's Form S-1 filed December 30, 2002.
10.2	2002 Equity Incentive Plan	Filed as Exhibit 10.13 to registrant's Form S-1 filed December 30, 2002.
10.3	Form of Stock Option Agreement under 2002 Equity Incentive Plan	Filed as Exhibit 10.3 to registrant's Form 10-K filed March 14, 2007.
10.4	2002 Employee Stock Purchase Plan	Filed as Exhibit 10.14 to registrant's Form S-1 filed December 30, 2002.
10.5	2005 Molina Deferred Compensation Plan adopted November 6, 2006	Filed as Exhibit 10.4 to registrant's Form 10-Q filed November 9, 2006.
10.6	2005 Incentive Compensation Plan	Filed as Appendix A to registrant's Proxy Statement filed March 28, 2005.
10.7	Form of Restricted Stock Award Agreement (Executive Officer) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.8	Form of Restricted Stock Award Agreement (Outside Director) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.9	Form of Restricted Stock Award Agreement (Employee) under Molina Healthcare, Inc. 2002 Equity Incentive Plan	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.10	Employment Agreement with J. Mario Molina, M.D. dated January 2, 2002	Filed as Exhibit 10.7 to registrant's Form S-1 filed December 30, 2002.
10.10.1	Amendment to Employment Agreement with J. Mario Molina dated July 1, 2006	Filed as Exhibit 10.2 to registrant's Form 10-Q filed August 8, 2006.
10.11	Employment Agreement with John C. Molina dated January 1, 2002	Filed as Exhibit 10.8 to registrant's Form S-1 filed December 30, 2002.
10.12	Employment Agreement with Mark L. Andrews dated December 1, 2001	Filed as Exhibit 10.9 to registrant's Form S-1 filed December 30, 2002.
10.13	Change in Control Agreement dated June 15, 2006 with Terry Bayer	Filed as Exhibit 10.1 to registrant's Form 8-K filed June 16, 2006.
10.14	Change in Control Agreement dated May 29, 2007 with James W. Howatt, M.D.	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 30, 2007.
10.15	Change in Control Agreement dated March 1, 2008 with Joseph White	Filed herewith.
10.16	Form of Indemnification Agreement	Filed as Exhibit 10.14 to registrant's Form 10-K filed March 14, 2007.
10.17	Health Services Agreement between Foundation Health and Molina Medical Centers dated February 1, 1996	Filed as Exhibit 10.2 to registrant's Form S-1 filed December 30, 2002.

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Number		
10.17.1	Amendment to Health Services Agreement effective October 1, 2002 between Foundation Health and Molina Medical Centers dated February 1, 1996	Filed as Exhibit 10.18 to registrant's Form S-1/A filed June 3, 2003.
10.17.2	Amendment to Health Services Agreement effective October 1, 2002 between Foundation Health and Molina Medical Centers dated February 1, 1996	Filed as Exhibit 10.19 to registrant's Form S-1/A filed June 3, 2003.
10.17.3	Amendment to Health Services Agreement effective October 28, 2003 between Foundation Health and Molina Medical Centers dated February 1, 1996	Filed as Exhibit 10.18 to registrant's Form 10-K filed February 20, 2004.
10.18	Two Plan Model Medi-Cal contract for Riverside and San Bernardino Counties (Inland Empire) with California Department of Health Services	Filed as Exhibit 10.16 to registrant's Form 10-K filed March 14, 2007.
10.19	Contract between Molina Healthcare of California Partner Plan, Inc. and the California Department of Health Services regarding San Diego Geographic Managed Care Program**	Filed as Exhibit 10.3 to registrant's Form 10-Q filed August 7, 2007.
10.20	Contract between Molina Healthcare of California Partner Plan, Inc. and the California Department of Health Services regarding Sacramento Geographic Managed Care Program**	Filed as Exhibit 10.4 to registrant's Form 10-Q filed August 7, 2007.
10.21	Contract Extension between Molina Healthcare of Michigan, Inc. and State of Michigan Department of Management and Budget effective as of October 1, 2006	Filed as Exhibit 10.2 to registrant's Form 10-Q filed November 9, 2006.
10.21.1	Contract Extension between Molina Healthcare of Michigan, Inc. and State of Michigan Department of Management and Budget effective as of October 1, 2007	Filed herewith.
10.22	Contract Extension between Molina Healthcare of Michigan, Inc. and State of Michigan Department of Management and Budget effective as of October 1, 2006	Filed as Exhibit 10.3 to registrant's Form 10-Q filed November 9, 2006.
10.23	Medicaid Managed Care Services Agreement between Molina Healthcare of New Mexico, Inc. and the New Mexico Human Services Department	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.23.1	Amendment No. 2 to the Salud! Medicaid Managed Care Services Contract between Molina Healthcare of New Mexico, Inc. and the New Mexico Human Services Department(2)	Filed as Exhibit 10.1 to registrant's Form 10-K filed August 31, 2007.
10.24	Ohio Medical Assistance Provider Agreement for Managed Care Plan CFC Eligible Population effective July 1, 2007	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 7, 2007.
10.24.1	Amendment to Ohio Medical Assistance Provider Agreement for Managed Care Plan CFC Eligible Population effective January 1, 2008	Filed herewith.
10.25	Ohio Medical Assistance Provider Agreement for Managed Care Plan ABD Eligible Population effective July 1, 2007	Filed as Exhibit 10.2 to registrant's Form 10-Q filed August 7, 2007.

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Number		
10.25.1	Amendment to Ohio Medical Assistance Provider Agreement for Managed Care Plan ABD Eligible Population effective January 1, 2008	Filed herewith.
10.26	Medicaid Contract with Texas Health & Human Services Commission	Filed as Exhibit 10.23 to registrant's Form 10-K filed March 14, 2007.
10.27	Contract between Molina Healthcare of Utah, Inc. and the Utah Department of Health effective July 1, 2007	Filed as Exhibit 10.5 to registrant's Form 10-Q filed August 7, 2007.
10.27	Basic Health Plan and Basic Health Plus Program contract with Washington State Health Care Authority (HCA)	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 10, 2006.
10.27.1	Contract amendment between Molina Healthcare of Utah, Inc. and the Utah Department of Health effective January 1, 2008	Filed as Exhibit 10.1 to registrant's Form 8-K filed December 28, 2007.
10.28	Basic Health Plan and Basic Health Plus Program contract with Washington State Health Care Authority (HCA)	Filed as Exhibit 10.3 to registrant's Form 10-Q filed May 10, 2006.
10.28.1	One-Year Extension of Basic Health Plan and Basic Health Plus Program contract with Washington State Health Care Authority	Filed as Exhibit 10.1 to registrant's Form 8-K filed January 3, 2008.
10.29	Healthy Options Program (including Medicaid and SCHIP) contract with State of Washington Department of Social and Health Services	Filed as Exhibit 10.2 to registrant's Form 10-Q filed May 10, 2006.
10.29.1	One-Year Extension of Healthy Options Program (including Medicaid and SCHIP) contract with State of Washington Department of Social and Health Services	Filed as Exhibit 10.2 to registrant's Form 8-K filed January 3, 2008.
10.30	MC+ Medicaid Managed Care contract between Mercy CarePlus and Missouri Department of Social Services	Filed herewith.
10.31	Common form of Medicare Advantage Special Needs Plan Contract for California, Michigan, Utah, and Washington health plans	Filed as Exhibit 10.27 to registrant's Form 10-K filed March 14, 2007.
10.32	Common form of Medicare Advantage Prescription Drug Plan Contract for California, Michigan, Nevada, New Mexico, Texas, Utah, and Washington health plans	Filed herewith.
10.33	Amended and Restated Credit Agreement, dated as of March 9, 2005, among Molina Healthcare, Inc., as the Borrower, certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed March 10, 2005.
10.33.1	First Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of October 5, 2005, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's current report on Form 8-K filed October 13, 2005.
10.33.2	Second Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of November 6, 2006, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 10-Q filed November 9, 2006.

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Number		
10.33.3	Third Amendment and Waiver to the Amended and Restated Credit Agreement, dated as of May 25, 2007, among Molina Healthcare, Inc., certain lenders, and Bank of America, N.A., as Administrative Agent	Filed as Exhibit 10.1 to registrant's Form 8-K filed May 31, 2007.
10.34	Office Lease with Pacific Towers Associates for 200 Oceangate Corporate Headquarters.	Filed herewith.
10.35	Summary of 2008 Base Salary and Bonus Targets for CEO and CFO	Filed herewith.
12.1	Computation of Ratio of Earnings to Fixed Charges	Filed herewith.
21.1	List of subsidiaries	Filed herewith.
23.1	Consent of Registered Independent Public Accounting Firm	Filed herewith.
31.1	Section 302 Certification of Chief Executive Officer	Filed herewith.
31.2	Section 302 Certification of Chief Financial Officer	Filed herewith.
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.	Filed herewith.
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.	Filed herewith.

** Confidential treatment has been requested for certain rate information in this Exhibit pursuant to Exchange Act Rule 24b-2.

CHANGE IN CONTROL AGREEMENT

THIS CHANGE IN CONTROL AGREEMENT (the "Agreement") is entered into as of March 1, 2008, (the "Effective Date"), by and between Joseph White (the "Executive") and Molina Healthcare, Inc., a Delaware corporation (the "Company").

1. Definitions. The following definitions shall apply for all purposes under this Agreement:

(a) Change in Control. "Change in Control" means the occurrence of any of the following events after the Effective Date:

- (i) The acquisition (other than by an Excluded Person), directly or indirectly, in one or more transactions, by any person or by any group of persons, within the meaning of Section 13(d) or 14(d) of the Exchange Act, of beneficial ownership (within the meaning of Rule 13d-3 of the Exchange Act) of more than fifty percent (50%) of either the outstanding shares of common stock or the combined voting power of the Company's outstanding voting securities entitled to vote generally, whether or not the acquisition was previously approved by the existing directors, other than an acquisition that complies with clause (x) and (y) of paragraph (ii);
- (ii) Consummation of a reorganization, merger, or consolidation of the Company or the sale or other disposition of all or substantially all of the Company's assets unless, immediately following such event, (x) all or substantially all of the stockholders of the Company immediately prior to such event own, directly or indirectly, more than fifty percent (50%) of the then outstanding voting securities of the resulting corporation (including without limitation, a corporation which as a result of such event owns the Company or all or substantially all of the Company's assets either directly or indirectly through one or more subsidiaries) and (y) the securities of the surviving or resulting corporation received or retained by the stockholders of the Company are publicly traded;
- (iii) Approval by the stockholders of the complete liquidation or dissolution of the Company; or
- (iv) A change in the composition of a majority of the directors on the Company's Board of Directors within 12 months if not approved by a majority of the pre-existing directors.

A transaction shall not constitute a Change in Control if its sole purpose is to change the state of the Company's incorporation or to create a holding company that will be owned in substantially the same proportions by the persons who held the Company's securities immediately before such transaction.

(b) Excluded Person. “Excluded Person” means:

- (i) Any person described in and satisfying the conditions of Rule 13d-1(b)(1) under the Exchange Act;
- (ii) The Company;
- (iii) An employee benefit plan (or related trust) sponsored or maintained by the Company or its successor;
- (iv) Any person who is the beneficial owner (as defined in Rule 13d-3 under the Exchange Act) of more than 15% of the Common Stock on the Effective Date (or any affiliate, successor, heir, descendant, or related party of or to such person).

(c) Good Reason. “Good Reason” shall mean that, on or after the effective date of a Change in Control, the Executive (without Executive’s written consent):

- (i) Has incurred a material reduction in his or her authority or responsibility in comparison to the Executive’s authority or responsibility prior to the public announcement of the Change in Control (the “Announcement”);
- (ii) Has incurred one or more reductions in his or her “total compensation” which is defined as follows:
 - (A) any reduction in base salary, or
 - (B) any reduction in the target annual bonus percentage of base salary; or
- (iii) Has been notified that his or her principal place of work will be relocated by a distance of 50 miles or more.

For purposes of this Agreement, “base salary” shall mean the Executive’s annualized base salary as of the Effective Date, as may be subsequently adjusted upward for increases.

(d) Just Cause. “Just Cause” includes but is not limited to any of the following committed by Executive (or omitted to be done by Executive) that occur on or after the Effective Date:

- (i) Theft, unethical or unlawful activity, or other dishonesty;
- (ii) Neglect of or failure to perform employment duties;
- (iii) Inability or unwillingness to perform employment duties;
- (iv) Insubordination;
- (v) Abuse of alcohol or other drugs or substances;

- (vi) Breach of this Agreement;
- (vii) A conviction or plea of “guilty” or “no contest” to a felony under the laws of the United States or any state thereof; or
- (viii) Any violation or breach of any Company policy that has been established to comply with either the Sarbanes-Oxley Act of 2002 (or any regulations or rules or decisions that implement/interpret such act) or any laws, rules, or requirements of the Securities and Exchange Commission or the New York Stock Exchange.

(e) Total Disability. “Total Disability” shall be deemed to occur on the ninetieth (90th) consecutive or non-consecutive calendar day within any twelve (12) month period that Executive is unable to perform his or her duties because of any physical or mental illness or disability.

2. Severance Payment and Equity Compensation.

(a) The Executive shall be entitled to receive a severance payment from the Company as provided herein (the “Severance Payment”) if within the first twelve (12) month period after the occurrence of a Change in Control, either:

- (i) The Executive voluntarily resigns his or her employment for Good Reason within sixty (60) days after the Executive becomes aware of the occurrence of an event specified in Section 1(c); or
- (ii) The Company terminates the Executive’s employment for any reason other than Just Cause, death, or Total Disability.

For all purposes under this Agreement, the amount of the Severance Payment shall be equal to two times (2X) the Executive’s annual base salary, as in effect on the date of the termination of Executive’s employment (or if Executive’s salary was greater, on the date of the Announcement), plus a prorata portion of the Executive’s target bonus for the fiscal year in which Executive’s employment is terminated, based on the number of entire months of such fiscal year that have elapsed through the date of Executive’s termination of employment as a fraction of twelve (12). The Severance Payment shall be made to Executive in a single lump sum cash payment not later than seven (7) business days following the date that Executive becomes entitled to a Severance Payment.

Except as may be provided under Sections 2(b) and 2(c), the Severance Payment shall be in lieu of any other post-termination employment payments.

(b) Incentive, Deferred Compensation, and Retirement Programs. If the Executive is entitled to a Severance Payment under Section 2(a) and notwithstanding anything to the contrary in any stock option or stock appreciation right (SAR) or deferred compensation plan or retirement plan or agreements, then (i) the Executive shall become immediately fully vested in all of his or her outstanding stock options, SARs, warrants, restricted stock, phantom stock, deferred compensation, retirement or similar plans or agreements of the Company, and (ii) the Executive (or his or her personal representative if applicable) shall be permitted to exercise any of his or her vested stock

options/SARs until the earlier of (i) one (1) year after Executive's termination of employment or (ii) the term of such unexercised stock options, warrants, or SARs.

(c) Health Coverage. If the Executive is entitled to a Severance Payment under Section 2(a), the Company shall reimburse Executive for a portion of the cost of any group health continuation coverage that the Company is otherwise required to offer under the Consolidated Omnibus Budget Reconciliation Act of 1986 ("COBRA") until the earlier of the date that (i) the Executive becomes covered by comparable health coverage, offered by another employer, or (ii) is twelve (12) months after the date upon which the Executive becomes entitled to a Severance Payment under Section 2(a). The Executive shall continue to be responsible to pay for the cost of the employee portion of COBRA coverage (such employee portion cost shall not be reimbursed by the Company).

(d) Mitigation. Except as may be expressly provided elsewhere in this Agreement, the Executive shall not be required to mitigate the amount of any payment or benefit contemplated by this Section 2 (whether by seeking new employment or in any other manner). No such payment shall be reduced by earnings that the Executive may receive from any other source.

(e) Conditions. All payments and benefits provided under this Section 2 are conditioned on Executive's continuing compliance with this Agreement and the Company's policies. All payments and benefits are also conditioned on, and in consideration for, Executive's execution (and effectiveness) of a release of claims and covenant not to sue substantially in the form provided in Exhibit A upon termination of employment, to be delivered by Executive simultaneously upon payment by the Company.

3. Successors.

(a) Company's Successors. Any successor (whether direct or indirect and whether by purchase, lease, merger, consolidation, liquidation, or otherwise) to all or substantially all of the Company's business and/or assets, shall be obligated to perform this Agreement in the same manner and to the same extent as the Company would be required to perform it in the absence of a succession.

(b) Executive's Successors. This Agreement and all rights of the Executive hereunder shall inure to the benefit of, and be enforceable by, the Executive's personal or legal representatives, executors, administrators, successors, heirs, distributees, devisees, and legatees.

4. Miscellaneous Provisions.

(a) Notice. Notices and all other communications contemplated by this Agreement shall be in writing and shall be deemed to have been duly given when personally delivered or when mailed by U.S. registered or certified mail, return receipt requested and postage prepaid. In the case of the Executive, mailed notices shall be addressed to him or her at the home address which he or she most recently communicated to the Company in writing. In the case of the Company, mailed notices shall be addressed to its corporate headquarters, and all notices shall be directed to the attention of its Secretary.

(b) Waiver. No provision of this Agreement shall be modified, waived or discharged unless the modification, waiver or discharge is agreed to in writing and signed by the Executive and by an authorized officer of the Company (other than the Executive). No waiver by either party of any breach of, or of compliance with, any condition or provision of this Agreement by the other party shall be considered a waiver of any other condition or provision or of the same condition or provision at another time.

(c) Whole Agreement. This Agreement contains all the legally binding understandings and agreements between Executive and the Company pertaining to the subject matter of this Agreement and supersedes all such agreements, whether oral or in writing, previously entered into between the parties.

(d) Withholding Taxes. All payments made under this Agreement shall be subject to reduction to reflect taxes required to be withheld by law.

(e) Choice of Law. The validity, interpretation, construction, and performance of this Agreement shall be governed by the laws of the State of California without regard to the conflicts of laws principles thereof.

(f) Severability. The invalidity or unenforceability of any provision or provisions of this Agreement shall not affect the validity or enforceability of any other provision hereof, which shall remain in full force and effect.

(g) Arbitration. Any controversy or claim arising out of or relating to this Agreement, or the breach thereof, shall be settled by arbitration in Los Angeles County in accordance with the Commercial Arbitration Rules of the American Arbitration Association. Discovery shall be permitted to the same extent as in a proceeding under the Federal Rules of Civil Procedure, including (without limitation) such discovery as is specifically authorized by section 1283.05 of the California Code of Civil Procedure, without need of prior leave of the arbitrator under section 1283.05(e) of such Code. Judgment on the award rendered by the arbitrator may be entered in any court having jurisdiction thereof. All fees and expenses of the arbitrator and such Association and attorney fees shall be paid as determined by the arbitrator.

(h) No Assignment. The rights of Executive to payments or benefits under this Agreement shall not be made subject to option or assignment, either by voluntary or involuntary assignment or by operation of law, including (without limitation) bankruptcy, garnishment, attachment or other creditor's process, and any action in violation of this Subsection (h) shall be void.

(i) Nondisparagement; Confidentiality. On the Effective Date and thereafter, Executive agrees that he/she will not disparage the Company or its directors, officers, employees, affiliates, subsidiaries, predecessors, successors or assigns in any written or oral communications to any third party. Executive further agrees that he/she will not direct anyone to make any disparaging oral or written remarks to any third parties. During Executive's employment and following Executive's termination of employment for any reason, Executive agrees to not intentionally use or disclose the confidential information or trade secrets of the Company.

(j) Nonsolicit. During the Executive's employment with Company and for twelve months after Executive's termination of employment and payment of the Severance Payment hereunder, the Executive shall not, directly or indirectly, either as an individual or as an employee, agent, consultant, advisor, independent contractor, general partner, officer, director, stockholder, investor, lender, or in any other capacity whatsoever, of any person, firm, corporation, or partnership: (i) induce or attempt to induce any person who at the time of such inducement is an employee of the Company to perform work or service for any other person or entity other than the Company or (ii) participate or engage in the design, development, manufacture, production, marketing, sale, or servicing of any product, or the provision of any service, that directly or indirectly relates to Company business.

(k) Notice of Employment. During Executive's employment and for twelve months after Executive's termination of employment and payment of the Severance Payment hereunder, the Executive will promptly notify the Company in writing if Executive becomes (or agrees to become) an employee or director of any other employer. Such notice shall include the name of the other employer and the date of commencement of employment or service as a director.

IN WITNESS WHEREOF, each of the parties has executed this Agreement, in the case of the Company by its duly authorized officer, as of the day and year first above written.

EXECUTIVE:

/s/ Joseph White

Joseph White

MOLINA HEALTHCARE, INC.:

/s/ John C. Molina

By: John C. Molina

Its: Chief Financial Officer

EXHIBIT A

Form of Release of Claims and Covenant Not To Sue

In consideration of the payments and other benefits that Molina Healthcare, Inc., a Delaware corporation (the "Company"), is providing to Joseph White ("Executive") under the Change in Control Agreement entered into by and between Executive and the Company, dated June 12, 2006, the Executive, on his or her own behalf and on behalf of Employee's representatives, agents, heirs and assigns, waives, releases, discharges and promises never to assert any and all claims, demands, actions, costs, rights, liabilities, damages or obligations of every kind and nature, whether known or unknown, suspected or unsuspected that Executive ever had, now have or might have as of the date of Executive's termination of employment with the Company against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, attorneys, insurers, successors, or assigns (including all such persons or entities that have a current and/or former relationship with the Company) for any claims arising from or related to Executive's employment with the Company, its parent or any of its affiliates and subsidiaries and the termination of that employment.

These released claims also specifically include, but are not limited to, any claims arising under any federal, state and local statutory or common law, such as (as amended and as applicable) Title VII of the Civil Rights Act, the Age Discrimination in Employment Act, the Americans With Disabilities Act, the Employee Retirement Income Security Act, the Family Medical Leave Act, the Equal Pay Act, the Fair Labor Standards Act, the Industrial Welfare Commission's Orders, the California Fair Employment and Housing Act, the California Constitution, the California Government Code, the California Labor Code and any other federal, state or local constitution, law, regulation or ordinance governing the terms and conditions of employment or the termination of employment, and the law of contract and tort and any claim for attorneys' fees.

Furthermore, the Executive acknowledges that this waiver and release is knowing and voluntary and that the consideration given for this waiver and release is in addition to anything of value to which Executive was already entitled. Executive acknowledges that there may exist facts or claims in addition to or different from those which are now known or believed by Executive to exist. Nonetheless, this Agreement extends to all claims of every nature and kind whatsoever, whether known or unknown, suspected or unsuspected, past or present. Executive also expressly waives the provisions of California Civil Code section 1542, which provides: "A general release does not extend to claims which the creditor does not know or suspect to exist in his favor at the time of executing the release, which if known by him/her must have materially affected his settlement with the debtor." With respect to the claims released in the preceding sentences, the Executive will not initiate or maintain any legal or administrative action or proceeding of any kind against the Company or its predecessors, parent, affiliates, subsidiaries, stockholders, owners, directors, officers, employees, agents, successors, or assigns (including all such persons or entities that have a current or former relationship with the Company), for the purpose of obtaining any personal relief, nor assist or participate in any such proceedings, including any proceedings brought by any third parties (except as otherwise required or permitted by law). The Executive further acknowledges that he has been advised by this writing that:

- he should consult with an attorney prior to executing this release;
- he has at least twenty-one (21) days within which to consider this release;
- he has up to seven (7) days following the execution of this release by the parties to revoke the release; and
- this release shall not be effective until such seven (7) day revocation period has expired.

Executive agrees that the release set forth above shall be and remain in effect in all respects as a complete general release as to the matters released.

EXECUTIVE

Joseph White

Date:

Form No. DMB 234 (Rev. 1/96)
 AUTHORITY: Act 431 of 1984
 COMPLETION: Required
 PENALTY: Contract will not be executed unless form is filed

September 20, 2007

STATE OF MICHIGAN
DEPARTMENT OF MANAGEMENT AND BUDGET
PURCHASING OPERATIONS
P.O. BOX 30026, LANSING, MI 48909
OR
530 W. ALLEGAN, LANSING, MI 48933

CHANGE NOTICE NO. 12
TO
CONTRACT NO. 071B5200018
between
THE STATE OF MICHIGAN
and

NAME & ADDRESS OF VENDOR Molina Healthcare of Michigan Inc. 100 West Big Beaver Road, Suite 600 Troy, MI 48084 <div style="text-align: right;">Roman.kulich@Molinahealthcare.com</div>	TELEPHONE (248) 925-1710 Roman T. Kulich VENDOR NUMBER/MAIL CODE (2) 38-3341599 (004) BUYER/CA (517) 241-4225 Kevin Dunn
Contract Compliance Inspector: Cheryl Bupp 241-7933 Comprehensive Health Care for Medicaid Beneficiaries — Regions 1, 4, 6, 7, 9, 10 — DCH	
CONTRACT PERIOD: From: October 1, 2004 To: September 30, 2008	
TERMS <div style="text-align: center;">N/A</div>	SHIPMENT <div style="text-align: center;">N/A</div>
F.O.B. <div style="text-align: center;">N/A</div>	SHIPPED FROM <div style="text-align: center;">N/A</div>
MINIMUM DELIVERY REQUIREMENTS <div style="text-align: center;">N/A</div>	

NATURE OF CHANGE (S):
 Effective October 1, 2007, the attached changes are incorporated into this Contract. Furthermore, FY08 rates are included in the Contract. All other terms, conditions, specifications, and pricing remain unchanged.

AUTHORITY/REASON:
 Per DCH request and DMB/Purchasing Operations' approval.

TOTAL ESTIMATED CONTRACT VALUE REMAINS: **\$667,875,969.33**

FOR THE VENDOR: <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> Molina Healthcare of Michigan Inc. <div style="text-align: center;">Firm Name</div> </div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <div style="text-align: center;">Authorized Agent Signature</div> </div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <div style="text-align: center;">Authorized Agent (Print or Type)</div> </div> <div style="border-bottom: 1px solid black;"> <div style="text-align: center;">Date</div> </div>	FOR THE STATE: <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <div style="text-align: center;">Signature</div> </div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <div style="text-align: center;">Elise A. Lancaster</div> <div style="text-align: center;">Name</div> </div> <div style="border-bottom: 1px solid black; margin-bottom: 10px;"> <div style="text-align: center;">Director, Purchasing Operations</div> <div style="text-align: center;">Title</div> </div> <div style="border-bottom: 1px solid black;"> <div style="text-align: center;">Date</div> </div>
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CHANGES FOR THE FY08 MEDICAID HEALTH PLAN CONTRACT

Effective Date 10/1/07

Contract Change #1 — Service Area Expansions

Modify section II-C (Targeted Geographical Area for Implementation of the CHCP) to clarify the State's policy with regard to the approval of requests for service area expansion. Specifically, modify Section II-C-2 to clarify that approval of requests will be at the sole discretion of the State.

DCH may consider Contractors' requests for service area expansion during the term of the Contract. Approval of service area expansion requests will be at the ~~sole~~ discretion of the State. ~~and will be contingent upon~~ The state may consider certain factors **including, but not limited to**, the need for additional capacity, **Contractor performance, Contractor fiscal status, and Contractor provider network.** ~~in the counties proposed under the expansion request.~~ Requests should be submitted using the provider profile information form contained in Appendix 1 of the Contract.

Rationale

This change clarifies that the State reserves the right to determine criteria upon which requests for service area expansion are approved.

Contract Change #2 — Change in Mandatory Population

Modify Sections II-D-1, II-D-2, and II-H to reflect that pregnant women, whose pregnancy is the basis for Medicaid eligibility, residing in rural exception counties, are changed from a voluntary to mandatory population. Specifically, modify sections II-D-1 and II-D-2 as follows and add a new section II-H-19.

1. Medicaid Eligible Groups Who Must Enroll in the CHCP:
 - Families with children receiving assistance under the Financial Independence Program (FIP)
 - 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 residing in a county listed in Appendix 6**
2. Medicaid Eligible Groups Who May Voluntarily Enroll in the CHCP:
 - Migrants
 - Native Americans
 - Pregnant women, whose pregnancy is the basis for Medicaid eligibility, **who do not reside in a county listed in Appendix 6**

II-H-19. Pregnant Women

Special conditions apply to new mandatory Enrollees in the Contractor's health plan whose Medicaid eligibility was determined based on pregnancy. These Enrollees must be allowed to select or remain with the Medicaid obstetrician of her choice and are entitled to receive all medically necessary obstetrical and prenatal care without preauthorization from the health plan. In the event that the

Contractor does not have a contract with the provider, all claims should be paid at the Medicaid fee-for-service rate.

Rationale

The single MHP operating in the Upper Peninsula counties through the rural exception waiver maintains an extensive provider network. The network includes all Local Health Departments and the overwhelming majority of obstetricians practicing in the Upper Peninsula. Therefore, pregnant women in these counties may be made a mandatory population without impairment to continuity of care and further will receive all of the benefits from managed care such as case management and ease of transportation. The special coverage provisions are included to emphasize DCH requirements regarding new mandatory-enrolled pregnant women.

Contract Change #3 — Special Disenrollments

Modify Section II-F-11 (a) (Disenrollment Requests Initiated by the Contractor, Special Disenrollments) to clarify the circumstances under which Medicaid Health Plans can request a disenrollment for enrollee noncompliance. Specifically, modify section II-F-11 (a) as follows:

- Other noncompliance situations involving the repeated use of non-Contractor providers **when in-network providers are available;** discharge from the practices of available Contractor's network providers; repeated emergency room use for non-emergent services; and other situations that impede care

Rationale

Based on the State's review of noncompliance disenrollment requests submitted by the Medicaid Health Plans, the State determined that the language regarding "failure to follow treatment plan" may be broad and misleading. Several factors may impact an enrollee's failure to follow a treatment plan and a special disenrollment is not appropriate in all cases. Additionally, the State wishes to clarify that repeated use of out-of-network providers is a rationale for special disenrollment only in those cases where in-network providers are available.

Contract Change #4 — State and Federal False Claims Act

Add a new subsection to section II-I (Observance of Federal, State and Local Laws) to specifically require Medicaid Health Plans (MHPs) to comply with all applicable portions of the State and Federal False Claims Act. Specifically, the new Section II-I-9 shall read as follows:

9. Compliance with False Claims Acts

The Contractor shall comply with all applicable provisions of the Federal False Claims Act and Michigan Medicaid False Claims Act. Actions taken to comply with the federal and state laws specifically include, but are not limited to, the following:

- **Establish and disseminate written policies for employees of the entity (including management) and any contractor or agent of the entity regarding the detection and prevention of waste, fraud, and abuse.**
- **The written policies must include detailed information about the False Claim Act and the other provisions named in section 1902(a)(68)(A).**
- **The written policies must specify the rights of employees to be protected as whistleblowers.**
- **The written policies must also be adopted by the Contractor's contractors or agents A "contractor" or "agent" includes any contractor, subcontractor, agent, or other**

person which or who, on behalf of the entity, furnishes, or otherwise authorizes the furnishing of Medicaid health care items or services, performs billing or coding functions, or is involved in monitoring of health care provided by the entity. Contractors or agents that meet or surpass the monetary threshold are subject to the requirements in this Section.

- If the Contractor currently has an employee handbook, the handbook must contain the Contractor's written policies for employees including an explanation of the rights of employees to be protected as whistleblowers.

Rationale

Based on feedback from the Office of Inspector General and Centers for Medicare and Medicaid Services, Michigan's Medicaid False Claims Act does not include certain specific provisions required under the Deficit Reduction Act. This contract change highlights these provisions and ensures that the MHPs requirements are aligned with the key requirements under the federal law.

Contract Change #5 — Reporting Fraud and Abuse

Modify Section II-L-4 (Program Integrity) to more specifically define the requirements regarding Contractor fraud and abuse reporting requirements. Specifically, modify this section as indicated:

1. 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 42 CFR 438.608:

- Written policies and procedures that describes how the Contractor will comply with federal and state fraud and abuse standards.
- 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 for the 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

The Contractor ~~should~~ must report all suspected fraud and/or abuse that warrant investigation to the DCH, Program Investigation Section.

~~When reporting suspected fraud and/or abuse,~~ Additionally, the Contractor shall provide the number of complaints that warrant a preliminary investigation each year. Further, for each complaint that warrants full investigation, the Contractor must provide to the DCH Program Investigation Section the following information:

- The name of the **provider**, 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
- **Source of the complaint**
- **Type of provider**
- Nature of the complaint
- **Approximate range of dollars involved**
- **Legal and administrative disposition of the case, including actions taken by law enforcement officials to whom the case has been referred.**

The Contractor shall inform the DCH of actions taken to investigate or resolve the reported suspicion, knowledge, or action. Contractors must also cooperate fully in any investigation by the DCH or Office of Attorney General and any subsequent legal action that may result from such investigation.

Contractors shall be permitted to disclose protected health information to DCH or the Attorney General without first obtaining authorization from the enrollee to disclose such information. DCH and the Attorney General shall ensure that such disclosures meet the requirements for disclosures made as part of the Contractor's treatment, payment, or health care operations as defined in 45 CFR 164.501.

Rationale

The current contract does not include all the reporting components specified in the Balanced Budget Act. The contract change is necessary to bring the contract into alignment with all specific requirements of 42 CFR 455.17. All information required in this section remains an integral component of the fraud and abuse site visits.

Contract Change #6 — Payment to Providers

Modify Section II-M (Payment to Providers) to incorporate language that enables MHPs to collaborate with DCH and providers in the development and implementation of programs for improving access, quality, and performance. Specifically, modify the introductory paragraph to read as follows:

The Contractor must make timely payments to all providers for covered services rendered to enrollees as required by MCL 400.11li and in compliance with established DCH performance standards (Appendix 4). **Upon request from DCH, Contractors must develop programs for improving access, quality, and performance with providers. Such programs must include DCH in the design methodology, data collection, and evaluation. The Contractor must make all payments to both network and out-of-network providers dictated by the methodology jointly developed by the Contractor and DCH.**

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.

Rationale

The intent of this contract change is to enable MHPs and DCH to work collaboratively to develop innovative programs with health care providers. The contract language permits MHPs to make payments to providers that participate in the programs designed to improve access, quality and performance.

Contract Change #7 — Clinical Practice Guidelines

Modify section II-O-I to clarify the time period required for provider assessment, feedback, and review of clinical practice guidelines. Specifically, the 7th and 8th bullet requirement for the written quality plan will be changed as follows:

- At least ~~twice~~ annually, provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the Contractor.
- Develop, ~~and/or~~ adopt, **and periodically review** 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.

Rationale

This contract change is designed to better align the contract provisions with the requirements included as part of the on-site review process.

Contract Change #8 — Consumer Survey

Modify section II-O-6 to reflect the name change of the Consumer Assessment survey. Specifically, the first sentence of section II-O-6 will be changed as follows:

Contractors must conduct an annual survey of their adult enrollee population using the Consumer Assessment of Health **care Providers and Systems Plan Survey** (CAHPS®) instrument.

Rationale

The contract change is needed to accurately reflect the description of the CAHPS survey.

Contract Change #9 — Prevalent Language

Modify Section II-S (Enrollee Services) to clarify Contractor's requirements regarding the provision of interpretation services. Specifically, revise the fourth paragraph in Section II-S-3 to read as follows:

The handbook must be written at no higher than a 6.9 grade reading level and must be available in alternative formats for enrollees with special needs. Member handbooks must be available in a prevalent language when more than five percent (5%) of the Contractor's enrollees speak a prevalent language, as defined by the Contract. Contractors must also provide a mechanism for enrollees who speak the prevalent language to obtain member materials in the prevalent language **and a mechanism for enrollees** or to obtain assistance with interpretation. The Contractor must agree to make modifications in the handbook language ~~so as~~ to comply with the specifications of this Contract.

Rationale

The current contract does not clearly delineate language requirements for written materials and language requirements for oral interpretations services. The Balanced Budget Act Checklist provided by the Center for Medicare and Medicaid Services emphasizes that managed care organizations must make oral interpretation services available free of charge to all enrollees not just enrollees who speak the prevalent non-English language.

Contract Change #10 — Provider Directory

Modify section II-S-2 to clarify that all Contractors are required to place the provider directory on a web site available to the members. Prior to this contract change, placing the provider directory on the Contractor's web site was options. Specifically, modify the final bullet of II-S-2(a) as follows:

- A website, maintained by the Contractor, that includes information on preventive health strategies, health/wellness promotion programs offered by the Contractor, updates related to covered services, access to providers, **complete provider directory**, and updated policies and procedures.

Additionally, because placing the provider directory on the web site is no longer optional, the following changes are needed in the final paragraph of II-S-3:

~~¶~~The Contractor **must** maintains a complete provider directory on the Contractor's web site; the Contractor is not required to a mail provider directory to all new enrollees. The web provider directory must be reviewed for accuracy and updated at least monthly. The Contractor must inform new enrollees that the provider directory is available upon request and on the Contractor's web site and must mail the provider directory within five business days of the enrollee's request

Rationale

Most MHPs have chosen to place the provider directory on the web site. With the increasing access to computers, providing access to the provider directory on the web site may improve access to network providers and facilitate compliance with network limitations. Because the provider directory will be available on the web site, MHPs are only required to mail the provider directory to members upon request.

Contract Change #11 — Payment Withhold

Modify Section II-Z-1 (Contractor Performance Bonus) to reflect the revised withhold amount. DCH has increased the threshold to .19%. The first sentence of this section will read as follows:

During each Contract year, DCH will withhold ~~0012~~ **.0019** of the approved capitation payment from each Contractor until the performance bonus withhold reaches approximately \$35.0 million dollars.

Rationale

In order to implement an increased performance bonus withhold of approximately \$5.0 million, DCH must increase the percentage of the capitation withhold amount.

Contract Change #12 — Appendix 6

Insert a new appendix at the end of the contract that lists the rural exception counties in which pregnant women will be a mandatory population. Specifically, the newly inserted Appendix 6 will read as follows:

**Appendix 6
Rural Exception Counties in which Pregnant Women are a Mandatory Population**

Alger
Baraga
Chippewa
Delta
Dickinson
Gogebic
Houghton
Iron
Keweenaw
Luce
Mackinac
Marquette
Menominee
Ontonagon
Schoolcraft

Rationale

The Centers for Medicare and Medicaid Services requested that the Department specifically lists the counties in which pregnant women would be a mandatory population.

MEDICAID MANAGED CARE
PERFORMANCE MONITORING STANDARDS
(Contract Year October 1, 2007 — September 30, 2008)

Appendix 4 — 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. The performance monitoring standards are part of the Contract between the State of Michigan and Contracting Health Plans (Appendix 4).

The process is dynamic and reflects state and national issues that may change on a year-to-year basis. Performance measurement is shared with Health Plans during the fiscal year and compares performance of each Plan over time, to other health plans, and to industry standards, where available.

The Performance Monitoring Standards address the following performance areas:

- Quality of Care
- Access to Care
- Customer Services
- Claims Reporting and Processing
- Encounter Data
- Provider File reporting

For each performance area the following categories are identified:

- Measure
- Goal
- Minimum Standard for each measure
- Data Source
- Monitoring Intervals, (annually, quarterly, monthly)

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-V.

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
<ul style="list-style-type: none"> Quality of Care: Childhood Immunization Status 	Fully immunize children who turn two years old during the calendar year.	Combination 2 ≥ 82%	HEDIS report	Annual
<ul style="list-style-type: none"> Quality of Care: Prenatal Care 	Pregnant women receive an initial prenatal care visit in the first trimester or within 42 days of enrollment	≥ 85%	MDCH Data Warehouse	Quarterly
<ul style="list-style-type: none"> Quality of Care: Postpartum Care 	Women delivering a live birth received a postpartum visit on or between 21 days and 56 days after delivery.	≥ 62%	HEDIS report	Annual
<ul style="list-style-type: none"> Quality of Care: Blood Lead Testing 	Children at the age of 3 years old receive at least one blood lead test on/before 3 rd birthday	≥ 80% for total enrollment and ≥ 80% for continuous enrollment	MDCH Data Warehouse	Monthly
<ul style="list-style-type: none"> Access to care: Well-Child Visits in the First 15 Months of Life 	Children 15 months of age receive six or more well child visits during first 15 months of life	≥ 60%	Encounter data	Quarterly
<ul style="list-style-type: none"> Access to care: Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life 	Children three, four, five, and six years old receive one or more well child visits during twelve-month period.	≥ 68%	Encounter data	Quarterly

PERFORMANCE AREA	GOAL	MINIMUM STANDARD	DATA SOURCE	MONITORING INTERVALS
<ul style="list-style-type: none"> Customer Services: Enrollee Complaints 	Plan will have minimal enrollee contacts through the Medicaid Helpline for issues determined to be complaints	Complaint rate < .25 per 1000 member months	Beneficiary/Provider contacts tracking (BPCT)	Quarterly
<ul style="list-style-type: none"> Claims Reporting and Processing 	Health Plan submits timely and complete report, and processes claims in accordance with minimum standard	Timely, ≥ 95% of clean claims paid within 30 days, and ≤1.85% of ending inventory over 45 days old	Claims report submitted by health plan	Monthly
<ul style="list-style-type: none"> Encounter Data Reporting (Institutional, Professional) 	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
<ul style="list-style-type: none"> Encounter Data Reporting (Pharmacy) 	Timely and complete encounter data submission by the 15th of the month while meeting minimum volume requirements	Timely and Complete submission while meeting minimum volume	MDCH Data Exchange Gateway (DEG) and MDCH Data Warehouse	Monthly
<ul style="list-style-type: none"> Provider File Reporting 	Timely and accurate provider file update/submission before the last Tuesday of the month	Timely and Complete submission	MI Enrolls	Monthly

Minimum standard will be updated effective October 1, 2007 for HEDIS measures based on 2007 HEDIS Michigan Medicaid Avg.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Molina Healthcare 0004318627 0004318645; Counties 82

Region 01

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	356.82	112.83	39.18	3.38	512.21	0.996			510.16	-0.97	509.19
2	TANF < 1	F	329.61	98.22	34.77	3.38	465.98	0.996			464.12	-0.88	463.24
3	TANF 1 - 4	M	85.16	15.43	2.33	3.38	106.3	0.996			105.87	-0.20	105.67
4	TANF 1 - 4	F	69.67	10.59	1.73	3.38	85.37	0.996			85.03	-0.16	84.87
5	TANF 5 - 14	M	54.51	7.12	0.96	3.38	65.97	0.996			65.71	-0.12	65.59
6	TANF 5 - 14	F	46.82	6.12	0.85	3.38	57.17	0.996			56.94	-0.11	56.83
7	TANF 15 - 20	M	56.48	10.11	1.76	3.38	71.73	0.996			71.44	-0.14	71.30
8	TANF 15 - 20	F	84.04	12.68	2.06	3.38	102.16	0.996			101.75	-0.19	101.56
9	TANF 21 - 25	M	94.10	21.43	3.69	3.38	122.6	0.996			122.11	-0.23	121.88
10	TANF 21 - 25	F	150.86	30.15	5.63	3.38	190.02	0.996			189.26	-0.36	188.90
11	TANF 26 - 44	M	213.46	45.38	10.83	3.38	273.05	0.996			271.96	-0.52	271.44
12	TANF 26 - 44	F	220.76	44.85	8.21	3.38	277.2	0.996			276.09	-0.52	275.57
13	TANF 45 +	M	407.57	82.90	21.09	3.38	514.94	0.996			512.88	-0.97	511.91
14	TANF 45 +	F	416.01	91.52	19.29	3.38	530.2	0.996			528.08	-1.00	527.08
15	ABAD 0 - 20	M	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
16	ABAD 0 - 20	F	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
17.1	ABAD 21 - 39 Medicare	M	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
18.1	ABAD 21 - 39 Medicare	F	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
17.2	ABAD 21 - 39	M	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
18.2	ABAD 21 - 39	F	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
19.1	ABAD 40 - 64 Medicare	M	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
20.1	ABAD 40 - 64 Medicare	F	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
19.2	ABAD 40 - 64	M	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
20.2	ABAD 40 - 64	F	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
21.1	ABAD 65 + Medicare	M	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
22.1	ABAD 65 + Medicare	F	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
21.2	ABAD 65 +	M	639.42	146.86	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
22.2	ABAD 65 +	F	639.42	146.88	36.85	6.76	829.91		0.9200		763.52	-1.45	762.07
23.1	OAA 0 + Medicare	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.1	OAA 0 + Medicare	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
23.2	OAA 0 +	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.2	OAA 0 +	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
59.9	Rate MCR		4,529.56	1545.03	605.58	0.00	6680.17				6,680.17	-12.69	6667.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

State of Michigan Managed Care Rates FY08
Effective October 1, 2007

Molina Healthcare 0004318627 0004318645; County 58

Region 02

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	342.76	99.34	35.21	3.38	480.69	1.029			494.63	-0.94	493.69
2	TANF < 1	F	307.20	90.78	32.19	3.38	433.55	1.029			446.12	-0.85	445.27
3	TANF 1 - 4	M	81.05	14.58	2.12	3.38	101.13	1.029			104.06	-0.20	103.86
4	TANF 1 - 4	F	69.36	11.19	1.68	3.38	85.61	1.029			88.09	-0.17	87.92
5	TANF 5 - 14	M	64.56	7.76	1.00	3.38	76.7	1.029			78.92	-0.15	78.77
6	TANF 5 - 14	F	54.83	6.59	0.78	3.38	65.58	1.029			67.48	-0.13	67.35
7	TANF 15 - 20	M	68.86	11.50	1.83	3.38	85.57	1.029			88.05	-0.17	87.88
8	TANF 15 - 20	F	111.50	17.54	2.29	3.38	134.71	1.029			138.62	-0.26	138.36
9	TANF 21 - 25	M	101.22	20.74	3.15	3.38	128.49	1.029			132.22	-0.25	131.97
10	TANF 21 - 25	F	186.03	35.64	4.54	3.38	229.59	1.029			236.25	-0.45	235.80
11	TANF 26 - 44	M	230.29	56.57	7.86	3.38	298.1	1.029			306.74	-0.58	306.16
12	TANF 26 - 44	F	264.38	48.52	8.14	3.38	324.42	1.029			333.83	-0.63	333.20
13	TANF 45 +	M	429.31	83.78	19.59	3.38	536.06	1.029			551.61	-1.05	550.56
14	TANF 45 +	F	465.00	83.28	18.90	3.38	570.56	1.029			587.11	-1.12	585.99
15	ABAD 0 - 20	M	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
16	ABAD 0 - 20	F	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
17.1	ABAD 21 - 39 Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
18.1	ABAD 21 - 39 Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
17.2	ABAD 21 - 39	M	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
18.2	ABAD 21 - 39	F	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
19.1	ABAD 40 - 64 Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
20.1	ABAD 40 - 64 Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
19.2	ABAD 40 - 64	M	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
20.2	ABAD 40 - 64	F	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
21.1	ABAD 65 + Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
22.1	ABAD 65 + Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
21.2	ABAD 65 +	M	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
22.2	ABAD 65 +	F	603.27	112.96	26.45	6.76	749.44		1.0020		750.94	-1.43	749.51
23.1	OAA 0 + Medicare	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.1	OAA 0 + Medicare	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
23.2	OAA 0 +	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.2	OAA 0 +	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
59.9	Rate MCR		4,246.33	1298.79	522.24	0.00	6067.36				6,067.36	-11.53	6056.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

State of Michigan Managed Care Rates FY08
Effective October 1, 2007

Molina Healthcare 0004318627 0004318645; Counties 03, 10, 34, 41, 43, 51, 53, 54, 57, 59, 61, 62, 64, 67, 70, 83

Region 04

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	342.76	99.34	35.21	3.38	480.69	0.986			473.96	-0.90	473.06
2	TANF < 1	F	307.20	90.78	32.19	3.38	433.55	0.986			427.48	-0.81	426.67
3	TANF 1 - 4	M	81.05	14.58	2.12	3.38	101.13	0.986			99.71	-0.19	99.52
4	TANF 1 - 4	F	69.36	11.19	1.68	3.38	85.61	0.986			84.41	-0.16	84.25
5	TANF 5 - 14	M	64.56	7.76	1.00	3.38	76.7	0.986			75.63	-0.14	75.49
6	TANF 5 - 14	F	54.83	6.59	0.78	3.38	65.58	0.986			64.66	-0.12	64.54
7	TANF 15 - 20	M	68.86	11.50	1.83	3.38	85.57	0.986			84.37	-0.16	84.21
8	TANF 15 - 20	F	111.50	17.54	2.29	3.38	134.71	0.986			132.82	-0.25	132.57
9	TANF 21 - 25	M	101.22	20.74	3.15	3.38	128.49	0.986			126.69	-0.24	126.45
10	TANF 21 - 25	F	186.03	35.64	4.54	3.38	229.59	0.986			226.38	-0.43	225.95
11	TANF 26 - 44	M	230.29	56.57	7.86	3.38	298.1	0.986			293.93	-0.56	293.37
12	TANF 26 - 44	F	264.38	48.52	8.14	3.38	324.42	0.986			319.88	-0.61	319.27
13	TANF 45+	M	429.31	83.78	19.59	3.38	536.06	0.986			528.56	-1.00	527.56
14	TANF 45+	F	465.00	83.28	18.90	3.38	570.56	0.986			562.57	-1.07	561.50
15	ABAD 0 - 20	M	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
16	ABAD 0 - 20	F	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
17.1	ABAD 21 - 39 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
18.1	ABAD 21 - 39 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
17.2	ABAD 21 - 39	M	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
18.2	ABAD 21 - 39	F	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
19.1	ABAD 40 - 64 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
20.1	ABAD 40 - 64 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
19.2	ABAD 40 - 64	M	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
20.2	ABAD 40 - 64	F	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
21.1	ABAD 65 + Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
22.1	ABAD 65 + Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
21.2	ABAD 65 +	M	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
22.2	ABAD 65 +	F	603.27	112.96	26.45	6.76	749.44		0.9270		694.73	-1.32	693.41
23.1	OAA 0 + Medicare	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.1	OAA 0 + Medicare	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
23.2	OAA 0 +	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.2	OAA 0 +	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
59.9	Rate MCR		3,930.83	1298.79	522.24	0.00	5751.86				5,751.86	-10.93	5741.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Molina Healthcare 0004318627 0004318645; County 25

Region 06

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF < 1	M	342.76	99.34	35.21	3.38	480.69	0.998			479.73	-0.91	478.82
2	TANF < 1	F	307.20	90.78	32.19	3.38	433.55	0.998			432.68	-0.82	431.86
3	TANF 1 - 4	M	81.05	14.58	2.12	3.38	101.13	0.998			100.93	-0.19	100.74
4	TANF 1 - 4	F	69.36	11.19	1.68	3.38	85.61	0.998			85.44	-0.16	85.28
5	TANF 5 - 14	M	64.56	7.76	1.00	3.38	76.7	0.998			76.55	-0.15	76.40
6	TANF 5 - 14	F	54.83	6.59	0.78	3.38	65.58	0.998			65.45	-0.12	65.33
7	TANF 15 - 20	M	68.86	11.50	1.83	3.38	85.57	0.998			85.40	-0.16	85.24
8	TANF 15 - 20	F	111.50	17.54	2.29	3.38	134.71	0.998			134.44	-0.26	134.18
9	TANF 21 - 25	M	101.22	20.74	3.15	3.38	128.49	0.998			128.23	-0.24	127.99
10	TANF 21 - 25	F	186.03	35.64	4.54	3.38	229.59	0.998			229.13	-0.44	228.69
11	TANF 26 - 44	M	230.29	56.57	7.86	3.38	298.1	0.998			297.50	-0.57	296.93
12	TANF 26 - 44	F	264.38	48.52	8.14	3.38	324.42	0.998			323.77	-0.62	323.15
13	TANF 45 +	M	429.31	83.78	19.59	3.38	536.06	0.998			534.99	-1.02	533.97
14	TANF 45 +	F	465.00	83.28	18.90	3.38	570.56	0.998			569.42	-1.08	568.34
15	ABAD 0 - 20	M	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
16	ABAD 0 - 20	F	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
17.1	ABAD 21 - 39 Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
18.1	ABAD 21 - 39 Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
17.2	ABAD 21 - 39	M	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
18.2	ABAD 21 - 39	F	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
19.1	ABAD 40 - 64 Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
20.1	ABAD 40 - 64 Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
19.2	ABAD 40 - 64	M	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
20.2	ABAD 40 - 64	F	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
21.1	ABAD 65 + Medicare	M	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
22.1	ABAD 65 + Medicare	F	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
21.2	ABAD 65 +	M	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
22.2	ABAD 65 +	F	603.27	112.96	26.45	6.76	749.44		1.0030		751.69	-1.43	750.26
23.1	OAA 0 + Medicare	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.1	OAA 0 + Medicare	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
23.2	OAA 0 +	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.2	OAA 0 +	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
59.9	Rate MCR		4,502.46	1298.79	522.24	0.00	6323.49				6,323.49	-12.01	6311.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Molina Healthcare 0004318627 0004318645; Counties 01, 06, 09, 20, 26, 29, 32, 35, 37, 56, 60, 65, 68, 69, 71, 72, 73, 76, 79
Region 07

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF <1	M	342.76	99.34	35.21	3.38	480.69	1.009			485.02	-0.92	484.10
2	TANF <1	F	307.20	90.78	32.19	3.38	433.55	1.009			437.45	-0.83	436.62
3	TANF 1-4	M	81.05	14.58	2.12	3.38	101.13	1.009			102.04	-0.19	101.85
4	TANF 1-4	F	69.36	11.19	1.68	3.38	85.61	1.009			86.38	-0.16	86.22
5	TANF 5-14	M	64.56	7.76	1.00	3.38	76.7	1.009			77.39	-0.15	77.24
6	TANF 5-14	F	54.83	6.59	0.78	3.38	65.58	1.009			66.17	-0.13	66.04
7	TANF 15-20	M	68.86	11.50	1.83	3.38	85.57	1.009			86.34	-0.16	86.18
8	TANF 15-20	F	111.50	17.54	2.29	3.38	134.71	1.009			135.92	-0.26	135.66
9	TANF 21-25	M	101.22	20.74	3.15	3.38	128.49	1.009			129.65	-0.25	129.40
10	TANF 21-25	F	186.03	35.64	4.54	3.38	229.59	1.009			231.66	-0.44	231.22
11	TANF 26-44	M	230.29	56.57	7.86	3.38	298.1	1.009			300.78	-0.57	300.21
12	TANF 26-44	F	264.38	48.52	8.14	3.38	324.42	1.009			327.34	-0.62	326.72
13	TANF 45 +	M	429.31	83.78	19.59	3.38	536.06	1.009			540.88	-1.03	539.85
14	TANF 45 +	F	465.00	83.28	18.90	3.38	570.56	1.009			575.70	-1.09	574.61
15	ABAD 0-20	M	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
16	ABAD 0-20	F	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
17.1	ABAD 21-39 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
18.1	ABAD 21-39 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
17.2	ABAD 21-39	M	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
18.2	ABAD 21-39	F	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
19.1	ABAD 40-64 Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
20.1	ABAD 40-64 Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
19.2	ABAD 40-64	M	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
20.2	ABAD 40-64	F	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
21.1	ABAD 65 + Medicare	M	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
22.1	ABAD 65 + Medicare	F	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
21.2	ABAD 65 +	M	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
22.2	ABAD 65 +	F	603.27	112.96	26.45	6.76	749.44		0.9910		742.70	-1.41	741.29
23.1	OAA 0 + Medicare	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.1	OAA 0 + Medicare	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
23.2	OAA 0 +	M	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
24.2	OAA 0 +	F	603.27	112.96	26.45	6.76	749.44			0.848	635.53	-1.21	634.32
59.9	Rate MCR		4,190.98	1298.79	522.24	0.00	6012.01				6,012.01	-11.42	6001.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

State of Michigan Managed Care Rates FY08
Effective October 1, 2007

Molina Healthcare 0004318627 0004318645; Counties 50, 74
Region 09

				Base	Hosp	Phys		New			Adj	0.19%	Rate	
Rate Cell	Description		Sex	Rate	Adj	GME	Access	Base	Area	Risk	OAA	Base	Bonus	after
							Fee	Rate	Factor	Adj.	Factor	Rate	W/H	W/H
1	TANF	<1	M	356.82	112.83	39.18	3.38	512.21	0.998			511.19	-0.97	510.22
2	TANF	<1	F	329.61	98.22	34.77	3.38	465.98	0.998			465.05	-0.88	464.17
3	TANF	1-4	M	85.16	15.43	2.33	3.38	106.3	0.998			106.09	-0.20	105.89
4	TANF	1-4	F	69.67	10.59	1.73	3.38	85.37	0.998			85.20	-0.16	85.04
5	TANF	5-14	M	54.51	7.12	0.96	3.38	65.97	0.998			65.84	-0.13	65.71
6	TANF	5-14	F	46.82	6.12	0.85	3.38	57.17	0.998			57.06	-0.11	56.95
7	TANF	15-20	M	56.48	10.11	1.76	3.38	71.73	0.998			71.59	-0.14	71.45
8	TANF	15-20	F	84.04	12.68	2.06	3.38	102.16	0.998			101.96	-0.19	101.77
9	TANF	21-25	M	94.10	21.43	3.69	3.38	122.6	0.998			122.35	-0.23	122.12
10	TANF	21-25	F	150.86	30.15	5.63	3.38	190.02	0.998			189.64	-0.36	189.28
11	TANF	26-44	M	213.46	45.38	10.83	3.38	273.05	0.998			272.50	-0.52	271.98
12	TANF	26-44	F	220.76	44.85	8.21	3.38	277.2	0.998			276.65	-0.53	276.12
13	TANF	45 +	M	407.57	82.90	21.09	3.38	514.94	0.998			513.91	-0.98	512.93
14	TANF	45 +	F	416.01	91.52	19.29	3.38	530.2	0.998			529.14	-1.01	528.13
15	ABAD	0-20	M	639.42	146.88	36.85	6.76	829.91		0.9920		823.27	-1.56	821.71
16	ABAD	0-20	F	639.42	146.88	36.85	6.76	829.91		0.9920		823.27	-1.56	821.71
17.1	ABAD	21-39	Medicare	M	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
18.1	ABAD	21-39	Medicare	F	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
17.2	ABAD	21-39		M	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
18.2	ABAD	21-39		F	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
19.1	ABAD	40-64	Medicare	M	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
20.1	ABAD	40-64	Medicare	F	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
19.2	ABAD	40-64		M	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
20.2	ABAD	40-64		F	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
21.1	ABAD	65 +	Medicare	M	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
22.1	ABAD	65 +	Medicare	F	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
21.2	ABAD	65 +		M	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
22.2	ABAD	65 +		F	639.42	146.88	36.85	6.76	829.91		0.9920	823.27	-1.56	821.71
23.1	OAA	0 +	Medicare	M	639.42	146.88	36.85	6.76	829.91		0.758	629.07	-1.20	627.87
24.1	OAA	0 +	Medicare	F	639.42	146.88	36.85	6.76	829.91		0.758	629.07	-1.20	627.87
23.2	OAA	0 +		M	639.42	146.88	36.85	6.76	829.91		0.758	629.07	-1.20	627.87
24.2	OAA	0 +		F	639.42	146.88	36.85	6.76	829.91		0.758	629.07	-1.20	627.87
59.9	Rate MCR				4,377.00	1545.03	605.58	0.00	6527.61			6,527.61	-12.40	6515.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

**State of Michigan Managed Care Rates FY08
Effective October 1, 2007**

Molina Healthcare 0004318627 0004318645; County 63
Region 10

Rate Cell	Description	Sex	Base Rate	Hosp Adj	GME	Phys Access Fee	New Base Rate	Area Factor	Risk Adj.	OAA Factor	Adj Base Rate	0.19% Bonus W/H	Rate after W/H
1	TANF <1	M	356.82	112.83	39.18	3.38	512.21	1.022			523.48	-0.99	522.49
2	TANF <1	F	329.61	98.22	34.77	3.38	465.98	1.022			476.23	-0.90	475.33
3	TANF 1-4	M	85.16	15.43	2.33	3.38	106.3	1.022			108.64	-0.21	108.43
4	TANF 1-4	F	69.67	10.59	1.73	3.38	85.37	1.022			87.25	-0.17	87.08
5	TANF 5-14	M	54.51	7.12	0.96	3.38	65.97	1.022			67.42	-0.13	67.29
6	TANF 5-14	F	46.82	6.12	0.85	3.38	57.17	1.022			58.43	-0.11	58.32
7	TANF 15-20	M	56.48	10.11	1.76	3.38	71.73	1.022			73.31	-0.14	73.17
8	TANF 15-20	F	84.04	12.68	2.06	3.38	102.16	1.022			104.41	-0.20	104.21
9	TANF 21-25	M	94.10	21.43	3.69	3.38	122.6	1.022			125.30	-0.24	125.06
10	TANF 21-25	F	150.86	30.15	5.63	3.38	190.02	1.022			194.20	-0.37	193.83
11	TANF 26-44	M	213.46	45.38	10.83	3.38	273.05	1.022			279.06	-0.53	278.53
12	TANF 26-44	F	220.76	44.85	8.21	3.38	277.2	1.022			283.30	-0.54	282.76
13	TANF 45 +	M	407.57	82.90	21.09	3.38	514.94	1.022			526.27	-1.00	525.27
14	TANF 45 +	F	416.01	91.52	19.29	3.38	530.2	1.022			541.86	-1.03	540.83
15	ABAD 0-20	M	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
16	ABAD 0-20	F	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
17.1	ABAD 21-39	Medicare M	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
18.1	ABAD 21-39	Medicare F	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
17.2	ABAD 21-39	M	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
18.2	ABAD 21-39	F	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
19.1	ABAD 40-64	Medicare M	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
20.1	ABAD 40-64	Medicare F	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
19.2	ABAD 40-64	M	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
20.2	ABAD 40-64	F	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
21.1	ABAD 65 + Medicare	M	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
22.1	ABAD 65 + Medicare	F	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
21.2	ABAD 65 +	M	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
22.2	ABAD 65 +	F	639.42	146.88	36.85	6.76	829.91		0.9870		819.12	-1.56	817.56
23.1	OAA 0 + Medicare	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.1	OAA 0 + Medicare	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
23.2	OAA 0 +	M	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
24.2	OAA 0 +	F	639.42	146.88	36.85	6.76	829.91			0.758	629.07	-1.20	627.87
59.9	Rate MCR		4,512.89	1545.03	605.58	0.00	6663.5				6,663.50	-12.66	6651.00

NOTE: Due to MDCH Medicaid claims system limitations, MCR (Rate Cell 59.9) is rounded to nearest whole dollar after the bonus withhold.

PROVIDER AGREEMENT
BETWEEN
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
AND
MOLINA HEALTHCARE OF OHIO, INC

Amendment No. 1

Pursuant to Article IX.A. the Provider Agreement between the State of Ohio, Department of Job and Family Services, (hereinafter referred to as "ODJFS") and MOLINA HEALTHCARE OF OHIO, INC (hereinafter referred to as "MCP") for the Covered Families and Children (hereinafter referred to as "CFC") population dated July 1, 2007, is hereby amended as follows:

1. Appendices C, D, E, F, G, H, J, K, L, M, N and O are modified as attached.
2. All other terms of the provider agreement are hereby affirmed.

The amendment contained herein shall be effective January 1, 2008.

MOLINA HEALTHCARE OF OHIO, INC:

BY: /s/ Kathie Mancini
KATHIE MANCINI, PRESIDENT On behalf of Kathie Mancini

DATE: 12/20/07

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES:

BY: /s/ Helen E. Jones-Kelley
HELEN E. JONES-KELLEY, DIRECTOR

DATE: 12/20/07

APPENDIX C
MCP RESPONSIBILITIES
CFC ELIGIBLE POPULATION

The MCP must meet on an ongoing basis, all program requirements specified in Chapter 5101:3-26 of the Ohio Administrative Code (OAC) and the Ohio Department of Job and Family Services (ODJFS) — MCP Provider Agreement. The following are MCP responsibilities that are not otherwise specifically stated in OAC rule provisions or elsewhere in the MCP provider agreement, but are required by ODJFS.

General Provisions

1. The MCP agrees to implement program modifications as soon as reasonably possible or no later than the required effective date, in response to changes in applicable state and federal laws and regulations.
 2. The MCP must submit a current copy of their Certificate of Authority (COA) to ODJFS within 30 days of issuance by the Ohio Department of Insurance.
 3. The MCP must designate the following:
 - a. A primary contact person (the Medicaid Coordinator) who will dedicate a majority of their time to the Medicaid product line and coordinate overall communication between ODJFS and the MCP. ODJFS may also require the MCP to designate contact staff for specific program areas. The Medicaid Coordinator will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCP submissions to ODJFS.
 - b. A provider relations representative for each service area included in their ODJFS provider agreement. This provider relations representative can serve in this capacity for only one service area (as specified in Appendix H).

As long as the MCP serves both the CFC and ABD populations, they are not required to have separate provider relations representatives or Medicaid coordinators.
 4. All MCP employees are to direct all day-to-day submissions and communications to their ODJFS-designated Contract Administrator unless otherwise notified by ODJFS.
 5. The MCP must be represented at all meetings and events designated by ODJFS as requiring mandatory attendance.
 6. The MCP must have an administrative office located in Ohio.
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Appendix C

Covered Families and Children (CFC) population

Page 2

7. Upon request by ODJFS, the MCP must submit information on the current status of their company's operations not specifically covered under this provider agreement (for example, other product lines, Medicaid contracts in other states, NCQA accreditation, etc.) unless otherwise excluded by law.
 8. The MCP must have all new employees trained on applicable program requirements, and represent, warrant and certify to ODJFS that such training occurs, or has occurred.
 9. If an MCP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it must immediately notify ODJFS to coordinate the implementation of this change. MCPs will be required to notify their members of this change at least thirty (30) days prior to the effective date. The MCP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services that the MCP will not provide.
 10. For any data and/or documentation that MCPs are required to maintain, ODJFS may request that MCPs provide analysis of this data and/or documentation to ODJFS in an aggregate format, such format to be solely determined by ODJFS.
 11. The MCP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5101:3-26-03. Notwithstanding such responsibility, ODJFS retains the right to make the final determination on medical necessity in specific member situations.
 12. In addition to the timely submission of medical records at no cost for the annual external quality review as specified in OAC rule 5101:3-26-07, the MCP may be required for other purposes to submit medical records at no cost to ODJFS and/or designee upon request.
 13. The MCP must notify the BMHC of the termination of an MCP panel provider that is designated as the primary care provider for 500 or more of the MCP's CFC members. The MCP must provide notification within one working day of the MCP becoming aware of the termination.
 14. Upon request by ODJFS, MCPs may be required to provide written notice to members of any significant change(s) affecting contractual requirements, member services or access to providers.
 15. MCPs may elect to provide services that are in addition to those covered under the Ohio Medicaid fee-for-service program. Before MCPs notify potential or current members of the availability of these services, they must first notify ODJFS and advise ODJFS of such
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planned services availability. If an MCP elects to provide additional services, the MCP must ensure to the satisfaction of ODJFS that the services are readily available and accessible to members who are eligible to receive them.

- a. MCPs are **required** to make transportation available to any member requesting transportation when they **must** travel (thirty) 30 miles or more from their home to receive a medically-necessary Medicaid-covered service. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.
 - b. Additional benefits may not vary by county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). MCPs approved to serve consumers in more than one region may vary additional benefits between regions.
 - c. MCPs must give ODJFS and members (ninety) 90 days prior notice when decreasing or ceasing any additional benefit(s). When it is beyond the control of the MCP, as demonstrated to ODJFS' satisfaction, ODJFS must be notified within (one) 1 working day.
16. MCPs must comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff adheres to such laws when furnishing services to its members. MCPs shall include a requirement in its contracts with affiliated providers that such providers also adhere to applicable Federal and State laws when providing services to members.
 17. MCPs must comply with any other applicable Federal and State laws (such as Title VI of the Civil rights Act of 1964, etc.) and other laws regarding privacy and confidentiality, as such may be applicable to this Agreement.
 18. Upon request, the MCP will provide members and potential members with a copy of their practice guidelines.
 19. The MCP is responsible for promoting the delivery of services in a culturally competent manner, as solely determined by ODJFS, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds.

All MCPs must comply with the requirements specified in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08 and 5101:3-26-08.2 for providing assistance to LEP members and eligible individuals. In addition, MCPs must provide written translations of certain MCP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

- a. When 10% or more of the CFC eligible individuals in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved marketing materials into the primary language of that group. The MCP must monitor changes in the eligible population on an ongoing basis and conduct an assessment no less often than annually to determine which, if any, primary language groups meet the 10% threshold for the eligible individuals in each service area. When the 10% threshold is met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their marketing materials, and make these marketing materials available to eligible individuals. MCPs must submit to ODJFS, upon request, their prevalent non-English language analysis of eligible individuals and the results of this analysis.
 - b. When 10% or more of an MCP's CFC members in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved member materials into the primary language of that group. The MCP must monitor their membership and conduct a quarterly assessment to determine which, if any, primary language groups meet the 10% threshold. When the 10% threshold is met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their member materials, and make these materials available to their members. MCPs must submit to ODJFS, upon request, their prevalent non-English language member analysis and the results of this analysis.
 20. The MCP must utilize a centralized database which records the special communication needs of all MCP members (i.e., those with limited English proficiency, limited reading proficiency, visual impairment, and hearing impairment) and the provision of related services (i.e., MCP materials in alternate format, oral interpretation, oral translation services, written translations of MCP materials, and sign language services). This database must include all MCP member primary language information (PLI) as well as all other special communication needs information for MCP members, as indicated above, when identified by any source including but not limited to ODJFS, ODJFS selection services entity, MCP staff, providers, and members. This centralized database must be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a PCP who speaks the primary language of an LEP member, when such a provider is available. MCPs must share specific communication needs information with their providers [e.g., PCPs, Pharmacy Benefit Managers (PBMs), and Third Party Administrators (TPAs)], as applicable. MCPs must submit to ODJFS, upon request, detailed information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members
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(i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider).

Additional requirements specific to providing assistance to hearing-impaired, vision-impaired, limited reading proficient (LRP), and LEP members and eligible individuals are found in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08, and 5101:3-26-08.2.

21. The MCP is responsible for ensuring that all member materials use easily understood language and format. The determination of what materials comply with this requirement is in the sole discretion of ODJFS.
 22. Pursuant to OAC rules 5101:3-26-08 and 5101:3-26-08.2, the MCP is responsible for ensuring that all MCP marketing and member materials are prior approved by ODJFS before being used or shared with members. Marketing and member materials are defined as follows:
 - a. Marketing materials are those items produced in any medium, by or on behalf of an MCP, including gifts of nominal value (i.e., items worth no more than \$15.00), which can reasonably be interpreted as intended to market to eligible individuals.
 - b. Member materials are those items developed, by or on behalf of an MCP, to fulfill MCP program requirements or to communicate to all members or a group of members. Member health education materials that are produced by a source other than the MCP and which do not include any reference to the MCP are not considered to be member materials.
 - c. All MCP marketing and member materials must represent the MCP in an honest and forthright manner and must not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODJFS.
 - d. All MCP marketing cannot contain any assertion or statement (whether written or oral) that the MCP is endorsed by CMS, the Federal or State government or similar entity.
 - e. MCPs must establish positive working relationships with the CDJFS offices and must not aggressively solicit from local Directors, MCP County Coordinators, or other staff. Furthermore, MCPs are prohibited from offering gifts of nominal value (i.e. clipboards, pens, coffee mugs, etc.) to CDJFS offices or managed care enrollment center (MCEC) staff, as these may influence an individual's decision to select a particular MCP.
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23. Advance Directives — All MCPs must comply with the requirements specified in 42 CFR 422.128. At a minimum, the MCP must:
- a. Maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Subpart I of part 489.
 - b. Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCP to ensure that the MCP:
 - i. Provides written information to all adult members concerning:
 - a. the member's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. (In meeting this requirement, MCPs must utilize form JFS 08095 entitled *You Have the Right*, or include the text from JFS 08095 in their ODJFS-approved member handbook).
 - b. the MCP's policies concerning the implementation of those rights including a clear and precise statement of any limitation regarding the implementation of advance directives as a matter of conscience;
 - c. any changes in state law regarding advance directives as soon as possible but no later than (ninety) 90 days after the proposed effective date of the change; and
 - d. the right to file complaints concerning noncompliance with the advance directive requirements with the Ohio Department of Health.
 - ii. Provides for education of staff concerning the MCP's policies and procedures on advance directives;
 - iii. Provides for community education regarding advance directives directly or in concert with other providers or entities;
 - iv. Requires that the member's medical record document whether or not the member has executed an advance directive; and
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- v. Does not condition the provision of care, or otherwise discriminate against a member, based on whether the member has executed an advance directive.

24. New Member Materials

Pursuant to OAC rule 5101:3-26-08.2 (B)(3), MCPs must provide to each member or assistance group, as applicable, an MCP identification (ID) card, a new member letter, a member handbook, a provider directory, and information on advance directives.

- a. MCPs must use the model language specified by ODJFS for the new member letter.
- b. The ID card and new member letter must be mailed together to the member via a method that will ensure their receipt prior to the member's effective date of coverage.
- c. The member handbook, provider directory and advance directives information may be mailed to the member separately from the ID card and new member letter. MCPs will meet the timely receipt requirement for these materials if they are mailed to the member within (twenty-four) 24 hours of the MCP receiving the ODJFS produced monthly membership roster (MMR). This is provided the materials are mailed via a method with an expected delivery date of no more than five (5) days. If the member handbook, provider directory and advance directives information are mailed separately from the ID card and new member letter and the MCP is unable to mail the materials within twenty-four (24) hours, the member handbook, provider directory and advance directives information must be mailed via a method that will ensure receipt by no later than the effective date of coverage. If the MCP mails the ID card and new member letter with the other materials (e.g., member handbook, provider directory, and advance directives), the MCP must ensure that all materials are mailed via a method that will ensure their receipt prior to the member's effective date of coverage.
- d. MCPs must designate two (2) MCP staff members to receive a copy of the new member materials on a monthly basis in order to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address.

25. Call Center Standards

The MCP must provide assistance to members through a member services toll-free call-in system pursuant to OAC rule 5101:3-26-08.2(A)(1). MCP member services staff must be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm Eastern Time, except for the following major holidays:

- New Year's Day
 - Martin Luther King's Birthday
 - Memorial Day
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- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day
- 2 optional closure days: These days can be used independently or in combination with any of the major holiday closures but cannot both be used within the same closure period.

Before announcing any optional closure dates to members and/or staff, MCPs must receive ODJFS prior-approval which verifies that the optional closure days meet the specified criteria.

If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday. MCP member services closure days must be specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least (thirty) 30 days in advance of the closure.

The MCP must also provide access to medical advice and direction through a centralized twenty-four-hour, seven day (24/7) toll-free call-in system, available nationwide, pursuant to OAC rule 5101:3-26-03.1(A)(6). The 24/7 call-in system must be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses, and registered nurses.

MCPs must meet the current American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer. By the 10th of each month, MCPs must self-report their prior month performance in these three areas for their member services and 24/7 toll-free call-in systems to ODJFS. ODJFS will inform the MCPs of any changes/updates to these URAC call center standards.

MCPs are not permitted to delegate grievance/appeal functions [Ohio Administrative Code (OAC) rule 5101:3-26-08.4(A)(9)]. Therefore, the member services call center requirement may not be met through the execution of a Medicaid Delegation Subcontract Addendum or Medicaid Combined Services Subcontract Addendum.

26. Notification of Optional MCP Membership

In order to comply with the terms of the ODJFS State Plan Amendment for the managed care program (i.e., 42 CFR 438.50), MCPs in mandatory membership service areas must inform new members that MCP membership is optional for certain populations. Specifically, MCPs must inform any applicable pending member or member that the following CFC populations are not required to select an MCP in order to receive their

Medicaid healthcare benefit and what steps they need to take if they do not wish to be a member of an MCP:

- Indians who are members of federally-recognized tribes.
- Children under 19 years of age who are:
 - O Eligible for Supplemental Security Income under title XVI;
 - O In foster care or other out-of-home placement;
 - O Receiving foster care of adoption assistance;
 - O Receiving services through the Ohio Department of Health's Bureau for Children with Medical Handicaps (BCMh) or any other family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the State in terms of either program participation or special health care needs.

27. HIPAA Privacy Compliance Requirements

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR. § 164.502(e) and § 164.504(e) require ODJFS to have agreements with MCPs as a means of obtaining satisfactory assurance that the MCPs will appropriately safeguard all personal identified health information. Protected Health Information (PHI) is information received from or on behalf of ODJFS that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 164.501, and any amendments thereto. MCPs must agree to the following:

- a. MCPs shall not use or disclose PHI other than is permitted by this agreement or required by law.
 - b. MCPs shall use appropriate safeguards to prevent unauthorized use or disclosure of PHI.
 - c. MCPs shall report to ODJFS any unauthorized use or disclosure of PHI of which it becomes aware. Any breach by the MCP or its representatives of protected health information (PHI) standards shall be immediately reported to the State HIPAA Compliance Officer through the Bureau of Managed Health Care. MCPs must provide documentation of the breach and complete all actions ordered by the HIPAA Compliance Officer.
 - d. MCPs shall ensure that all its agents and subcontractors agree to these same PHI conditions and restrictions.
 - e. MCPs shall make PHI available for access as required by law.
 - f. MCP shall make PHI available for amendment, and incorporate amendments as
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appropriate as required by law.

- g. MCPs shall make PHI disclosure information available for accounting as required by law.
 - h. MCPs shall make its internal PHI practices, books and records available to the Secretary of Health and Human Services (HHS) to determine compliance.
 - i. Upon termination of their agreement with ODJFS, the MCPs, at ODJFS' option, shall return to ODJFS, or destroy, all PHI in its possession, and keep no copies of the information, except as requested by ODJFS or required by law.
 - j. ODJFS will propose termination of the MCP's provider agreement if ODJFS determines that the MCP has violated a material breach under this section of the agreement, unless inconsistent with statutory obligations of ODJFS or the MCP .
28. Electronic Communications – MCPs are required to purchase/utilize Transport Layer Security (TLS) for all e-mail communication between ODJFS and the MCP. The MCP's e-mail gateway must be able to support the sending and receiving of e-mail using Transport Layer Security (TLS) and the MCP's gateway must be able to enforce the sending and receiving of email via TLS.
29. MCP Membership acceptance, documentation and reconciliation
- a. Selection Services Contractor: The MCP shall provide to the MCEC ODJFS prior-approved MCP materials and directories for distribution to eligible individuals who request additional information about the MCP.
 - b. Monthly Reconciliation of Membership and Premiums: The MCP shall reconcile member data as reported on the MCEC produced consumer contact record (CCR) with the ODJFS-produced monthly member roster (MMR) and report to the ODJFS any difficulties in interpreting or reconciling information received. Membership reconciliation questions must be identified and reported to the ODJFS prior to the first of the month to assure that no member is left without coverage. The MCP shall reconcile membership with premium payments and delivery payments as reported on the monthly remittance advice (RA).
- The MCP shall work directly with the ODJFS, or other ODJFS-identified entity, to resolve any difficulties in interpreting or reconciling premium information. Premium reconciliation questions must be identified within thirty (30) days of receipt of the RA.
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- c. Monthly Premiums and Delivery Payments: The MCP must be able to receive monthly premiums and delivery payments in a method specified by ODJFS.(ODJFS monthly prospective premium and delivery payment issue dates are provided in advance to the MCPs.) Various retroactive premium payments (e.g., newborns), and recovery of premiums paid (e.g., retroactive terminations of membership for children in custody, deferments, etc.,) may occur via any ODJFS weekly remittance.
- d. Hospital/Inpatient Facility Deferment: When an MCP learns of a currently hospitalized member's intent to disenroll through the CCR or the 834, the disenrolling MCP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCP of the change in enrollment within five (5) business days of receipt of the CCR or 834. The disenrolling MCP must notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and must notify the treating providers that it will remain responsible for provider charges through the date of disenrollment.

When the enrolling MCP learns through the disenrolling MCP, through ODJFS or other means, that a new member who was previously enrolled with another MCP was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall contact the hospital/inpatient facility within five (5) business days of learning of the hospitalization. The enrolling MCP shall verify that it is responsible for all medically necessary Medicaid covered services from the effective date of MCP membership, including treating provider services related to the inpatient stay; the enrolling MCP must reiterate that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCP shall work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

When an MCP learns that a new member who was previously on Medicaid fee for service was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall notify the hospital/ inpatient facility and treating providers that the MCP may not be the payer. The MCP shall work with hospital/inpatient facility, treating providers and the ODJFS to assure that discharge planning assures continuity of care and accurate payment. Notwithstanding the MCP's right to request a hospital deferment up to six (6) months following the member's effective date, when the enrolling MCP learns of a deferment-eligible hospitalization, the MCP shall notify the ODJFS **and** request the deferment within five (5) business days of learning of the potential deferment.

- e. Just Cause Requests: The MCP shall follow procedures as specified by ODJFS in assisting the ODJFS in resolving member requests for member-initiated requests affecting membership.
- f. Newborn Notifications: The MCP is required to submit newborn notifications to ODJFS in accordance with the ODJFS Newborn Notification File and Submissions Specifications.
- g. Eligible Individuals: If an eligible individual contacts the MCP, the MCP must provide any MCP-specific managed care program information requested. The MCP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, MCPs shall provide an assurance that all MCPs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.
- h. Pending Member

If a pending member (i.e., an eligible individual subsequent to plan selection or assignment, but prior to their membership effective date) contacts the selected MCP, the MCP must provide any membership information requested, including but not limited to, assistance in determining whether the current medications require prior authorization. The MCP must also ensure that any care coordination (e.g., PCP selection, prescheduled services and transition of services) information provided by the pending member is logged in the MCP's system and forwarded to the appropriate MCP staff for processing as required. MCPs may confirm any information provided on the CCR at this time. Such communication does not constitute confirmation of membership. MCPs are prohibited from initiating contact with a pending member. Upon receipt of the 834, the MCP may contact a pending member to confirm information provided on the CCR or the 834, assist with care coordination and transition of care, and inquire if the pending member has any membership questions.

- i. Transition of Fee-For-Service Members

Providing care coordination for prescheduled health services and existing care treatment plans, is critical for members transitioning from Medicaid fee-for service (FFS) to managed care. Therefore, MCPs must:

- i. Allow their new members that are transitioning from Medicaid fee-for-service to receive services from out-of-panel providers if the member or provider contacts the MCP to discuss the scheduled health
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services in advance of the service date and one of the following applies:

- a. The member is in her third trimester of pregnancy and has an established relationship with an obstetrician and/or delivery hospital;
- b. The member has been scheduled for an inpatient/outpatient surgery and has been prior-approved and/or precertified pursuant to OAC rule 5101:3-2-40 (surgical procedures would also include follow-up care as appropriate);
- c. The member has appointments within the initial month of MCP membership with specialty physicians that were scheduled prior to the effective date of membership; or
- d. The member is receiving ongoing chemotherapy or radiation treatment.

If contacted by the member, the MCP must contact the provider's office as expeditiously as the situation warrants to confirm that the service(s) meets the above criteria.

- ii. Allow their new members that are transitioning from Medicaid fee-for-service to continue receiving home care services (i.e., nursing, aide, and skilled therapy services) and private duty nursing (PDN) services if the member or provider contacts the MCP to discuss the health services in advance of the service date. These services must be covered from the date of the member or provider contact at the current service level, and with the current provider, whether a panel or out-of-panel provider, until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1. As soon as the MCP becomes aware of the member's current home care services, the MCP must initiate contact with the current provider and member as applicable to ensure continuity of care and coordinate a transfer of services to a panel provider, if appropriate.
 - iii. Honor any current fee-for-service prior authorization to allow their new members that are transitioning from Medicaid fee-for-service to receive services from the authorized provider, whether a panel or out-of-panel provider, for the following approved services:
 - a. an organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule 5101:3-2-07.1;
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- b. dental services that have not yet been received;
- c. vision services that have not yet been received;
- d. durable medical equipment (DME) that has not yet been received. Ongoing DME services and supplies are to be covered by the MCP as previously-authorized until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.
- e. private duty nursing (PDN) services. PDN services must be covered at the previously-authorized service level until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.

As soon as the MCP becomes aware of the member's current fee-for-service authorization approval, the MCP must initiate contact with the authorized provider and member as applicable to ensure continuity of care. The MCP must implement a plan to meet the member's immediate and ongoing medical needs and, with the exception of organ, bone marrow, or hematopoietic stem cell transplants, coordinate the transfer of services to a panel provider, if appropriate.

When an MCP medical necessity review results in a decision to reduce, suspend, or terminate services previously authorized by fee-for-service Medicaid, the MCP must notify the member of their state hearing rights no less than 15 calendar days prior to the effective date of the MCP's proposed action, per rule 5101:3-26-08.4 of the Administrative Code.

- iv. Reimburse out-of-panel providers that agree to provide the transition services at 100% of the current Medicaid fee-for-service provider rate for the service(s) identified in Section 29.i. (i., ii., and iii.) of this appendix.
 - v. Document the provision of transition of services identified in Section 29.i. (i., ii., and iii.) of this appendix as follows:
 - a. For non-panel providers, notification to the provider confirming the provider's agreement/disagreement to provide the service and accept 100% of the current Medicaid fee-for-service rate as payment. If the provider agrees, the distribution of the MCP's materials as outlined in Appendix G.3.e.
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- b. Notification to the member of the non-panel provider's agreement/disagreement to provide the service. If the provider disagrees, notification to the member of the MCP's availability to assist with locating a provider as expeditiously as the member's health condition warrants.
 - c. For panel providers, notification to the provider and member confirming the MCP's responsibility to cover the service.
- MCPs must use the ODJFS-specified model language for the provider and member notices and maintain documentation of all member and/or provider contacts relating to such services.

30. Health Information System Requirements

The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODJFS therefore requires MCPs to demonstrate their ongoing capacity in this area by meeting several related specifications.

- a. Health Information System
 - i. As required by 42 CFR 438.242(a), each MCP must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and MCP membership terminations for other than loss of Medicaid eligibility.
 - ii. As required by 42 CFR 438.242(b)(1), each MCP must collect data on member and provider characteristics and on services furnished to its members.
 - iii. As required by 42 CFR 438.242(b)(2), each MCP must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.
 - iv. As required by 42 CFR 438.242(b)(3), each MCP must make all collected data available upon request by ODJFS or the Center for Medicare and Medicaid Services (CMS).
 - v. Acceptance testing of any data that is electronically submitted to ODJFS is required:
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- a. Before an MCP may submit production files
- b. Whenever an MCP changes the method or preparer of the electronic media; and/or
- c. When the ODJFS determines an MCP's data submissions have an unacceptably high error rate.

MCPs that change or modify information systems that are involved in producing any type of electronically submitted files, either internally or by changing vendors, are required to submit to ODJFS for review and approval a transition plan including the submission of test files in the ODJFS-specified formats. Once an acceptable test file is submitted to ODJFS, as determined solely by ODJFS, the MCP can return to submitting production files. ODJFS will inform MCPs in writing when a test file is acceptable. Once an MCP's new or modified information system is operational, that MCP will have up to ninety (90) days to submit an acceptable test file and an acceptable production file.

Submission of test files can start before the new or modified information system is in production. ODJFS reserves the right to verify any MCP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period. Penalties for noncompliance with this requirement are specified in Appendix N, Compliance Assessment System of the Provider Agreement.

- b. Electronic Data Interchange and Claims Adjudication Requirements

Claims Adjudication

The MCP must have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures must be provided to non-contracting providers within thirty (30) days of a request. MCPs must inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information must be initiated by the MCP and not only in response to provider requests.

The MCP must notify providers who have submitted claims of claims status [paid, denied, pended (suspended)] within one month of receipt. Such notification be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis.

Electronic Data Interchange

The MCP shall comply with all applicable provisions of HIPAA including electronic data interchange (EDI) standards for code sets and the following electronic transactions:

Health care claims;
Health care claim status request and response;
Health care payment and remittance status;
Standard code sets; and
National Provider Identifier (NPI).

Each EDI transaction processed by the MCP shall be implemented in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal rule or regulation.

The MCP must have the capacity to accept the following transactions from the Ohio Department of Job and Family services consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODJFS:

ASC X12 820 — Payroll Deducted and Other Group Premium Payment for Insurance Products; and

ASC X12 834 — Benefit Enrollment and Maintenance.

The MCP shall comply with the HIPAA mandated EDI transaction standards and code sets no later than the required compliance dates as set forth in the federal regulations.

Documentation of Compliance with Mandated EDI Standards

The capacity of the MCP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA must be demonstrated, to the satisfaction of ODJFS, as outlined below.

Verification of Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1995)

MCPs shall comply with the transaction standards and code sets for sending and receiving applicable transactions as specified in 45 CFR Part 162 – Health Insurance Reform: Standards for Electronic Transactions (HIPAA regulations) In addition the MCP must enter into the appropriate trading partner agreement and implemented standard code sets. If the MCP has obtained third-party certification

of HIPAA compliance for any of the items listed below, that certification may be submitted in lieu of the MCP's written verification for the applicable item(s).

- i. Trading Partner Agreements
- ii. Code Sets
- iii. Transactions
 - a. Health Care Claims or Equivalent Encounter Information (ASC X12N 837 & NCPDP 5.1)
 - b. Eligibility for a Health Plan (ASC X12N 270/271)
 - c. Referral Certification and Authorization (ASC X12N 278)
 - d. Health Care Claim Status (ASC X12N 276/277)
 - e. Enrollment and Disenrollment in a Health Plan (ASC X12N 834)
 - f. Health Care Payment and Remittance Advice (ASC X12N 835)
 - g. Health Plan Premium Payments (ASC X12N 820)
 - h. Coordination of Benefits

Trading Partner Agreement with ODJFS

MCPs must complete and submit an EDI trading partner agreement in a format specified by the ODJFS. Submission of the copy of the trading partner agreement prior to entering into this Agreement may be waived at the discretion of ODJFS; if submission prior to entering into this Agreement is waived, the trading partner agreement must be submitted at a subsequent date determined by ODJFS.

Noncompliance with the EDI and claims adjudication requirements will result in the imposition of penalties, as outlined in Appendix N, Compliance Assessment System, of the Provider Agreement.

c. Encounter Data Submission Requirements

General Requirements

Each MCP must collect data on services furnished to members through an encounter data system and must report encounter data to the ODJFS. MCPs are required to submit this data electronically to ODJFS on a monthly basis in the following standard formats:

- Institutional Claims — UB92 flat file
- Noninstitutional Claims — National standard format
- Prescription Drug Claims — NCPDP

ODJFS relies heavily on encounter data for monitoring MCP performance. The ODJFS uses encounter data to measure clinical performance, conduct access and utilization reviews, reimburse MCPs for newborn deliveries and aid in setting

MCP capitation rates. For these reasons, it is important that encounter data is timely, accurate, and complete. Data quality, performance measures and standards are described in the Agreement.

An encounter represents all of the services, including medical supplies and medications, provided to a member of the MCP by a particular provider, regardless of the payment arrangement between the MCP and the provider. For example, if a member had an emergency department visit and was examined by a physician, this would constitute two encounters, one related to the hospital provider and one related to the physician provider. However, for the purposes of calculating a utilization measure, this would be counted as a single emergency department visit. If a member visits their PCP and the PCP examines the member and has laboratory procedures done within the office, then this is one encounter between the member and their PCP.

If the PCP sends the member to a lab to have procedures performed, then this is two encounters; one with the PCP and another with the lab. For pharmacy encounters, each prescription filled is a separate encounter.

Encounters include services paid for retrospectively through fee-for-service payment arrangements, and prospectively through capitated arrangements. Only encounters with services (line items) that are paid by the MCP, fully or in part, and for which no further payment is anticipated, are acceptable encounter data submissions, except for immunization services. Immunization services submitted to the MCP must be submitted to ODJFS if these services were paid for by another entity (e.g., free vaccine program).

All other services that are unpaid or paid in part and for which the MCP anticipates further payment (e.g., unpaid services rendered during a delivery of a newborn) may not be submitted to ODJFS until they are paid. Penalties for noncompliance with this requirement are specified in Appendix N, Compliance Assessment System of the Agreement.

Acceptance Testing

The MCP must have the capability to report all elements in the Minimum Data Set as set forth in the ODJFS Encounter Data Specifications and must submit a test file in the ODJFS-specified medium in the required formats prior to contracting or prior to an information systems replacement or update.

Acceptance testing of encounter data is required as specified in Section 29(a)(v) of this Appendix.

Encounter Data File Submission Procedures

A certification letter must accompany the submission of an encounter data file in the ODJFS-specified medium. The certification letter must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

Timing of Encounter Data Submissions

ODJFS recommends that MCPs submit encounters no more than thirty-five (35) days after the end of the month in which they were paid. For example, claims paid in January are due March 5. ODJFS recommends that MCPs submit files in the ODJFS-specified medium by the 5th of each month. This will help to ensure that the encounters are included in the ODJFS master file in the same month in which they were submitted.

d. Information Systems Review

ODJFS or its designee may review the information system capabilities of each MCP, before ODJFS enters into a provider agreement with a new MCP, when a participating MCP undergoes a major information system upgrade or change, when there is identification of significant information system problems, or at ODJFS' discretion. Each MCP must participate in the review. The review will assess the extent to which MCPs are capable of maintaining a health information system including producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its members.

The following activities, at a minimum, will be carried out during the review. ODJFS or its designee will:

- i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS; which the MCP will be required to complete.
 - ii. Review the completed ISCA and accompanying documents;
 - iii. Conduct interviews with MCP staff responsible for completing the ISCA, as well as staff responsible for aspects of the MCP's information systems function;
 - iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCP staff, and write a statement of findings about the MCP's information system.
-

- v. Assess the ability of the MCP to link data from multiple sources;
- vi. Examine MCP processes for data transfers;
- vii. If an MCP has a data warehouse, evaluate its structure and reporting capabilities;
- viii. Review MCP processes, documentation, and data files to ensure that they comply with state specifications for encounter data submissions; and
- ix. Assess the claims adjudication process and capabilities of the MCP.

31. Delivery Payments

MCPs will be reimbursed for paid deliveries that are identified in the submitted encounters using the methodology outlined in the *ODJFS Methods for Reimbursing for Deliveries* (as specified in Appendix L). The delivery payment represents the facility and professional service costs associated with the delivery event and postpartum care that is rendered in the hospital immediately following the delivery event; no prenatal or neonatal experience is included in the delivery payment.

If a delivery occurred, but the MCP did not reimburse providers for any costs associated with the delivery, then the MCP shall not submit the delivery encounter to ODJFS and is not entitled to receive payment for the delivery. MCPs are required to submit all delivery encounters to ODJFS no later than one year after the date of the delivery. Delivery encounters which are submitted after this time will be denied payment. MCPs will receive notice of the payment denial on the remittance advice.

If an MCP is denied payment through ODJFS' automated payment system because the delivery encounter was not submitted within a year of the delivery date, then it will be necessary for the MCP to contact BMHC staff to receive payment. Payment will be made for the delivery, at the discretion of ODJFS if a payment had not been made previously for the same delivery.

To capture deliveries outside of institutions (e.g., hospitals) and deliveries in hospitals without an accompanying physician encounter, both the institutional encounters (UB-92) and the noninstitutional encounters (NSF) are searched for deliveries.

If a physician and a hospital encounter is found for the same delivery, only one payment will be made. The same is true for multiple births; if multiple delivery encounters are submitted, only one payment will be made. The method for reimbursing for deliveries

includes the delivery of stillborns where the MCP incurred costs related to the delivery.

Rejections

If a delivery encounter is not submitted according to ODJFS specifications, it will be rejected and MCPs will receive this information on the exception report (or error report) that accompanies every file in the ODJFS-specified format. Tracking, correcting and resubmitting all rejected encounters is the responsibility of the MCP and is required by ODJFS.

Timing of Delivery Payments

MCPs will be paid monthly for deliveries. For example, payment for a delivery encounter submitted with the required encounter data submission in March, will be reimbursed in March. The delivery payment will cover any encounters submitted with the monthly encounter data submission regardless of the date of the encounter, but will not cover encounters that occurred over one year ago.

This payment will be a part of the weekly update (adjustment payment) that is in place currently. The third weekly update of the month will include the delivery payment. The remittance advice is in the same format as the capitation remittance advice.

Updating and Deleting Delivery Encounters

The process for updating and deleting delivery encounters is handled differently from all other encounters. See the *ODJFS Encounter Data Specifications* for detailed instructions on updating and deleting delivery encounters.

The process for deleting delivery encounters can be found on page 35 of the UB-92 technical specifications (record/field 20-7) and page III-47 of the NSF technical specifications (record/field CA0-31.0a).

Auditing of Delivery Payments

A delivery payment audit will be conducted periodically. If medical records do not substantiate that a delivery occurred related to the payment that was made, then ODJFS will recoup the delivery payment from the MCP. Also, if it is determined that the encounter which triggered the delivery payment was not a paid encounter, then ODJFS will recoup the delivery payment.

32. If the MCP will be using the Internet functions that will allow approved users to access member information (e.g., eligibility verification), the MCP must receive prior approval from ODJFS that verifies that the proper safeguards, firewalls, etc., are in place to protect member data.
 33. MCPs must receive prior written approval from ODJFS before adding any information to their website that would require ODJFS prior approval in hard copy form (e.g., provider listings, member handbook information).
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34. Pursuant to 42 CFR 438.106(b), the MCP acknowledges that it is prohibited from holding a member liable for services provided to the member in the event that the ODJFS fails to make payment to the MCP.
 35. In the event of an insolvency of an MCP, the MCP, as directed by ODJFS, must cover the continued provision of services to members until the end of the month in which insolvency has occurred, as well as the continued provision of inpatient services until the date of discharge for a member who is institutionalized when insolvency occurs.
 36. Franchise Fee Assessment Requirements
 - a. Each MCP is required to pay a franchise permit fee to ODJFS for each calendar quarter as required by ORC Section 5111.176. The current fee to be paid is an amount equal to $4\frac{1}{2}$ percent of the managed care premiums, minus Medicare premiums that the MCP received from any payer in the quarter to which the fee applies. Any premiums the MCP returned or refunded to members or premium payers during that quarter are excluded from the fee.
 - b. The franchise fee is due to ODJFS in the ODJFS-specified format on or before the 30th day following the end of the calendar quarter to which the fee applies.
 - c. At the time the fee is submitted, the MCP must also submit to ODJFS a completed form and any supporting documentation pursuant to ODJFS specifications.
 - d. Penalties for noncompliance with this requirement are specified in Appendix N, Compliance Assessment System of the Provider Agreement and in ORC Section 5111.176.
 37. Information Required for MCP Websites
 - a. On-line Provider Directory – MCPs must have an internet-based provider directory available in the same format as their ODJFS-approved provider directory, that allows members to electronically search for the MCP panel providers based on name, provider type, geographic proximity, and population (as specified in Appendix H). MCP provider directories must include all MCP-contracted providers [except as specified by ODJFS] as well as certain ODJFS non-contracted providers.
 - b. On-line Member Website – MCPs must have a secure internet-based website which is regularly updated to include the most current ODJFS approved materials. The website at a minimum must include: (1) a list of the counties that are covered
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in their service area; (2) the ODJFS-approved MCP member handbook, recent newsletters/announcements, MCP contact information including member services hours and closures; (3) the MCP provider directory as referenced in section 36(a) of this appendix; (4) the MCP's current preferred drug list (PDL), including an explanation of the list, which drugs require prior authorization (PA), and the PA process; (5) the MCP's current list of drugs covered only with PA, the PA process, and the MCP's policy for covering generic for brand-name drugs; and (6) the ability for members to submit questions/comments/grievances/appeals/etc. and receive a response (members must be given the option of a return e-mail or phone call) within one working day of receipt. MCPs must ensure that all member materials designated specifically for CFC and/or ABD consumers (i.e. the MCP member handbook) are clearly labeled as such. The MCP's member website cannot be used as the only means to notify members of new and/or revised MCP information (e.g., change in holiday closures, change in additional benefits, revisions to approved member materials etc.). ODJFS may require MCPs to include additional information on the member website, as needed.

- c. On-line Provider Website – MCPs must have a secure internet-based website for contracting providers where they will be able to confirm a consumer's MCP enrollment and through this website (or through e-mail process) allow providers to electronically submit and receive responses to prior authorization requests. This website must also include: (1) a list of the counties that are covered in their service area; (2) the MCP's provider manual; (3) MCP contact information; (4) a link to the MCP's on-line provider directory as referenced in section 37(a) of this appendix; (5) the MCP's current PDL list, including an explanation of the list, which drugs require PA, and the PA process; (6) the MCP's current list of drugs covered only with PA, the PA process, and the MCP's policy for covering generic for brand-name drugs. MCPs must ensure that all provider materials designated specifically for CFC and/or ABD consumers (i.e. the MCP's provider manual) are clearly labeled as such; and (7) information regarding the availability of expedited prior authorization requests, as well as the information that is required from that provider in order to substantiate an expedited prior authorization request.

ODJFS may require MCPs to include additional information on the provider website, as needed.

- 38. MCPs must provide members with a printed version of their PDL and PA lists, upon request.
 - 39. MCPs must not use, or propose to use, any offshore programming or call center services in fulfilling the program requirements.
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40. Coordination of Benefits

When a claim is denied due to third party liability, the managed care plan must timely share appropriate and available information regarding the third party to the provider for the purposes of coordination of benefits, including, but not limited to third party liability information received from the Ohio Department of Job and Family Services.

APPENDIX D
ODJFS RESPONSIBILITIES
CFC ELIGIBLE POPULATION

The following are ODJFS responsibilities or clarifications that are not otherwise specifically stated in OAC Chapter 5101: 3-26 or elsewhere in the ODJFS-MCP provider agreement.

General Provisions

1. ODJFS will provide MCPs with an opportunity to review and comment on the rate-setting time line and proposed rates, and proposed changes to the OAC program rules or the provider agreement.
 2. ODJFS will notify MCPs of managed care program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation.
 3. ODJFS will provide regular opportunities for MCPs to receive program updates and discuss program issues with ODJFS staff.
 4. ODJFS will provide technical assistance sessions where MCP attendance and participation is required. ODJFS will also provide optional technical assistance sessions to MCPs, individually or as a group.
 5. ODJFS will provide MCPs with an annual MCP Calendar of Submissions outlining major submissions and due dates.
 6. ODJFS will identify contact staff, including the Contract Administrator, selected for each MCP.
 7. ODJFS will recalculate the minimum provider panel specifications if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population.
 8. ODJFS will recalculate the geographic accessibility standards, using the geographic information systems (GIS) software, if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population and/or the ODJFS provider panel specifications.
 9. On a monthly basis, ODJFS will provide MCPs with an electronic file containing their MCP's provider panel as reflected in the ODJFS Provider Verification System (PVS) database, or other designated system.
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10. On a monthly basis, ODJFS will provide MCPs with an electronic Master Provider File containing all the Ohio Medicaid fee-for-service providers, which includes their Medicaid Provider Number, as well as all providers who have been assigned a provider reporting number for current encounter data purposes.
 11. It is the intent of ODJFS to utilize electronic commerce for many processes and procedures that are now limited by HIPAA privacy concerns to FAX, telephone, or hard copy. The use of TLS will mean that private health information (PHI) and the identification of consumers as Medicaid recipients can be shared between ODJFS and the contracting MCPs via e-mail such as reports, copies of letters, forms, hospital claims, discharge records, general discussions of member-specific information, etc. ODJFS may revise data/information exchange policies and procedures for many functions that are now restricted to FAX, telephone, and hard copy, including, but not limited to, monthly membership and premium payment reconciliation requests, newborn reporting, Just Cause disenrollment requests, information requests etc. (as specified in Appendix C).
 12. ODJFS will immediately report to Center for Medicare and Medicaid Services (CMS) any breach in privacy or security that compromises protected health information (PHI), when reported by the MCP or ODJFS staff.
 13. Service Area Designation

Membership in a service area is mandatory unless ODJFS approves membership in the service area for consumer initiated selections only. It is ODJFS' current intention to implement a mandatory managed care program in service areas wherever choice and capacity allow and the criteria in 42 CFR 438.50(a) are met.
 14. Consumer information
 - a. ODJFS or its delegated entity will provide membership notices, informational materials, and instructional materials relating to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODJFS or designee will provide MCP eligible individuals, including current MCP members, with a Consumer Guide. The Consumer Guide will describe the managed care program and include information on the MCP options in the service area and other information regarding the managed care program as specified in 42 CFR 438.10.
 - b. ODJFS will notify members or ask MCPs to notify members about significant changes affecting contractual requirements, member services or access to providers.
 - c. If an MCP elects not to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, ODJFS will provide coverage and reimbursement for these services for the MCP's members.
-

ODJFS will provide information on what services the MCP will not cover and how and where the MCP's members may obtain these services in the applicable Consumer Guides.

15. Membership Selection and Premium Payment

- a. The managed care enrollment center (MCEC): The ODJFS-contracted MCEC will provide unbiased education, selection services, and community outreach for the Medicaid managed care program. The MCEC shall operate a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

The MCEC shall distribute the most current Consumer Guide that includes the managed care program information as specified in 42 CFR 438.10, as well as ODJFS prior-approved MCP materials, such as solicitation brochures and provider directories, to consumers who request additional materials.

- b. Auto-Assignment Limitations – In order to ensure market and program stability, ODJFS may limit an MCP's auto-assignments if they meet any of the following enrollment thresholds:
- 40% of **statewide** Covered Families and Children (CFC) eligible population; and/or
 - 60% of the CFC eligibles in **any region with two MCPs**; and/or
 - 40% of the CFC eligibles in **any region with three MCPs**.

Once an MCP meets one of these enrollment thresholds, the MCP will only be permitted to receive the additional new membership (in the region or statewide, as applicable) through: (1) consumer-initiated enrollment; and (2) auto-assignments which are based on previous enrollment in that MCP or an historical provider relationship with a provider who is not on the panel of any other MCP in that region. In the event that an MCP in a region meets one or more of these enrollment thresholds, ODJFS, in their sole discretion, may not impose the auto-assignment limitation and auto-assign members to the MCPs in that region as ODJFS deems appropriate.

- c. Consumer Contact Record (CCR): ODJFS or their designated entity shall forward CCRs to MCPs on no less than a weekly basis. The CCRs are a record of each consumer-initiated MCP enrollment, change, or termination, and each MCEC initiated MCP assignment processed through the MCEC. The CCR contains information that is not included on the monthly member roster.
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- d. Monthly member roster (MR): ODJFS verifies managed care plan enrollment on a monthly basis via the monthly membership roster. ODJFS or its designated entity provides a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.
 - e. Monthly Premiums and Delivery Payments: ODJFS will remit payment to the MCPs via an electronic funds transfer (EFT), or at the discretion of ODJFS, by paper warrant.
 - f. Remittance Advice: ODJFS will confirm all premium payments and delivery payments paid to the MCP during the month via a monthly remittance advice (RA), which is sent to the MCP the week following state cut-off. ODJFS or its designated entity provides a record of each payment via HIPAA 820 compliant transactions.
 - g. MCP Reconciliation Assistance: ODJFS will work with an MCP-designated contact(s) to resolve the MCP's member and newborn eligibility inquiries, premium and delivery payment inquiries/discrepancies and to review/approve hospital deferment requests.
16. ODJFS will make available a website which includes current program information.
17. ODJFS will regularly provide information to MCPs regarding different aspects of MCP performance including, but not limited to, information on MCP-specific and statewide external quality review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys and provider profiles.
18. ODJFS will periodically review a random sample of online and printed directories to assess whether MCP information is both accessible and updated.
19. Communications
- a. ODJFS/BMHC: The Bureau of Managed Health Care (BMHC) is responsible for the oversight of the MCPs' provider agreements with ODJFS. Within the BMHC, a specific Contract Administrator (CA) has been assigned to each MCP. Unless expressly directed otherwise, MCPs shall first contact their designated CA for questions/assistance related to Medicaid and/or the MCP's program requirements /responsibilities. If their CA is not available and the MCP needs immediate assistance, MCP staff should request to speak to a supervisor within the Contract Administration Section. MCPs should take all necessary and appropriate steps to ensure all MCP staff are aware of, and follow, this communication process.
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- b. ODJFS contracting-entities: ODJFS-contracting entities should never be contacted by the MCPs unless the MCPs have been specifically instructed to contact the ODJFS contracting entity directly.
 - c. MCP delegated entities: In that MCPs are ultimately responsible for meeting program requirements, the BMHC will not discuss MCP issues with the MCPs' delegated entities unless the applicable MCP is also participating in the discussion. MCP delegated entities, with the applicable MCP participating, should only communicate with the specific CA assigned to that MCP.
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APPENDIX E
RATE METHODOLOGY
CFC ELIGIBLE POPULATION



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December 12, 2007

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RE: CY 2008 RATE DEVELOPMENT METHODOLOGY — COVERED FAMILIES AND CHILDREN

Dear Jon:

Milliman, Inc. (Milliman) was retained by the State of Ohio, Department of Job and Family Services (ODJFS) to develop the calendar year 2008 actuarially sound capitation rates for the Covered Families and Children (CFC) Risk Based Managed Care (RBMC) program. This letter provides the documentation for the actuarially sound capitation rates.

LIMITATIONS

The information contained in this letter, including the enclosures, has been prepared for the State of Ohio, Department of Job and Family Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

The information contained in this letter was prepared as documentation of the actuarially sound capitation rates for Medicaid managed care organization health plans in the State of Ohio. The information may not be appropriate for any other purpose.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.

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FINAL and CONFIDENTIAL**SUMMARY OF METHODOLOGY**

ODJFS contracted with Milliman to develop the CY 2008 CFC actuarially sound capitation rates. The actuarially sound capitation rates were developed from historical claims and enrollment data for the fee for service (FFS) and managed care populations. The composite of the FFS and managed care populations are considered a comparable population to the population enrolled with the health plans. The historical experience was converted to a per member per month (PMPM) basis and stratified by region, age / gender rating group, and category of service. The historical experience was trended forward using projected trend rates to a center point of July 1, 2008 for the 2008 calendar year contract period. The historical experience was adjusted to reflect adjustments to the utilization and average cost per service that would be expected in a managed care environment.

Appendix 1 contains a chart outlining the methodology that was used to develop the CY 2008 capitation rates for the CFC populations.

Appendix 2 contains the actuarial certification regarding the actuarial soundness of the capitation rates.

Appendix 3 contains the CY 2008 capitation rates by rate group and region, including the segmentation of the administrative cost allowance between guaranteed and at-risk components.

DETAILS OF METHODOLOGY**I. COVERED POPULATION**

The CY 2008 CFC capitation rates have been developed using historical experience for the population eligible for managed care enrollment based on age, gender, and program assignment. The program assignments shown in Table 1 were included in the development of the CY 2008 CFC capitation rates.

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Table 1
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Summary of Managed Care Eligible Population

Program Assignment	Description
PREG	Healthy Start Pregnant Women
PREGEX	Healthy Start Pregnant Women Expansion
PREGEX	Healthy Start Expedited Pregnant Women
RPREGEX	Healthy Start Expedited Pregnant Women RMF
HSC	Healthy Start Children
HSCE	Healthy Start Expansion <= 150%
RHSC	Healthy Start Children RMF
CHIP1	Healthy Start CHIP 1 <=150%
CHIP2	Healthy Start CHIP 2 151-200%
RCHIP1	Healthy Start CHIP 1 <=150% RMF
RCHIP2	Healthy Start CHIP 2 151-200% RMF
RCHSUP	Healthy Family Child Support Extended RMF
CHSUP	Healthy Family Child Support Extended
OWFFAM	Ohio Works First Families — Cash
ROWFFAM	Ohio Works First Families — Cash RMF
LIFAM	Low Income Families
RLIFAM	Low Income Families RMF
HYFAM	Healthy Families (Expansion 7/00 Reduced 1/06)
TRANS	Transitional
LIIND	Low Income Individuals
RLIIND	Low Income Individuals RMF

Milliman extracted the eligible population information from historical data. The eligible population includes the Healthy Start and Healthy Families populations. If a member was ineligible during a month, all claims and eligibility for the month were excluded from the actuarial models.

II. CATEGORY OF SERVICE DEFINITIONS

The categories of service listed in Table 2 describe the actuarial model service groupings. The units associated with the categories have been indicated. Further, the primary method of classifying the claims has been provided.

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Table 2
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Categories of Service

Type of Service	Service Category	Utilization Units	Classification Basis
<i>Inpatient Hospital</i>	Medical/Surgical	Admits/Days	COS, DRG
	MH/SA	Admits/Days	
	Well Newborn	Admits/Days	
	Maternity Non-Deliveries	Admits/Days	
	Nursing Facility	Admits/Days	
	Other Inpatient	Admits/Days	
<i>Outpatient Hospital</i>	Emergency Room	Claims	COS, Revenue Code
	Surgery/ASC	Services	
	Cardiovascular	Services	
	PT/ST/OT	Services	
	Clinic	Services	
	Other	Services	
<i>Professional</i>	Inpatient/Outpatient Surgery	Services	COS, Provider Type, Procedure, Modifier
	Anesthesia	Line Items	
	Obstetrics	Services	
	Office Visits/Consults	Services	
	Hospital Inpatient Visits	Services	
	Periodic Exams		
	Emergency Room Visits	Services	
	Immunizations & Injections	Services	
	Physical Medicine	Services	
	Miscellaneous Services	Line Items, Services	
<i>Rad/Path/Lab</i>	Radiology	Services	COS, Revenue Code, Provider Type, Procedure
	Pathology/Laboratory	Services	
<i>Ancillaries</i>	MH/SA	Services	COS, Provider Type, Procedure
	FQHC/RHF/OP Health Facility	Services	COS
	Pharmacy	Line Items	COS
	Dental	Services	COS
	Vision	Services	COS, Provider Type, Procedure
	Home Health	Line Items	COS
	Non- Emergent Transportation	Line Items	COS
	Ambulance	Line Items	COS, Procedure Code
	Supplies and DME	Line Items	COS, Provider Type, Procedure
	Miscellaneous Services	Line Items	COS

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III. RATE GROUPS

The CY 2008 CFC capitation rates are segmented by region and rate group. Table 3 contains the rate groups used for the CFC population. The non-delivery rate groups vary by age, gender, and program assignment. The delivery rate group is determined based on the CFC Program Delivery Payment Reporting Procedures for ODJFS Managed Care Plans, effective September 7, 2005.

Table 3
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Rate Groups

Age/Gender Groups	Benefit Type	Population
M/F- <1	Non - Delivery	Healthy Start / Healthy Families
M/F- 1	Non - Delivery	Healthy Start / Healthy Families
M/F -2 to 13	Non - Delivery	Healthy Start / Healthy Families
M-14 to 18	Non - Delivery	Healthy Start / Healthy Families
F- 14 to 18	Non - Delivery	Healthy Start / Healthy Families
M- 19 to 44	Non - Delivery	Healthy Families
F- 19 to 44	Non - Delivery	Healthy Families
M/F - 45 to 64	Non - Delivery	Healthy Families
F- 19 to 64	Non - Delivery	Healthy Start
F - All Ages	Delivery	Healthy Start / Healthy Families

IV. DEVELOPMENT OF CY 2006 ADJUSTED FFS DATA

a. Historical Data Summaries

The CY 2008 CFC capitation rates were developed, in part, using FFS claims for two state fiscal year (SFY) periods:

- SFY 2005 (Incurred during the 12 months ending June 30, 2005 paid through May 31, 2007).
- SFY 2006 (Incurred during the 12 months ending June 30, 2006 paid through May 31, 2007).

The claims data was provided by ODJFS from the data warehouse. The experience was stratified into geographic region based on the member's county of residence.

The reimbursement amounts captured on the FFS actuarial models reflect the amount paid by ODJFS, net of third party liability recoveries and member co-payment amounts. The reimbursement amounts have not been adjusted for payments made outside the claims processing system. These amounts are discussed later in the documentation.

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The FFS data summaries represent historical experience for those services that are included in the capitation payment. Services that are not covered under the capitation payment have been excluded from the experience. The excluded services were identified by the ODJFS defined category of service field, as shown in Table 4.

Table 4
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Claims Excluded from the FFS Data Summaries

COS Field Value	Description
08	PACE
13	ICF/MR Public
18	ICF/MR Private
35	Core Services
36	Home Care Facilitator Services
41	Mental Health Services
42	Mental Retardation
46	Model 50 Waiver Services
58	HMO Services
59	Mental Health Support Services
60	Mental Retardation Support Services
63	PPO Services
64	Passport
66	Passport Waiver III
67	OBRA MR/DD Waiver
80	Alcohol and Drug Abuse
82	Department of Education
84	ODADAS

b. Completion Factors

Milliman utilized 24 months of claims experience for the FFS population that was incurred through June 2006 and paid through May 2007 (eleven months of run-out). Milliman applied claim completion factors to the twelve months of SFY 2005 and twelve months of SFY 2006 claims experience. The claim completion factors were developed by service category based on claims experience for the FFS population incurred and paid through May 2007.

c. Historical Program Adjustments

The base FFS data summaries represent a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program

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change effective date. For example, a program change implemented on January 1, 2006 will only be reflected in the second half of SFY 2006. As such, an adjustment was applied to all of SFY 2005 and half of SFY 2006 to include the program change in all periods of the base experience data.

ODJFS has provided a listing of all program changes impacting the base experience data. Table 5 summarizes the historical program changes that were reflected in the development of the CY 2008 capitation rates.

Table 5
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Historical Program Adjustments — FFS

Program Adjustment	Effective Date	Service Category(s)	Rate Group
Inpatient Market Basket Increase	1/1/2005	Inpatient Hospital	All Rate Groups (incl. Delivery)
Dental Fee Schedule Reduction	1/1/2006	Dental	All Rate Groups (incl. Delivery)
Inpatient Recalibration and Outlier Policy	1/1/2006	Inpatient	All Rate Groups (incl. Delivery)
Pharmacy Co-pay (\$2 Per Brand Prescription)	1/1/2006	Pharmacy	HF M-19 to 44 HF F-19 to 44 HF M/F-45 to 64
Dental Co-pay (\$3 Per Date of Service)	1/1/2006	Dental	HF M-19 to 44 HF F-19 to 44 HF M/F-45 to 64 HST F-19 to 64
Vision Exam Co-Pay (\$2 Per Exam)	1/1/2006	Vision / Optometric	HF M-19 to 44 HF F-19 to 44 HF M/F-45 to 64 HST F-19 to 64
Vision Hardware Co-Pay (\$1 Per Item)	1/1/2006	Vision / Optometric	HF M-19 to 44 HF F-19 to 44 HF M/F-45 to 64 HST F-19 to 64
ER Co-Pay (\$3 Per Non-Emergency Visit)	1/1/2006	Emergency Room	HF M-19 to 44 HF F-19 to 44 HF M/F-45 to 64 HST F-19 to 64
Dental Benefit Reduction	1/1/2006	Dental	HF M-19 to 44 HF F-19 to 44 HF M/F-45 to 64 HST F-19 to 64

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d. Third-Party Liability

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. The paid amounts reflect a reduction for the amounts paid by third party carriers. Additionally, Milliman reduced the FFS experience to reflect third party liability recoveries following payment of claims. The reduction represents the average third party liability recovery rate received by the state under the “pay-and-chase” recovery program for each base year. It is expected that the health plans will collect the third party liability recoveries for managed care enrolled individuals.

e. Fraud and Abuse

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. Milliman reduced the FFS experience to reflect fraud and abuse recoveries following payment of claims. The reduction represents the average fraud and abuse recovery rate received by the state for each base year. It is expected that the health plans will pursue fraud and abuse detection activities for managed care enrolled individuals.

f. Gross Adjustments

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. Milliman adjusted the FFS experience to reflect payments/refunds occurring outside of normal claim adjudication. Milliman received a “gross adjustments” file from ODJFS containing the additional adjustments.

g. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The FFS data does not contain any such services. As such, no adjustment was applied to the base FFS data for non-state plan services.

h. Historical Selection Adjustments

Milliman applied a historical selection adjustment to the base FFS data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the FFS experience to the morbidity level of the entire managed care eligible population and is similar in methodology to previous years.

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FINAL and CONFIDENTIAL**i. Trends/Inflation to CY 2006**

Milliman developed trend rates to progress the historical experience from SFY 2005 and SFY 2006 forward to a common center point (CY 2006). Milliman reviewed historical experience and performed linear regression on the experience data to develop trend rates by category of service for both utilization and unit cost. Additionally, Milliman reviewed the resulting trends with internal data sources to develop the trends used in the development of the CY 2008 CFC capitation rates.

The base experience data was normalized for artificial program adjustments prior to the trend rate development. Milliman did not consider items such as fee schedule changes or benefit modifications as standard components of trend. Removing the impact of historical changes allows for transparent inclusion of prospective program changes for future periods.

j. Blend Base Experience Years

Each of the base experience years was trended to CY 2006. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing more credibility on the most recent experience and is consistent with the CY 2007 methodology. Specifically, SFY 2005 received a weight of 30% and SFY 2006 received a weight of 70%.

k. Managed Care Adjustments

Utilization and cost per service adjustments were developed for each rate group, service category, and region.

Utilization

Milliman adjusted the FFS utilization and cost per service to reflect the managed care environment. After reviewing utilization benchmarks in the Milliman Medicaid Guidelines (*Guidelines*) as well as other sources, Milliman calculated percentage adjustments to reflect the utilization differential between an economic and efficiently managed plan and the FFS base experience.

Cost Per Service

Milliman adjusted the cost per service amounts to reflect changes in the mix / intensity of services due to the management of health care. The reimbursement rate changes were also developed following a review of benchmarks in the *Guidelines* as well as other sources.

In addition to the intensity adjustments applied to the cost per service amounts, Milliman also included adjustments to reflect the health plan contracted rates with providers in the managed care adjustments.

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V. DEVELOPMENT OF CY 2006 ADJUSTED ENCOUNTER DATA

a. Historical Data Summaries

The CY 2008 CFC capitation rates were developed, in part, using Encounter claims for two SFY periods:

- SFY 2005 (Incurred during the 12 months ending June 30, 2005 paid through May 31, 2007).
- SFY 2006 (Incurred during the 12 months ending June 30, 2006 paid through May 31, 2007).

The claims data was provided by ODJFS from the data warehouse. The experience was stratified into geographic region based on the member's county of residence.

The Encounter data summaries represent historical experience for those services that are included in the capitation payment. Services that are not covered under the capitation payment have been excluded from the experience. The excluded services were identified by the ODJFS defined category of service field, as shown in Section IV. Table 4.

The historical data summaries for the base encounter experience reflect only region, county, health plan combinations with sufficient experience to be considered credible. As such, counties considered "voluntary" and health plans with low enrollment were not included in the base data. Table 6 provides the region/county and health plan combinations contained in the capitation rate development.

Table 6
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Region/County and Health Plan Inclusions — Encounter

Region — County	Health Plans
Central — Franklin	Caresource; Molina
East Central — Stark	Buckeye; Caresource; Mediplan
East Central — Summit	Buckeye; Caresource; Surnmacare
Northeast — Cuyahoga	Caresource; Anthem/Qualchoice
Northeast — Lorain	Caresource; Anthem/Qualchoice
Northeast Central — Mahoning	Caresource; Gateway; Unison
Northeast Central — Trumbull	Caresource; Gateway; Unison
Northwest — Lucas	Buckeye; Paramount
Southwest — Butler	Amerigroup; Caresource
Southwest — Hamilton	Amerigroup; Caresource
West Central — Clark	Caresource; Molina
West Central — Montgomery	Caresource; Molina

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b. Imputed Cost per Service

Milliman applied a cost per service amount to the managed care encounter data to reflect the missing financial information in the base managed care encounter experience. The cost per service was applied by rate group on a statewide basis for all categories of service except for inpatient services. The cost per service was applied by rate group and region for inpatient services.

Additionally, the cost per service was re-priced based on the mix/intensity of services included in the encounter base experience. The cost per service was developed from the Medicaid FFS reimbursement rates. In addition to reflecting the health plan mix of services, the cost per service was adjusted for other managed care factors as described below.

c. Completion Factors

Milliman utilized 24 months of claims experience for the managed care population that was incurred through June 2006 and paid through May 2007 (eleven months of run-out). Milliman applied claim completion factors to the twelve months of SFY 2005 and twelve months of SFY 2006 claims experience. The claim completion factors were developed by service category based on utilization experience for the managed care population incurred and paid through May 2007.

d. Historical Program Adjustments

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program change effective date. For example, a program change implemented on January 1, 2006 will only be reflected in the second half of SFY 2006. As such, an adjustment was applied to all of SFY 2005 and half of SFY 2006 to include the program change in all periods of the base experience data.

ODJFS has provided a listing of all program changes impacting the base experience data. Section IV, Table 5 summarizes the historical program changes that were reflected in the development of the CY 2008 capitation rates.

e. Third-Party Liability and Fraud-Abuse Recoveries

The cost reports submitted by the health plans contained information related to third-party liability and fraud-abuse recoveries. Milliman calculated the average recoveries and applied the reduction to the base encounter data.

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f. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The encounter data contains certain claims that are considered non-state plan services. The health plan submitted cost reports were used as the source of information for the non-state plan service adjustments.

g. Historical Selection Adjustments

Milliman applied a historical selection adjustment to the base encounter data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the encounter experience to the morbidity level of the entire managed care eligible population.

h. Trends/Inflation to CY 2006

Milliman developed trend rates to progress the historical experience from SFY 2005 and SFY 2006 forward to a common center point (CY 2006). Milliman reviewed historical experience and performed linear regression on the experience data to develop trend rates by category of service for both utilization and unit cost. Additionally, Milliman reviewed the resulting trends with internal data sources to develop the trends used in the development of the CY 2008 CFC capitation rates.

The base experience data was normalized for artificial program adjustments prior to the trend rate development. Milliman did not consider items such as fee schedule changes or benefit modifications as standard components of trend. Removing the impact of historical changes allows for transparent inclusion of prospective program changes for future periods.

i. Blend Base Experience Years

Each of the base experience years was trended to CY 2006. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing more credibility on the most recent experience. Generally, SFY 2006 was given 70% weight except where insufficient experience existed in either SFY 2005 or SFY 2006. In these situations, either SFY 2005 or SFY 2006 was given 100% credibility.

j. Managed Care Adjustments

Utilization and cost per service adjustments were developed for each rate group, service category, and region.

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FINAL and CONFIDENTIAL**Utilization**

Milliman adjusted the encounter utilization and cost per service to reflect changes anticipated in the managed care environment. After reviewing utilization benchmarks in the Milliman Medicaid Guidelines (*Guidelines*) as well as other sources, Milliman calculated percentage adjustments to reflect the utilization differential between an economic and efficiently managed plan and the encounter base experience.

Cost Per Service

Milliman adjusted the average reimbursement rates to reflect changes in the mix / intensity of services due to the management of health care. The reimbursement rate changes were also developed following a review of benchmarks in the *Guidelines* as well as other sources.

In addition to the intensity adjustments applied to the cost per service amounts, Milliman also included adjustments to reflect the health plan contracted rates with providers in the managed care adjustments.

VI. DEVELOPMENT OF CY 2006 ADJUSTED COST REPORT DATA**a. Historical Data Summaries**

The CY 2008 CFC capitation rates were developed, in part, using health plan submitted cost reports for two calendar year (CY) periods:

- CY 2005 {Incurred during the 12 months ending December 31, 2005 paid through December 31, 2006}.
- CY 2006 (Incurred during the 12 months ending December 31, 2006 paid through December 31, 2007).

The historical data summaries for the base cost report experience reflect only region, county, health plan combinations with sufficient experience to be considered credible. As such, counties considered “voluntary” and health plans with low enrollment were not included in the base data. Table 7 provides the region/county and health plan combinations contained in the capitation rate development.

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Table 7
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Region/County and Health Plan Inclusions — Cost Report

Region — County	Health Plans
Central — Franklin	Caresource; Molina
East Central — Stark	Buckeye; Caresource
East Central — Summit	Buckeye; Caresource
Northeast — Cuyahoga	Caresource; Anthem/Qualchoice
Northeast — Lorain	Caresource; Anthem/Qualchoice
Northeast Central — Mahoning	Caresource; Gateway; Unison
Northeast Central — Trumbull	Caresource; Gateway; Unison
Northwest — Lucas	Buckeye; Paramount
Southwest — Butler	Amerigroup; Caresource
Southwest — Hamilton	Amerigroup; Caresource
West Central — Clark	Caresource; Molina
West Central — Montgomery	Caresource; Molina

b. Completion Factors

The cost reports contained claim experience incurred through December 31, 2006 and paid through December 31, 2006, as well as health plan estimated 1BNR reserve amounts. Milliman reviewed the claims completion contained in the submitted cost reports for reasonableness. During this review, Milliman estimated a high and low completion percentage on a statewide basis. The claims completion implemented by the health plans in aggregate was within the range and, as such, no further adjustments were applied.

c. Historical Program Adjustments

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program change effective date. For example, a program change implemented on January 1, 2006 will only be reflected in the CY 2006 experience. As such, an adjustment was applied to CY 2005 to include the program change in all periods of the base experience data.

ODJFS has provided a listing of all program changes impacting the base experience data. Section IV, Table 5 summarizes the historical program changes that were reflected in the development of the CY 2008 capitation rates.

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d. Third-Party Liability and Fraud-Abuse Recoveries

The cost reports submitted by the health plans contained information related to third-party liability and fraud-abuse recoveries. Milliman calculated the average recoveries and applied the reduction to the base cost report data.

e. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The cost report data contains certain claims that are considered non-state plan services. The health plan submitted cost reports were used as the source of information for the non-state plan service adjustments.

f. Historical Selection Adjustments

Milliman applied a historical selection adjustment to the base cost report data to reflect that the base period contains a combination of FFS and managed care enrollment. The historical selection adjustment is intended to normalize the cost report experience to the morbidity level of the entire managed care eligible population.

g. Trends/Inflation to CY 2006

Milliman developed trend rates to progress the historical experience from calendar years 2005 and 2006 forward to a common center point (CY 2006). Milliman reviewed historical experience and performed linear regression on the experience data to develop trend rates by category of service for both utilization and unit cost. Additionally, Milliman reviewed the resulting trends with internal data sources to develop the trends used in the development of the CY 2008 capitation rates.

The base experience data was normalized for artificial program adjustments prior to the trend rate development. Milliman did not consider items such as fee schedule changes or benefit modifications as standard components of trend. Removing the impact of historical changes allows for transparent inclusion of prospective program changes for future periods.

h. Blend Base Experience Years

The base CY 2005 year was trended to CY 2006. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing more credibility on the most recent experience. Generally, CY 2006 was given 70% weight except where insufficient experience existed in either CY 2005 or CY 2006. In these situations, either CY 2005 or CY 2006 was given 100% credibility.

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FINAL and CONFIDENTIAL**i. Managed Care Adjustments**

Milliman adjusted the cost report experience data to reflect changes anticipated in the managed care environment. The cost report base experience was adjusted using the same managed care adjustments as the base encounter data with the exception of the health plan provider contracting adjustment. The health plan rate of provider reimbursement is already included in the cost report base experience.

Adjustments were developed for each rate group, service category, and region.

VII. CY 2006 ADJUSTED BASE DATA TO CY 2008 CAPITATION RATES

The adjusted CY 2006 utilization and cost per service rates are trended forward to CY 2008 and adjusted for prospective program changes that will be effective for the CY 2008 contract period. The resulting PMPM establishes the regional adjusted claim cost for the health plans in CY 2008. The administrative cost allowance and franchise fee components are applied to the adjusted claim cost to develop the CY 2008 capitation rates.

a. Trend to CY 2008

The trend rates that were used to progress the CY 2006 experience forward to the CY 2008 rating period were developed from the historical experience, the experience from other Medicaid managed care programs, and our actuarial judgment. The trend rates include a component for utilization and unit cost by major category of service.

b. Prospective Program Adjustments

The SFY 2008/2009 Budget contains several program changes that impacted the development of the capitation rates. The program changes include items such as provider fee changes, benefit changes, and administrative changes. Adjustments to the CY 2006 experience were developed for each item based on its expected impact to the prospective claims cost. Table 8 lists the program changes that were included in the CY 2008 capitation rate development.

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Table 8
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Prospective Program Adjustments

Program Adjustment	Effective Date	Service Category(s)	Rate Groups
Nursing Facility Fee Increase	7/1/2007	Nursing Facility	All Rate Groups (excl. Delivery)
Chiropractor Benefit Restoration	7/1/2008		HF M — 19 to 44
	1/1/2008	Miscellaneous Services	HF F — 19 to 44
			HF M/F — 45 to 64
			HST F — 19 to 64
Independent Psychologists Benefit Restoration	1/1/2008	Mental Health / Substance Abuse	HF M — 19 to 44
			HF F — 19 to 44
			HF M/F — 45 to 64
			HST F — 19 to 64
Occupational Therapy-Independent Provider Status	1/1/2008	Miscellaneous Services	All Rate Groups (excl. Delivery)
Developmental Therapies	1/1/2008	Miscellaneous Services	HST M/F — <1
Foster Children Expansion	1/1/2008	All Service Categories	HST M — 14 to 18
			HST F — 14 to 18
CHIP III Expansion	1/1/2008	All Service Categories	HF M — 19 to 44
			HF F — 19 to 44
			HST F — 19 to 64
			HST M/F — 2 to 13
			HST M — 14 to 18
			HST F — 14 to 18
			HST F — 19 to 64
Pregnant Women Expansion	1/1/2008	All Service Categories	Delivery
Improved TPL Management	1/1/2008	All Service Categories	All Rate Groups (incl. Delivery)
Expedite Managed Care Enrollment	1/1/2008	All Service Categories	All Rate Groups (incl. Delivery)
Expedite Newborn Enrollment	1/1/2008	All Service Categories	HST M/F — <1
Short Term Nursing Facility	1/1/2008	Nursing Facility	All Rate Groups (excl. Delivery)
Policy Change (consistent with ABD)			Delivery)
Prior Authorization Policy Change	1/1/2008	Pharmacy	All Rate Groups (excl. Delivery)
Prior Authorization of Atypical Anti-Psychotic Medication	1/1/2008	Pharmacy	All Rate Groups (excl. Delivery)

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c. Prospective Selection Adjustment

Milliman adjusted the base experience data to reflect the morbidity of the entire managed care eligible population. Subsequently, a prospective selection adjustment was developed to reflect that less than 100% of managed care eligibles will enroll in managed care. Table 9 provides the target managed care penetration used in the development of the CY 2008 capitation rates.

Table 9
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Prospective Selection Adjustments

Region	June 2007 MC Penetration	Target MC Penetration
Central	93.4%	95%
East Central	94.6%	95%
Northeast	95.2%	95%
Northeast Central	75.8%	95%
Northwest	94.5%	95%
Southeast	94.9%	95%
Southwest	93.6%	95%
West Central	94.0%	95%

d. Clinical Measures Adjustments

Appendix M of the provider agreement between contracted health plans and ODJFS contains certain clinical measures that each health plan must achieve. The agreement stipulates that, at a minimum, the experience improvement must reduce the discrepancy between the ultimate target and the actual rate by a certain percentage. Milliman developed adjustments to the capitation rates to reflect this required improvement in performance based on the CY 2006 actual results. Table 10 illustrates the measures for which adjustment factors were applied by category of service and rate group.

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Table 10
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Clinical Measures Adjustments

Clinical Measure Description	Measure	Service Category	Rate Groups
Ongoing Prenatal Care	80% receive 81+% of expected visits	Office Visits / Consults	HST F — 14 to 18 HF F — 19 to 44 HST F — 19 to 64
Postpartum Care	80% receive a visit	Obstetrics	HST F — 14 to 18 HF F — 19 to 44 HST F — 19 to 64
Well Child Visits	80% receive expected visits	Periodic Exams	HST M/F — <1 HST M/F — 1 HST M/F — 2 to 13 HST F — 14 to 18 HST M — 14 to 18
Asthma Medications	95% receive appropriate medications	Pharmacy	HST M/F — 2 to 13 HST F — 14 to 18 HST M — 14 to 18 HF F — 19 to 44 HF M — 19 to 44 HF M/F — 45 to 64 HST F — 19 to 64
Annual Dental Visits	60% receive a visit	Dental	HST M/F — 2 to 13 HST F — 14 to 18 HST M — 14 to 18
Lead Screening	80% receive a screening	Pathology / Laboratory	HST M/F — 1 HST M/F — 2 to 13

e. Delivery Cesarean Section Rates

Milliman reviewed the cesarean rates for both the FFS and managed care populations in the base period data summaries. In previous years, the capitation rates were adjusted to target a specific cesarean rate. For 2008, Milliman did not adjust the regional cost summaries, up or down, to reflect a different cesarean rate.

f. Blend FFS / Encounter / Cost Report

The FFS, encounter, and cost report data sets were projected to CY 2008 and composited to establish the CY 2008 total claims cost. The credibility between data sources was based upon the amount of managed

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care experience in the base data. The encounter and cost report data sources were given equal weight in each region.

g. Age/Gender Realignment

Milliman developed the 2008 capitation rates by rate group and region. The resulting capitation rates by rate group were then adjusted within each region to realign the age/gender relativities among regions. The realignment maintains the composite capitation rates for each region and in aggregate while allowing for more consistent age/gender relativities.

h. Administrative Allowance

Milliman included an administrative cost allowance in the development of the actuarially sound capitation rates for CY 2008. The administrative cost allowance contains provision for administrative expenses, profit/contingency, and surplus contribution and was calculated as a percentage of the capitation rate prior to the franchise fee. As such, the pre-franchise fee capitation rate will be determined by dividing the projected managed care claim cost by one minus the administrative cost allowance. By determining the pre-franchise fee capitation rate in this manner, the administrative allowance may be expressed as a percentage of the pre-franchise fee capitation rate. Milliman developed the administrative cost allowance following a review of actual health plan cost information contained in the cost reports as well as information from other representative Medicaid managed care organizations.

For health plans in plan year 3 or later, 1% of the administrative component will be at-risk and contingent upon performance requirements defined in the ODJFS provider agreements. Table 11 provides the administrative cost allowance for each plan year.

Table 11
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Administrative Cost Allowance
Non — Delivery

Plan Year	Guaranteed %	At-Risk %	Total %
Plan Year 1 (1-12 Months)	12.5%	0.0%	12.5%
Plan Year 2 (13-24 Months)	11.5%	0.0%	11.5%
Plan Year 3 (25 + Months)	10.5%	1.0%	11.5%

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Mr. Jon Barley, Ph.D.
December 12, 2007
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Delivery

Plan Year	Guaranteed %	At Risk %	Total %
Plan Year 1 (1-12 Months)	6.0%	0.0%	6.0%
Plan Year 2 (13-24 Months)	5.0%	0.0%	5.0%
Plan Year 3 (25 + Months)	4.0%	1.0%	5.0%

The administrative cost allowance percentages contained in Table 11 reflect a change from the 2007 methodology.

i Franchise Fee

Milliman included a franchise fee component in the development of the actuarially sound capitation rates for CY 2008. The franchise fee was calculated as a percentage of the capitation rates. Therefore, the capitation rate will be determined by dividing the pre-franchise fee capitation rate by one minus the franchise fee component. By determining the pre-franchise fee capitation rate in this manner, the franchise fee may be expressed as a percentage of the capitation rate. The franchise fee component is 4.5% of the capitation rate.

DATA RELIANCE

In developing the CY 2008 CFC capitation rates, we have relied upon certain data and information from ODJFS. While limited review was performed for reasonableness, the data and information was accepted without audit. To the extent that the data and information was not accurate or complete, the values shown in this letter will need to be revised.

◆ ◆ ◆

If you have any questions regarding the enclosed information, please do not hesitate to contact me at 317-524-3512.

Sincerely,

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/mle

cc: Dan Hecht (ODJFS)
Mitali Ghatak (ODJFS)
Robert Monks (ODJFS)

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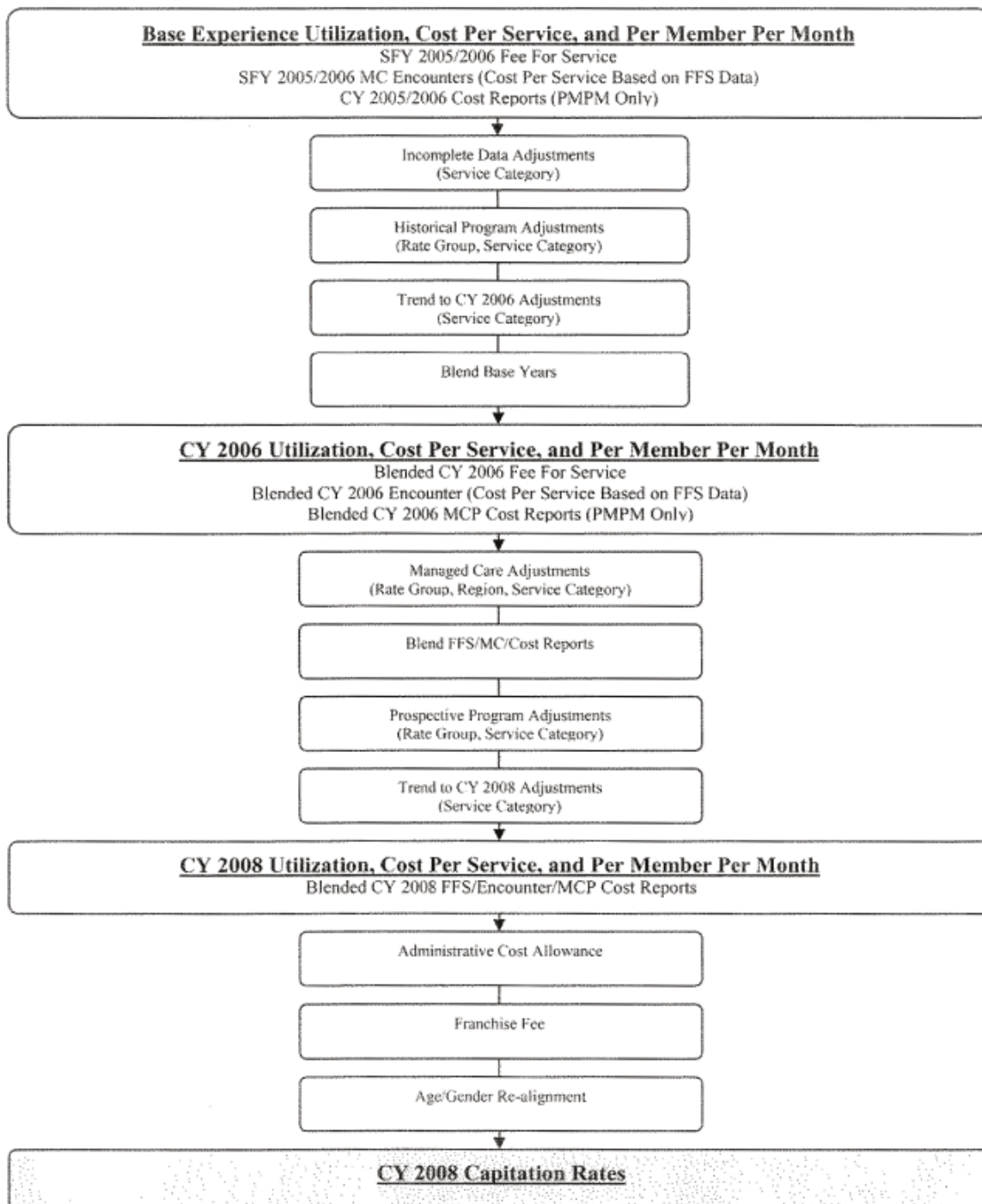


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APPENDIX 1

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.

Illustration of Rate Development Methodology



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APPENDIX 2

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**STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Covered Families and Children — CY 2008 Capitation Rates**

Actuarial Certification

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Ohio, Department of Job and Family Services to perform an actuarial review and certification regarding the development of the capitation rates to be effective for calendar year 2008. The capitation rates were developed for the Covered Families and Children managed care eligible populations. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods. I have complied with the elements of the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans.

The capitation rates provided with this certification are effective for a one-year rating period beginning January 1, 2008 through December 31, 2008. At the end of the one-year period, the capitation rates will be updated for calendar year 2009. The update may be based on fee-for-service experience, managed care utilization and trend experience, policy and procedure changes, and other changes in the health care market. A separate certification will be provided with the updated rates.

The capitation rates provided with this certification are considered actuarially sound, defined as:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Robert M. Damler, FSA
Member, American Academy of Actuaries

December 4, 2007

Date

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.



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APPENDIX 3

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**State of Ohio
Department of Job and Family Services
Capitation Rate Summary — Rate Group Level**

Region	Rate Group	Projected CY 2008 MMs/Deliveries	%of MMs	CY 2008 Guaranteed Rate	CY 2008 At Risk Rate	CY 2008 Rate
Central	HF/HST <1 M+F	203,519	7.4%	\$ 562.74	\$ 5.43	\$ 568.17
Central	HF/HST 1 M+F	158,456	5.8%	145.11	1.40	146.51
Central	HF/HST 2-13 M+F	1,226,460	44.7%	98.15	0.95	99.10
Central	HF/HST 14-18 F	163,216	5.9%	163.61	1.58	165.19
Central	HF/HST 14-18 M	146,796	5.3%	117.41	1.13	118.54
Central	HF 19-44 F	550,237	20.1%	301.40	2.91	304.31
Central	HF 19-44 M	168,204	6.1%	196.85	1.90	198.75
Central	HF 45+ M+F	65,409	2.4%	481.13	4.64	485.77
Central	HST 19-64 F	61,713	2.2%	372.66	3.59	376.25
Central	Composite Non-Delivery	2,744,010		\$ 202.36	\$ 1.95	\$ 204.31
Central	Delivery CFC	10,854		3,718.41	35.85	3,754.26
Central	Composite with Delivery	2,744,010		\$ 217.07	\$ 2.09	\$ 219.16
East Central	HF/HST <1 M+F	100,943	6.7%	\$ 548.66	\$ 5.29	\$ 553.95
East Central	HF/HST 1 M+F	75,476	5.0%	141.49	1.36	142.85
East Central	HF/HST 2-13 M+F	669,784	44.2%	95.70	0.92	96.62
East Central	HF/HST 14-18 F	96,465	6.4%	159.52	1.54	161.06
East Central	HF/HST 14-18 M	88,374	5.8%	114.47	1.10	115.57
East Central	HF 19-44 F	320,982	21.2%	293.86	2.83	296.69
East Central	HF 19-44 M	90,883	6.0%	191.93	1.85	193.78
East Central	HF 45+ M+F	39,563	2.6%	469.08	4.52	473.60
East Central	HST 19-64 F	33,888	2.2%	363.34	3.50	366.84
East Central	Composite Non-Delivery	1,516,358		\$ 196.72	\$ 1.90	\$ 198.62
East Central	Delivery CFC	6,386		3,952.33	38.11	3,990.44
East Central	Composite with Delivery	1,516,358		\$ 213.36	\$ 2.06	\$ 215.42
Northeast	HF/HST <1 M+F	162,387	6.2%	\$ 532.52	\$ 5.13	\$ 537.65
Northeast	HF/HST 1 M+F	130,937	5.0%	137.33	1.32	138.65
Northeast	HF/HST 2-13 M+F	1,160,029	44.5%	92.88	0.90	93.78
Northeast	HF/HST 14-18 F	180,843	6.9%	154.83	1.49	156.32
Northeast	HF/HST 14-18 M	164,388	6.3%	111.11	1.07	112.18
Northeast	HF 19-44 F	561,019	21.5%	285.22	2.75	287.97
Northeast	HF 19-44 M	119,830	4.6%	186.28	1.80	188.08
Northeast	HF 45+ M+F	78,748	3.0%	455.29	4.39	459.68
Northeast	HST 19-64 F	50,934	2.0%	352.64	3.40	356.04
Northeast	Composite Non-Delivery	2,609,115		\$ 189.57	\$ 1.83	\$ 191.40
Northeast	Delivery CFC	9,871		4,066.54	39.21	4,105.75
Northeast	Composite with Delivery	2,609,115		\$ 204.96	\$ 1.98	\$ 206.93
Northeast Central	HF/HST <1 M+F	42,798	6.2%	\$ 575.16	\$ 5.55	\$ 580.71
Northeast Central	HF/HST 1 M+F	32,550	4.7%	148.33	1.43	149.76
Northeast Central	HF/HST 2-13 M+F	306,477	44.2%	100.32	0.97	101.29
Northeast Central	HF/HST 14-18 F	47,853	6.9%	167.23	1.61	168.84
Northeast Central	HF/HST 14-18 M	44,376	6.4%	120.00	1.16	121.16
Northeast Central	HF 19-44 F	145,323	20.9%	308.07	2.97	311.04
Northeast Central	HF 19-44 M	41,692	6.0%	201.20	1.94	203.14
Northeast Central	HF 45+ M+F	18,583	2.7%	491.75	4.74	496.49
Northeast Central	HST 19-64 F	14,085	2.0%	380.88	3.67	384.55
Northeast Central	Composite Non-Delivery	693,737		\$ 203.51	\$ 1.96	\$ 205.47
Northeast Central	Delivery CFC	2,683		4,074.59	39.29	4,113.88
Northeast Central	Composite with Delivery	693,737		\$ 219.27	\$ 2.11	\$ 221.38
Northwest	hf/hst <1 M+F	103,070	7.2%	\$ 560.41	\$ 5.40	\$ 565.81
Northwest	HF/HST 1 M+F	76,773	5.4%	144.52	1.39	145.91
Northwest	HF/HST 2-13 M+F	627,854	44.0%	97.75	0.94	98.69
Northwest	HF/HST 14-18 F	91,028	6.4%	162.94	1.57	164.51
Northwest	HF/HST 14-18 M	82,247	5.8%	116.91	1.13	118.04
Northwest	HF 19-44 F	290,044	20.3%	300.16	2.89	303.05
Northwest	HF 19-44 M	88,010	6.2%	196.05	1.89	197.94
Northwest	HF 45+ M+F	32,963	2.3%	479.14	4.62	483.76

Northwest	HST 19-64 F	36,142	2.5%	371.11	3.58	374.69
Northwest	Composite Non-Delivery	1,428,131		\$ 201.79	\$ 1.95	\$ 203.74
Northwest	Delivery CFC	6,080		3,732.40	35.99	3,768.39
Northwest	Composite with Delivery	1,428,131		\$ 217.69	\$ 2.10	\$ 219.79

FINAL AND CONFIDENTIAL

State of Ohio

**Department of Job and Family Services
Capitation Rate Summary — Rate Group Level**

Region	Rate Group	Projected CY 2008 MMs/Deliveries	% of MMs	CY 2008 Guaranteed Rate	CY 2008 At Risk Rate	CY 2008 Rate
Southeast	HF/HST<1 M+F	54,113	5.6%	\$ 569.55	\$ 5.49	\$ 575.04
Southeast	HF/HST 1 M+F	44,355	4.6%	146.87	1.42	148.29
Southeast	HF/HST 2-13 M+F	405,711	42.2%	99.34	0.96	100.30
Southeast	HF/HST 14-18 F	60,544	6.3%	165.59	1.60	167.19
Southeast	HF/HST 14-18 M	56,221	5.8%	118.83	1.15	119.98
Southeast	HF 19-44 F	205,174	21.3%	305.06	2.94	308.00
Southeast	HF 19-44 M	90,312	9.4%	199.24	1.92	201.16
Southeast	HF 45+ M+F	27,036	2.8%	486.93	4.70	491.63
Southeast	HST 19-64 F	18,943	2.0%	377.17	3.64	380.81
Southeast	Composite Non-Delivery	962,409		\$ 202.86	\$ 1.96	\$ 204.82
Southeast	Delivery CFC	3,528		3,523.18	33.97	3,557.15
Southeast	Composite with Delivery	962,409		\$ 215.78	\$ 2.08	\$ 217.86
Southwest	HF/HST <1 M+F	136,292	8.2%	\$ 601.16	\$ 5.80	\$ 606.96
Southwest	HF/HST 1 M+F	98,401	5.9%	155.03	1.49	156.52
Southwest	HF/HST 2-13 M+F	761,118	45.6%	104.86	1.01	105.87
Southwest	HF/HST 14-18 F	102,994	6.2%	174.78	1.69	176.47
Southwest	HF/HST 14-18 M	88,400	5.3%	125.43	1.21	126.64
Southwest	HF 19-44F	321,176	19.2%	321.99	3.10	325.09
Southwest	HF 19-44 M	84,540	5.1%	210.31	2.03	212.34
Southwest	HF 45+ M+F	34,189	2.0%	513.98	4.96	518.94
Southwest	HST 19-64 F	42,884	2.6%	398.11	3.84	401.95
Southwest	Composite Non-Delivery	1,669,994		\$ 216.72	\$ 2.09	\$ 218.81
Southwest	Delivery CFC	7,350		3,973.57	38.31	4,011.88
Southwest	Composite with Delivery	1,669,994		\$ 234.21	\$ 2.26	\$ 236.47
West Central	HF/HST < 1M+F	88,254	7.5%	\$ 567.07	\$ 5.47	\$ 572.54
West Central	HF/HST 1 M+F	65,856	5.6%	146.24	1.41	147.65
West Central	HF/HST 2-13 M+F	528,534	44.7%	98.91	0.95	99.86
West Central	HF/HST 14-18 F	77,143	6.5%	164.88	1.59	166.47
West Central	HF/HST 14-18 M	67,395	5.7%	118.32	1.14	119.46
West Central	HF 19-44 F	234,878	19.9%	303.73	2.93	306.66
West Central	HF-19-44 M	66,482	5.6%	198.38	1.91	200.29
West Central	HF 45+ M+F	27,032	2.3%	484.84	4.67	489.51
West Central	HST 19-64 F	27,422	2.3%	375.53	3.62	379.15
West Central	Composite Non-Delivery	1,182,996		\$ 203.36	\$ 1.96	\$ 205.32
West Central	Delivery CFC	4,916		4,301.21	41.47	4,342.68
West Central	Composite with Delivery	1,182,996		\$ 221.24	\$ 2.13	\$ 223.37
Statewide	HF/HST <1 M+F	891,376	7.0%	\$ 562.68	\$ 5.43	\$ 568.11
Statewide	HF/HST 1 M+F	682,804	5.3%	144.95	1.40	146.35
Statewide	HF/HST 2- 13 M+F	5,685,967	44.4%	97.92	0.94	98.86
Statewide	HF/HST 14-18F	820,086	6.4%	163.00	1.57	164.57
Statewide	HF/HST 14-18 M	738,197	5.8%	116.90	1.13	118.03
Statewide	HF 19-44 F	2,628,833	20.5%	300.26	2.90	303.16
Statewide	HF 19-44 M	749,953	5.9%	196.65	1.90	198.55
Statewide	HF 45 + M+F	323,523	2.5%	478.04	4.61	482.65
Statewide	HST 19-64 F	286,011	2.2%	372.59	3.59	376.18
Statewide	Composite Non-Delivery	12,806,750	100.0%	\$ 201.09	\$ 1.94	203.03
Statewide	Delivery CFC	51,668	0.4%	3,91.39	37.72	3,950.11
Statewide	Composite with Delivery	12,806,750	\$ 100.0%	\$ 216.87	\$ 2.09	\$ 218.96

**APPENDIX F
REGIONAL RATES**

1. PREMIUM RATES WITHOUT THE AT-RISK PAYMENT AMOUNTS FOR 01/01/08 THROUGH 06/30/08 SHALL BE AS FOLLOWS

MCP: MOLINA HEALTHCARE OF OHIO, INC.

SERVICE ENROLLMENT AREA	REGIONAL STATUS	HF/HST Age < 1	HF/HST Age 1	HF/HST Age 2-13	HF/HST Age 14-18 Male	HF/HST Age 14-18 Female	HF Age 19-44 Male	HF Age 19-44 Female	HF Age 45 and over	HST Age 19-64 Female	Delivery Payment
Central	Mandatory	\$562.74	\$ 145.11	\$ 98.15	\$ 117.41	\$ 163.61	\$ 196.85	\$ 301.40	\$ 481.13	\$ 372.66	\$3,718.41
Southeast	Mandatory	\$ 575.04	\$ 148.29	\$ 100.30	\$ 119.98	\$ 167.19	\$ 201.16	\$ 308.00	\$ 491.63	\$ 380.81	\$3,557.15
Southwest	Mandatory	\$ 606.96	\$ 156.52	\$ 105.87	\$ 126.64	\$ 176.47	\$ 212.34	\$ 325.09	\$ 518.94	\$ 401.95	\$4,011.88
West Central	Mandatory	\$ 567.07	\$ 146.24	\$ 98.91	\$ 118.32	\$ 164.88	\$ 198.38	\$ 303.73	\$484.84	\$ 375.53	\$ 4,301.21

List of Eligible Assistance Groups (AGs)

Healthy Families: — MA-C Categorically eligible due to TANF cash
 — MA-T Children under 21
 — MA-Y Transitional Medicaid

Healthy Start: — MA-P Pregnant Women and Children

Per Appendix E, Rate Methodology, MCPs in the first two years of operation of the MC program are not subject to an at-risk recovery amount.

For the SFY 2008 contract period, MCPs will be put-at risk for a portion of the premiums received for members in counties they served as of January 1, 2006, provided the MCP has participated in the program for more than twenty-four months.

MCPs will be put at-risk for a portion of the premiums received for members in counties they began serving after January 1, 2006, beginning with the MCP's twenty-fifth month of membership in each county's region.

Molina's regional counties at-risk: Clark, Franklin, Montgomery.

**APPENDIX F
REGIONAL RATES**

2. AT-RISK AMOUNTS FOR 01/01/08 THROUGH 06/30/08 SHALL BE AS FOLLOWS:

MCP: MOLINA HEALTHCARE OF OHIO, INC.

SERVICE ENROLLMENT AREA	REGIONAL STATUS	HF/HST Age < 1	HF/HST Age 1	HF/HST Age 2-13	HF/HST Age 14-18 Male	HF/HST Age 14-18 Female	HF Age 19-44 Male	HF Age 19-44 Female	HF Age 45 and over	HST Age 19-64 Female	Delivery Payment
Central	Mandatory	\$ 5.43	\$ 1.40	\$ 0.95	\$ 1.13	\$ 1.58	\$ 1.90	\$ 2.91	\$ 4.64	\$ 3.59	\$35.85
Southeast	Mandatory	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
Southwest	Mandatory	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00	\$ 0.00
West Central	Mandatory	\$ 5.47	\$ 1.41	\$ 0.95	\$ 1.14	\$ 1.59	\$ 1.91	\$ 2.93	\$ 4.67	\$ 3.62	\$ 41.47

List of Eligible Assistance Groups (AGs)

Healthy Families: — MA-C Categorically eligible due to TANF cash
 — MA-T Children under 21
 — MA-Y Transitional Medicaid

Healthy Start: — MA-P Pregnant Women and Children

Per Appendix E, Rate Methodology, MCPs in the first two years of operation in the MC program are not subject to an at-risk recovery amount.

For the SFY 2008 contract period, MCPs will be put-at risk for a portion of the premiums received for members in counties they served as of January 1, 2006, provided the MCP has participated in the program for more than twenty-four months.

MCPs will be put at-risk for a portion of the premiums received for members in counties they began serving after January 1, 2006, beginning with the MCP's twenty-fifth month of membership in each county's region.

Molina's regional counties at-risk: Clark, Franklin, Montgomery.

**APPENDIX F
REGIONAL RATES**

3. PREMIUM RATES FOR 01/01/08 THROUGH 06/30/08 SHALL BE AS FOLLOWS:

MCP: MOLINA HEALTHCARE OF OHIO, INC.

SERVICE ENROLLMENT AREA	REGIONAL STATUS	HF/HST Age < 1	HF/HST Age 1	HF/HST Age 2-13	HF/HST Age 14-18 Male	HF/HST Age 14-18 Female	HF Age 19-44 Male	HF Age 19-44 Female	HF Age 45 and over	HST Age 19-64 Female	Delivery Payment
Central	Mandatory	\$568.17	\$ 146.51	\$ 99.10	\$ 118.54	\$ 165.19	\$ 198.75	\$ 304.31	\$485.77	\$ 376.25	\$ 3,754.26
Southeast	Mandatory	\$ 575.04	\$ 148.29	\$ 100.30	\$ 119.98	\$ 167.19	\$ 201.16	\$ 308.00	\$ 491.63	\$ 380.81	\$ 3,557.15
Southwest	Mandatory	\$ 606.96	\$ 156.52	\$ 105.87	\$ 126.64	\$ 176.47	\$ 212.34	\$ 325.09	\$ 518.94	\$ 401.95	\$ 4,011.88
West Central	Mandatory	\$572.54	\$ 147.65	\$ 99.86	\$ 119.46	\$ 166.47	\$ 200.29	\$ 306.66	\$489.51	\$ 379.15	\$4,342.68

List of Eligible Assistance Groups (AGs)

Healthy Families: — MA-C Categorically eligible due to TANF cash
 — MA-T Children under 21
 — MA-Y Transitional Medicaid

Healthy Start: — MA-P Pregnant Women and Children

Per Appendix E, Rate Methodology, MCPs in the first two years of operation in the MC program are not subject to an at-risk recovery amount.

For the SFY 2008 contract period, MCPs will be put-at risk for a portion of the premiums received for members in counties they served as of January 1, 2006, provided the MCP has participated in the program for more than twenty-four months.

MCPs will be put at-risk for a portion of the premiums received for members in counties they began serving after January 1, 2006, beginning with the MCP's twenty-fifth month of membership in each county's region.

Molina's regional counties at-risk: Clark, Franklin, Montgomery.

APPENDIX G
COVERAGE AND SERVICES
CFC ELIGIBLE POPULATION

1. Basic Benefit Package

Pursuant to OAC rule 5101:3-26-03(A), with limited exclusions (see section G.2 of this appendix), MCPs must ensure that members have access to medically-necessary services covered by the Ohio Medicaid fee-for-service (FFS) program. For information (Medicaid-covered services, MCPs must refer to the ODJFS website. The following is general list of the benefits covered by the Ohio Medicaid fee-for-service program:

- Inpatient hospital services
 - Outpatient hospital services
 - Rural health clinics (RHCs) and Federally qualified health centers (FQHCs)
 - Physician services whether furnished in the physician's office, the covered person's home, a hospital, or elsewhere
 - Laboratory and x-ray services
 - Screening, diagnosis, and treatment services to children under the age of twenty-one (21) under the HealthChek (EPSDT) program
 - Family planning services and supplies
 - Home health and private duty nursing services
 - Podiatry
 - Chiropractic services
 - Physical therapy, occupational therapy, developmental therapy and speech therapy
 - Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
 - Prescription drugs
 - Ambulance and ambulette services
 - Dental services
-

- Durable medical equipment and medical supplies
- Vision care services, including eyeglasses
- Short-term rehabilitative stays in a nursing facility as specified in OAC rule 5101:3-26-03
- Hospice care
- Behavioral health services (see section G.2.b.iii of this appendix)

2. Exclusions, Limitations and Clarifications

a. Exclusions

MCPs are not required to pay for Ohio Medicaid FFS program (Medicaid) non-covered services. For information regarding Medicaid noncovered services, MCPs must refer to the ODJFS website. The following is a general list of the services not covered by the Ohio Medicaid fee-for-service program:

- Services or supplies that are not medically necessary
 - Experimental services and procedures, including drugs and equipment, not covered by Medicaid
 - Organ transplants that are not covered by Medicaid
 - Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
 - Infertility services for males or females
 - Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
 - Reversal of voluntary sterilization procedures
 - Plastic or cosmetic surgery that is not medically necessary*
 - Immunizations for travel outside of the United States
 - Services for the treatment of obesity unless medically necessary*
 - Custodial or supportive care not covered by Medicaid
-

- Sex change surgery and related services
- Sexual or marriage counseling
- Acupuncture and biofeedback services
- Services to find cause of death (autopsy)
- Comfort items in the hospital (e.g., TV or phone)
- Paternity testing

MCPs are also not required to pay for non-emergency services or supplies received without members following the directions in their MCP member handbook, unless otherwise directed by ODJFS.

* These services could be deemed medically necessary if medical complications/conditions in addition to the obesity or physical imperfection are present.

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in OAC rules 5101:3-26-05(D) and 5101:3-26-12, MCPs are permitted to impose the applicable member co-payment amount(s) for dental services, vision services, non-emergency emergency department services, or prescription drugs, other than generic drugs. MCPs must notify ODJFS if they intend to impose a co-payment. ODJFS must approve the notice to be sent to the MCP's members and the timing of when the co-payments will begin to be imposed. If ODJFS determines that an MCP's decision to impose a particular co-payment on their members would constitute a significant change for those members, ODJFS may require the effective date of the co-payment to coincide with the "Open Enrollment" month.

Notwithstanding the preceding paragraph, MCPs must provide an ODJFS-approved notice to all their members 90 days in advance of the date that the MCP will impose the co-payment. With the exception of member co-payments the MCP has elected to implement in accordance with OAC rules 5101:3-26-05(D) and 5101:3-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors must not charge members or ODJFS any additional co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise.

ii. Abortion and Sterilization

The use of federal funds to pay for abortion and sterilization services is prohibited unless the specific criteria found in 42 CFR 441 and OAC rules 5101:3-17-01 and 5101:3-21-01 are met. MCPs must verify that all of the information on the required forms (JFS 03197, 03198, and 03199) is provided and that the service meets the required criteria before any such claim is paid.

Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment. MCPs are responsible for educating their providers on the requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification/consent forms; and for maintaining documentation to justify any such claim payments.

iii. Behavioral Health Services

Coordination of Services: MCPs must have a process to coordinate benefits of and referrals to the publicly funded community behavioral health system. MCPs must ensure that members have access to all medically-necessary behavioral health services covered by the Ohio Medicaid FFS program and are responsible for coordinating those services with other medical and support services. MCPs must notify members via the member handbook and provider directory of where and how to access behavioral health services, including the ability to self-refer to mental health services offered through ODMH community mental health centers (CMHCs) as well as substance abuse services offered through Ohio Department of Alcohol and Drug Addiction Services (ODADAS)-certified Medicaid providers. Pursuant to ORC Section 5111.16, alcohol, drug addiction and mental health services covered by Medicaid are not to be paid by the managed care program when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than ODJFS. MCPs are also not responsible for providing mental health services to persons between 22 and 64 years of age while residing in an institution for mental disease (IMD) as defined in Section 1905(i) of the Social Security Act.

MCPs must provide Medicaid-covered behavioral health services for members who are unable to timely access services or are unwilling to access services through community providers.

Mental Health Services: There are a number of Medicaid-covered mental health (MH) services available through ODMH CMHCs.

Where an MCP is responsible for providing MH services for their members, the MCP is responsible for ensuring access to counseling and psychotherapy, physician/psychologist/psychiatrist services, outpatient clinic services, general hospital outpatient psychiatric services, pre-hospitalization screening, diagnostic assessment (clinical evaluation), crisis intervention, psychiatric hospitalization in general hospitals (for all ages), and Medicaid-covered prescription drugs and laboratory services. MCPs are not required to cover partial hospitalization, or inpatient psychiatric care in a private or public free-standing psychiatric hospital. However, MCPs are required to cover the payment of physician services in a private or public free-standing psychiatric hospital when such services are billed independent of the hospital.

Substance Abuse Services: There are a number of Medicaid-covered substance abuse services available through ODADAS-certified Medicaid providers.

Where an MCP is responsible for providing substance abuse services for their members, the MCP is responsible for ensuring access to alcohol and other drug (AOD) urinalysis screening, assessment, counseling, physician/psychologist/psychiatrist AOD treatment services, outpatient clinic AOD treatment services, general hospital outpatient AOD treatment services, crisis intervention, inpatient detoxification services in a general hospital, and Medicaid-covered prescription drugs and laboratory services. MCPs are not required to cover outpatient detoxification and methadone maintenance.

Financial Responsibility for Behavioral Health Services: MCPs are responsible for the following:

- payment of Medicaid-covered prescription drugs prescribed by an ODMH CMHC or ODADAS-certified provider when obtained through an MCP's panel pharmacy;
 - payment of Medicaid-covered services provided by an MCP's panel laboratory when referred by an ODMH CMHC or ODADAS-certified provider;
 - payment of all other Medicaid-covered behavioral health services obtained through providers other than those who are ODMH CMHCs or ODADAS-certified providers when arranged/authorized by the MCP.
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Limitations:

- Pursuant to ORC Section 5111.16, alcohol, drug addiction and mental health services covered by Medicaid are not to be paid by the managed care program when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than ODJFS. As part of this limitation:
 - MCPs are not responsible for paying for behavioral health services provided through ODMH CMHCs and ODADAS-certified Medicaid providers;
 - MCPs are not responsible for payment of partial hospitalization (mental health), inpatient psychiatric care in a private or public free-standing inpatient psychiatric hospital, outpatient detoxification, intensive outpatient programs (IOP) (substance abuse) or methadone maintenance.
 - However, MCPs are required to cover the payment of physician services in a private or public free standing psychiatric hospital when such services are billed independent of the hospital.
 - iv. Pharmacy Benefit: In providing the Medicaid pharmacy benefit to their members, MCPs must cover the same drugs covered by the Ohio Medicaid fee-for-service program.

MCPs may establish a preferred drug list for members and providers which includes a listing of the drugs that they prefer to have prescribed. Preferred drugs requiring prior authorization approval must be clearly indicated as such. Pursuant to ORC §5111.172, ODJFS may approve MCP-specific pharmacy program utilization management strategies (see appendix G.3.a).
 - v. Organ Transplants: MCPs must ensure coverage for organ transplants and related services in accordance with OAC 5101-3-2-07.1 (B)(4)&(5). Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the “Ohio Solid Organ Transplant Consortium” based on criteria established by Ohio organ transplant surgeons and authorization from the ODJFS prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the “Ohio Hematopoietic Stem Cell Transplant Consortium” again based on criteria established by Ohio experts in the field of bone marrow transplant. While MCPs may require prior authorization for these transplant services, the approval criteria would be limited to
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confirming the consumer is being considered and/or has been recommended for a transplant by either consortium and authorized by ODJFS. Additionally, in accordance with OAC 5101:3-2-03 (A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible.

3. Care Coordination

a. Utilization Management Programs

General Provisions — Pursuant to OAC rule 5101:3-26-03.1(A)(7), MCPs must implement a utilization management (UM) program to maximize the effectiveness of the care provided to members and may develop other UM programs, subject to prior approval by ODJFS. For the purposes of this requirement, the specific UM programs which require ODJFS prior-approval are an MCP's general pharmacy program, a controlled substances and member management program, and any other program designed by the MCP with the purpose of redirecting or restricting access to a particular service or service location.

- i. Pharmacy Programs — Pursuant to ORC Sec. 5111.172 and OAC rule 5101:3-26-03(A) and (B), MCPs may, subject to ODJFS prior-approval, implement strategies for the management of pharmacy utilization. Pharmacy utilization management strategies may include developing preferred drug lists, requiring prior authorization for certain drugs, placing limitations on the type of provider and locations where certain medications may be administered, and developing and implementing a specialized pharmacy program to address the utilization of controlled substances, as defined in section 3719.01 of the Ohio Revised Code.

Drug Prior Authorizations: MCPs must receive prior approval from ODJFS for the medications that they wish to cover through prior authorization. MCPs must establish their prior authorization system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services. MCPs must make their approved list of drugs covered only with prior authorization available to members and providers, as outlined in paragraphs 37(b) and (c) of Appendix C.

Beginning January 1, 2008, MCPs may require prior authorization for the coverage of antipsychotic drugs with ODJFS approval. MCPs must, however, allow any member to continue receiving a specific antipsychotic drug if the member is stabilized on that particular medication. The MCP must continue to cover that specific drug for the stabilized member for as long as that medication continues to be

effective for the member. MCPs may also implement a drug utilization review program designed to promote the appropriate clinical prescribing of antipsychotic drugs. This can be accomplished through the MCP's retrospective analysis of drug claims to identify potential inappropriate use and provide education to those providers who are outliers to acceptable standards for prescribing/dispensing antipsychotic drugs.

MCPs must comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(k)(3), and OAC rule 5101:3-26-03.1 regarding the timeframes for prior authorization of covered outpatient drugs.

Controlled Substances and Member Management Programs: MCPs may also, with ODJFS prior approval, develop and implement Controlled Substances and Member Management (CSMM) programs designed to address use of controlled substances. Utilization management strategies may include prior authorization as a condition of obtaining a controlled substance, as defined in section 3719.01 of the Ohio Revised Code. CSMM strategies may also include processes for requiring MCP members at high risk for fraud or abuse involving controlled substances to have their narcotic medications prescribed by a designated provider/providers and filled by a pharmacy, medical provider, or health care facility designated by the program.

- ii. Emergency Department Diversion (EDD) — MCPs must provide access to services in a way that assures access to primary, specialist and urgent care in the most appropriate settings and that minimizes frequent, preventable utilization of emergency department (ED) services. OAC rule 5101:3-26-03.1(A)(7)(d) requires MCPs to implement the ODJFS-required emergency department diversion (EDD) program for frequent utilizers.

Each MCP must establish an ED diversion (EDD) program with the goal of minimizing frequent ED utilization. The MCP's EDD program must include the monitoring of ED utilization, identification of frequent ED utilizers, and targeted approaches designed to reduce avoidable ED utilization. MCP EDD programs must, at a minimum, address those ED visits which could have been prevented through improved education, access, quality or care management approaches.

Although there is often an assumption that frequent ED visits are solely the result of a preference on the part of the member and education is therefore the standard remedy, it is also important to ensure that a member's frequent ED utilization is not due to

problems such as their PCP's lack of accessibility or failure to make appropriate specialist referrals. The MCP's EDD program must therefore also include the identification of providers who serve as PCPs for a substantial number of frequent ED utilizers and the implementation of corrective action with these providers as so indicated.

This requirement does not replace the MCP's responsibility to inform and educate all members regarding the appropriate use of the ED.

b. Case Management Programs

In accordance with 5101:3-26-03.1(A)(8), MCPs must offer and provide comprehensive case management services which coordinate and monitor the care of members with specific diagnoses, or who require high-cost and/or extensive services. The MCP's comprehensive case management program must also include a Children with Special Health Care Needs component as specified below.

- i. Each MCP must inform all members and contracting providers of the MCP's case management services.
- ii. Children with Special Health Care Needs (CSHCN):

CSHCN are a particularly vulnerable population which often have chronic and complex medical health care conditions. In order to ensure compliance with the provisions of 42 CFR 438.208, each MCP must establish a CSHCN component as part of the MCP's comprehensive case management program. The MCP must establish a process for the timely identification, completion of a comprehensive needs assessment, and providing appropriate and targeted case management services for any CSHCN.

CSHCN are defined as children age 17 and under who are pregnant, and members under 21 years of age with one or more of the following:

- Asthma
 - HIV/AIDS
 - A chronic physical, emotional or mental condition for which they are receiving treatment or counseling
 - Supplemental security income (SSI) for a health-related condition
 - A current letter of approval from the Bureau of Children with Medical Handicaps (BCMH), Ohio Department of Health
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iii. Comprehensive Case Management Program

1. The MCP must have a process to inform members and their PCPs in writing that they have been identified as meeting the criteria for case management, including their enrollment into case management services.

2. The MCP must assure and coordinate the placement of the member into case management — including identification of the member's need for case management services, completion of the comprehensive health needs assessment, and timely development of a care treatment plan. This process must occur within the following timeframes for:

- a) newly enrolled members, 90 days from the effective date of enrollment; and
- b) existing members, 90 days from identifying their need for case management.

3. The MCP's comprehensive case management program must include, at a minimum, the following components:

a. Identification

The MCP must have a variety of mechanisms in place to identify members potentially eligible for case management. These mechanisms must include an administrative data review (e.g., diagnosis, cost threshold, and/or service utilization) and may include provider/self referrals, telephone interviews, information as reported by MCEC during membership selection, or home visits.

b. Assessment

The MCP must arrange for or conduct a comprehensive assessment of the member's physical and/or behavioral health condition(s) to confirm the results of a positive identification, and determine the need for case management services. The assessment must be completed by a physician, physician assistant, RN, LPN, licensed social worker, or a graduate of a two- or four-year allied health program. If the assessment is completed by another medical professional, there should be oversight and monitoring by either a registered nurse or physician.

For CSHCN, the comprehensive assessment must include, at a minimum, the use of the *ODJFS CSHCN Standard Assessment Tool*.

c. Care Treatment Plan

The care treatment plan is defined by ODJFS as the one developed by the MCP for the member. The development of the care treatment plan must be based on the comprehensive health assessment and reflect the member's primary medical diagnosis and health conditions, any co-morbidities, and the member's psychological, behavioral health and community support needs. The care treatment plan must also include specific provisions for periodic reviews (i.e., no less than semi-annually) of the member's condition and appropriate updates to the plan. The member and the member's PCP must be actively involved in the development of and revisions to the care treatment plan. The designated PCP is the provider, or specialist, who will manage and coordinate the overall care for the member. Ongoing communication regarding the status of the care treatment plan may be accomplished between the MCP and the PCP's designee (i.e., qualified health professional). Revisions to the clinical portion of the care treatment plan should be completed in consultation with the PCP.

The elements of a comprehensive care treatment plan include:

Goals and actions that address medical, social, behavioral and psychological needs;

Member level interventions (i.e., referrals and making appointments) that assist members in obtaining services, providers and programs;

Continuous review, revision and contact follow-up, as needed, to insure the care treatment plan is adequately monitored including the following:

- Documentation that services are provided in accordance with the care treatment plan;
 - Re-evaluation to determine if the care treatment plan is adequate to meet the member's current needs;
 - Identification of gaps between recommended care and actual care provided;
 - A change in needs or status from the re-evaluation that requires revisions to the care treatment plan;
 - Active participation by the member or representative in the care treatment plan development;
 - Monitoring of specific service delivery including service utilization; and
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- Re-evaluation of a member's risk level with adjustment to the level of case management services provided.

4. Coordination of Care and Communication

The MCP must provide case management services for:

- all CSHCN, including the ODJFS mandated conditions as specified in Appendix M, Case Management Program Performance Measures;
- all members enrolled in an MCP's CSMM program as specified in Section G(3)(a)(i); and
- adults whose health conditions warrant case management services.

Case management services should not be limited only to members with the mandated conditions.

There should be an accountable point of contact (i.e., case manager) who can help obtain medically necessary care, assist with health-related services and coordinate care needs. The MCP must arrange or provide for professional case management services that are performed collaboratively by a team of professionals appropriate for the member's condition and health care needs. At a minimum, the MCP's case manager must attempt to coordinate with the member's case manager from other health systems, including behavioral health. The MCP must have a process to facilitate, maintain, and coordinate communication between service providers, the member, and the member's family. The MCP must have a provision to disseminate information to the member/caregiver concerning the health condition, types of services that may be available, and how to access the services.

The MCP must implement mechanisms to notify all Members with Special Health Care Needs of their right to directly access a specialist. Such access may be assured through, for example, a standing referral or an approved number of visits, and documented in the care treatment plan.

iv. Case Management Strategies

The MCP must follow best-practice and/or evidence based clinical guidelines when developing a member's care treatment plan and coordinating the case management needs. The MCP

must develop and implement mechanisms to educate and equip providers and case managers with evidence-based clinical guidelines or best practice approaches to assist in providing a high level of quality of care to members.

v. Case Management Program Staffing

The MCP must identify the staff that will be involved in the operations of the case management program, including but not limited to: case manager supervisors, case manager, and administrative support staff. The MCP must identify the role and functions of each case management staff member as well as the educational requirements, clinical licensure standards, certification and relevant experience with care management standards and/or activities. The MCP must provide case manager staff/member ratios based on the member risk stratification and different levels of care being provided to members.

vi. Case Management Data Submission

The MCP must submit a monthly electronic report to the Case Management System (CAMS) for all members who are case managed by the MCP as outlined in the *ODJFS Case Management File and Submission Specifications*. In order for a member to be submitted as case managed in CAMS, the MCP must (1) complete the identification process, a comprehensive health needs assessment and development of a care treatment plan for the member; and (2) document the member's written or verbal confirmation of his/her case management status in the case management record. ODJFS, or its designated entity, the external quality review vendor, will validate on an annual basis the accuracy of the information contained in CAMS with the member's case management record.

The CAMS files are due the 10th business day of each month.

The MCP must also have an ODJFS-approved case management program which includes the items in Section 3.b.. Each MCP should implement an evaluation process to review, revise and/or update the case management program. The MCP must annually submit its case management program for approval by ODJFS. Any subsequent changes to an approved case management program description must be submitted to ODJFS in writing for review and approval prior to implementation.

c. Care Coordination with ODJFS-Designated Providers

Per OAC rule 5101:3-26-03.1(A)(4), MCPs are required to share specific information with certain ODJFS-designated non- contracting providers in order to ensure that these providers have been supplied with specific information needed to coordinate care for the MCP's members. Once an MCP has obtained a provider agreement, but within the first month of operation, the MCP must provide to the ODJFS-designated providers (i.e., ODMH Community Mental Health Centers, ODADAS-certified Medicaid providers, FQHCs/RHCs, QFPPs, CNMs, CNPs [if applicable], and hospitals) a quick reference information packet which includes the following:

- i. A brief cover letter explaining the purpose of the mailing; and
 - ii. A brief summary document that includes the following information:
 - Claims submission information including the MCP's Medicaid provider number for each region;
 - The MCP's prior authorization and referral procedures or the MCP's website which includes this information;
 - A picture of the MCP's member identification card (front and back);
 - Contact numbers and website location for obtaining information for eligibility verification, claims processing, referrals/prior authorization, and information regarding the MCP's behavioral health administrator;
 - A listing of the MCP's major pharmacy chains and the contact number for the MCP's pharmacy benefit administrator (PBM);
 - A listing of the MCP's laboratories and radiology providers; and
 - A listing of the MCP's contracting behavioral health providers and how to access services through them (this information is only to be provided to non-contracting community mental health and substance abuse providers).
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d. Care coordination with Non-Contracting Providers

Per OAC rule 5101:3-26-05(A)(9), MCPs authorizing the delivery of services from a provider who does not have an executed subcontract must ensure that they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph D of OAC rule 5101:3-26-05. This notice is provided when an MCP authorizes a non-contracting provider to furnish services on a one-time or infrequent basis to an MCP member and must include required ODJFS-model language and information. This notice must also be included with the transition of services form sent to providers as outlined in paragraph 29.h of Appendix C.

e. Integration of Member Care

The MCP must ensure that a discharge plan is in place to meet a member's health care needs following discharge from a nursing facility, and integrated into the member's continuum of care. The discharge plan must address the services to be provided for the member and must be developed prior to the date of discharge from the nursing facility. The MCP must ensure follow-up contact occurs with the member, or authorized representative, within thirty (30) days of the member's discharge from the nursing facility to ensure that the member's health care needs are being met.

APPENDIX H
PROVIDER PANEL SPECIFICATIONS
CFC ELIGIBLE POPULATION

1. GENERAL PROVISIONS

MCPs must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as assure that they meet all applicable provider panel requirements for their entire designated service area. The ODJFS provider panel requirements are specified in the charts included with this appendix and must be met prior to the MCP receiving a provider agreement with ODJFS. The MCP must remain in compliance with these requirements for the duration of the provider agreement.

If an MCP is unable to provide the medically necessary, Medicaid-covered services through their contracted provider panel, the MCP must ensure access to these services on an as needed basis. For example, if an MCP meets the pediatrician requirement but a member is unable to obtain a timely appointment from a pediatrician on the MCP's provider panel, the MCP will be required to secure an appointment from a panel pediatrician or arrange for an out-of-panel referral to a pediatrician.

MCPs are **required** to make transportation available to any member requesting transportation when they **must** travel 30 miles or more from their home to receive a medically-necessary Medicaid-covered service. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may **not** be counted toward this trip limit (as specified in Appendix C).

In developing the provider panel requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Covered Families and Children (CFC) consumers, as well as the potential availability of the designated provider types. ODJFS has integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODJFS requires providers to be located anywhere in the region. Although all provider types listed in this appendix are required provider types, only those listed on the attached charts must be submitted for ODJFS prior approval.

2. PROVIDER SUBCONTRACTING

Unless otherwise specified in this appendix or OAC rule 5101:3-26-05, all MCPs are required to enter into fully-executed subcontracts with their providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODJFS-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable Ohio

Administrative Code rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCP's name.

ODJFS must prior approve all MCP providers in the ODJFS- required provider type categories before they can begin to provide services to that MCP's members. MCPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. As part of the prior approval process, MCPs must submit documentation verifying that all necessary contract documents have been appropriately completed. ODJFS will verify the approvability of the submission and process this information using the ODJFS Provider Verification System (PVS) or other designated process. The PVS is a centralized database system that maintains information on the status of all MCP-submitted providers.

Only those providers who meet the applicable criteria specified in this document, as determined by ODJFS, will be approved by ODJFS. MCPs must credential/recredential providers in accordance with the standards specified by the National Committee for Quality Assurance (or receive approval from ODJFS to use an alternate industry standard) and must have completed the credentialing review before submitting any provider to ODJFS for approval. Regardless of whether ODJFS has approved a provider, the MCP must ensure that the provider has met all applicable credentialing criteria before the provider can render services to the MCP's members.

MCPs must notify ODJFS of the addition and deletion of their contracting providers as specified in OAC rule 5101:3-26-05, and must notify ODJFS within one working day in instances where the MCP has identified that they are not in compliance with the provider panel requirements specified in this appendix.

2. PROVIDER PANEL REQUIREMENTS

The provider network criteria that must be met by each MCP are as follows:

a. Primary Care Providers (PCPs)

Primary Care Provider (PCP) means an individual physician (M.D. or D.O.), certain physician group practice/clinic (Primary Care Clinics [PCCs]), or an advanced practice nurse (APN) as defined in ORC 4723.43 or advanced practice nurse group practice within an acceptable specialty, contracting with an MCP to provide services as specified in paragraph (B) of OAC rule 5101: 3-26-03.1. Acceptable specialty types for PCPs include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Acceptable PCCs include FQHCs, RHCs and the acceptable group practices/clinics specified by ODJFS. As part of their subcontract with an MCP, PCPs must stipulate the total Medicaid member capacity that they can ensure for that individual MCP.

Each PCP must have the capacity and agree to serve at least 50 Medicaid members at each practice site in order to be approved by ODJFS as a PCP. The capacity-by-site requirement must be met for all ODJFS-approved PCPs.

In determining whether an MCP has sufficient PCP capacity for a region, ODJFS considers a provider who can serve as a PCP for 2000 Medicaid MCP members as one full-time equivalent (FTE).

ODJFS reviews the capacity totals for each PCP to determine if they appear excessive. ODJFS reserves the right to request clarification from an MCP for any PCP whose total stated capacity for all MCP networks added together exceeds 2000 Medicaid members (i.e., 1 FTE). Where indicated, ODJFS may set a cap on the maximum amount of capacity that we will recognize for a specific PCP. ODJFS may allow up to an additional 750 member capacity for each nurse practitioner or physician's assistant that is used to provide clinical support for a PCP.

For PCPs contracting with more than one MCP, the MCP must ensure that the capacity figure stated by the PCP in their subcontract reflects only the capacity the PCP intends to provide for that one MCP. ODJFS utilizes each approved PCP's capacity figure to determine if an MCP meets the provider panel requirements and this stated capacity figure does not prohibit a PCP from actually having a caseload that exceeds the capacity figure indicated in their subcontract.

ODJFS recognizes that MCPs will need to utilize specialty providers to serve as PCPs for some special needs members. Also, in some situations (e.g., continuity of care) a PCP may only want to serve a very small number of members for an MCP. In these situations it will not be necessary for the MCP to submit these PCPs to ODJFS for prior approval. These PCPs will not be included in the ODJFS PVS database, or other designated process, and therefore may not appear as PCPs in the MCP's provider directory. These PCPs will, however, need to execute a subcontract with the MCP which includes the appropriate Model Medicaid Addendum.

The PCP requirement is based on an MCP having sufficient PCP capacity to serve 40% of the eligibles in the region if three MCPs are serving the region and 55% of the eligibles in the region if two MCPs are serving the region. At a minimum, each MCP must meet both the PCP FTE requirement for that region, and a ratio of one PCP FTE for each 2,000 of their Medicaid members in that region. MCPs must also satisfy a PCP geographic accessibility standard. ODJFS will match the PCP practice sites and the stated PCP capacity with the geographic location of the eligible population in that region (on a county-specific basis) and perform analysis using Geographic Information Systems (GIS) software. The analysis will be used to determine if at least 40% of the eligible population is located within 10 miles of PCP with available capacity in urban counties and 40% of the eligible population within 30 miles of a PCP with available capacity in rural counties. [Rural areas are defined pursuant to 42 CFR 412.62(f)(1)(iii).]

In addition to the PCP FTE capacity requirement, MCPs must also contract with the specified number of pediatric PCPs for each region. These pediatric PCPs will have their stated capacity counted toward the PCP FTE requirement.

A pediatric PCP must maintain a general pediatric practice (e.g., a pediatric neurologist would not meet this definition unless this physician also operated a practice as a general pediatrician) at a site(s) located within the county/region and be listed as a pediatrician with the Ohio State Medical Board. In addition, half of the required number of pediatric PCPs must also be certified by the American Board of Pediatrics. The provider panel requirements for pediatricians are included in the practitioner charts in this appendix.

Until July 1, 2008, MCPs may only use PCPs who are individual physicians (M.D. or D.O.), physician group practices, or PCCs to meet capacity and FTE requirements.

b. Non-PCP Provider Network

In addition to the PCP capacity requirements, each MCP is also required to maintain adequate capacity in the remainder of its provider network within the following categories: hospitals, dentists, pharmacies, vision care providers, obstetricians/gynecologists (OB/GYNs), allergists, general surgeons, otolaryngologists, orthopedists, certified nurse midwives (CNMs), certified nurse practitioners (CNPs), federally qualified health centers (FQHCs)/rural health centers (RHCs) and qualified family planning providers (QFPs). CNMs, CNPs, FQHCs/RHCs and QFPs are federally-required provider types.

All Medicaid-contracting MCPs must provide all medically-necessary Medicaid-covered services to their members and therefore their complete provider network will include many other additional specialists and provider types. MCPs must ensure that all non-PCP network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members must wait from the time of their request to the first available time when the visit can occur).

Although there are currently no FTE capacity requirements of the non-PCP required provider types, MCPs are required to ensure that adequate access is available to members for all required provider types. Additionally, for certain non-PCP required provider types, MCPs must ensure that these providers maintain a full-time practice at a site(s) located in the specified county/region (i.e., the ODJFS-specified county within the region or anywhere within the region if no particular county is specified). A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week. ODJFS will monitor access to services through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures.

Hospitals - MCPs must contract with the number and type of hospitals specified by ODJFS for each county/region. In developing these hospital requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Covered Families and Children (CFC) consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODJFS may require that MCPs contract with out-of-state hospitals (i.e. Kentucky, West Virginia, etc.).

For each Ohio hospital, ODJFS utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health, in verifying types of services that hospital provides. Although ODJFS has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to an MCP's members, MCPs must still contract with the specified number and type of hospitals unless ODJFS approves a provider panel exception (see Section 4 of this appendix – Provider Panel Exceptions).

If an MCP-contracted hospital elects not to provide specific Medicaid-covered hospital services because of an objection on moral or religious grounds, the MCP must ensure that these hospital services are available to its members through another MCP-contracted hospital in the specified county/region.

OB/GYNs - MCPs must contract with the specified number of OB/GYNs for each county/region, all of whom must maintain a full-time obstetrical practice at a site(s) located in the specified county/region. Only MCP-contracting OB/GYNs with current hospital privileges at a hospital under contract with the MCP in the region can be submitted to the PVS, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory.

Certified Nurse Midwives (CNMs) and Certified Nurse Practitioners (CNP) - MCPs must ensure access to CNM and CNP services in the region if such provider types are present within the region. The MCP may contract directly with the CNM or CNP providers, or with a physician or other provider entity who is able to obligate the participation of a CNM or CNP. If an MCP does not contract for CNM or CNP services and such providers are present within the region, the MCP will be required to allow members to receive CNM or CNP services outside of the MCP's provider network.

Only CNMs with hospital delivery privileges at a hospital under contract with the MCP in the region can be submitted to the PVS, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory. The MCP must ensure a member's access to CNM and CNP services if such providers are practicing within the region.

Vision Care Providers - MCPs must contract with the specified number of ophthalmologists/optometrists for each specified county/region, all of whom must maintain a full-time practice at a site(s) located in the specified county/region. All ODJFS-approved vision providers must regularly perform routine eye exams. (MCPs will be expected to contract with an adequate number of ophthalmologists as part of their overall provider panel, but only

ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement.) If optical dispensing is not sufficiently available in a region through the MCP's contracting ophthalmologists/optometrists, the MCP must separately contract with an adequate number of optical dispensers located in the region.

Dental Care Providers - MCPs must contract with the specified number of dentists. In order to assure sufficient access to adult MCP members, no more than two-thirds of the dentists used to meet the provider panel requirement may be pediatric dentists.

Federally Qualified Health Centers/Rural Health Clinics (FQHCs/RHCs) - MCPs are required to ensure member access to any federally qualified health center or rural health clinic (FQHCs/RHCs), regardless of contracting status. Contracting FQHC/RHC providers must be submitted for ODJFS approval via the PVS process, or other designated process. Even if no FQHC/RHC is available within the region, MCPs must have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a member accesses these services outside of the region.

In order to ensure that any FQHC/RHC has the ability to submit a claim to ODJFS for the state's supplemental payment, MCPs must offer FQHCs/RHCs reimbursement pursuant to the following:

- MCPs must provide expedited reimbursement on a service-specific basis in an amount no less than the payment made to other providers for the same or similar service.
- If the MCP has no comparable service-specific rate structure, the MCP must use the regular Medicaid fee-for-service payment schedule for non-FQHC/RHC providers.
- MCPs must make all efforts to pay FQHCs/RHCs as quickly as possible and not just attempt to pay these claims within the prompt pay time frames.

MCPs are required to educate their staff and providers on the need to assure member access to FQHC/RHC services.

Qualified Family Planning Providers (QFPPs) - All MCP members must be permitted to self-refer to family planning services provided by a QFPP. A QFPP is defined as any public or not-for-profit health care provider that complies with Title X guidelines/standards, and receives either Title X funding or family planning funding from the Ohio Department of Health. MCPs must reimburse all medically-necessary Medicaid-covered family planning services provided to eligible members by a QFPP provider (including on-site pharmacy and diagnostic services) on a patient self-referral basis, regardless of the provider's status as a panel or non-panel provider. MCPs will be required to work with QFPPs in the region to develop mutually-agreeable HIPAA

compliant policies and procedures to preserve patient/provider confidentiality, and convey pertinent information to the member's PCP and/or MCP.

Behavioral Health Providers – MCPs must assure member access to all Medicaid-covered behavioral health services for members as specified in Appendix G.b.ii. Although ODJFS is aware that certain outpatient substance abuse services may only be available through Medicaid providers certified by the Ohio Department of Drug and Alcohol Addiction Services (ODADAS) in some areas, MCPs must maintain an adequate number of contracted mental health providers in the region to assure access for members who are unable to timely access services or unwilling to access services through community mental health centers. MCPs are advised not to contract with community mental health centers as all services they provide to MCP members are to be billed to ODJFS.

Other Specialty Types (pediatricians, general surgeons, otolaryngologists, allergists, and orthopedists) - MCPs must contract with the specified number of all other ODJFS designated specialty provider types. In order to be counted toward meeting the provider panel requirements, these specialty providers must maintain a full-time practice at a site(s) located within the specified county/region. Only contracting general surgeons, orthopedists, and otolaryngologists with admitting privileges at a hospital under contract with the MCP in the region can be submitted to the PVS, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory.

4. PROVIDER PANEL EXCEPTIONS

ODJFS may specify provider panel criteria for a service area that deviates from that specified in this appendix if:

- the MCP presents sufficient documentation to ODJFS to verify that they have been unable to meet or maintain certain provider panel requirements in a particular service area despite all reasonable efforts on their part to secure such a contract(s), and
- if notified by ODJFS, the provider(s) in question fails to provide a reasonable argument why they would not contract with the MCP, and
- the MCP presents sufficient assurances to ODJFS that their members will have adequate access to the services in question.

If an MCP is unable to contract with or maintain a sufficient number of providers to meet the ODJFS-specified provider panel criteria, the MCP may request an exception to these criteria by submitting a provider panel exception request as specified by ODJFS. ODJFS will review the exception request and determine whether the MCP has sufficiently demonstrated that all reasonable efforts were made to obtain contracts with providers of the type in question and that they will be able to provide access to the services in question.

ODJFS will aggressively monitor access to all services related to the approval of a provider panel exception request through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; member just-cause for termination requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures. ODJFS approval of a provider panel exception request does not exempt the MCP from assuring access to the services in question. If ODJFS determines that an MCP has not provided sufficient access to these services, the MCP may be subject to sanctions.

5. PROVIDER DIRECTORIES

MCP provider directories must include all MCP-contracted providers [except as specified by ODJFS] as well as certain non-contracted providers. At the time of ODJFS' review, the information listed in the MCP's provider directory for all ODJFS-required provider types specified on the attached charts must exactly match the data currently on file in the ODJFS PVS, or other designated process.

MCP provider directories must utilize a format specified by ODJFS. Directories may be region-specific or include multiple regions, however, the providers within the directory must be divided by region, county, and provider type, in that order.

The directory must also specify:

- provider address(es) and phone number(s);
- an explanation of how to access providers (e.g. referral required vs. self-referral);
- an indication of which providers are available to members on a self-referral basis
- foreign-language speaking PCPs and specialists and the specific foreign language(s) spoken;
- how members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals; and
- any PCP or specialist practice limitations.

Printed Provider Directory

Prior to receiving a provider agreement, all MCPs must develop a printed provider directory that shall be prior-approved by ODJFS for each covered population. For example, an MCP who serves CFC and ABD in the Central Region would have two provider directories, one for CFC and one for ABD. Once approved, this directory may be regularly updated with provider additions or deletions by the MCP without ODJFS prior-approval, however, copies of the revised directory (or inserts) must be submitted to ODJFS prior to distribution to members.

On a quarterly basis, MCPs **must** create an insert to each printed directory that lists those providers **deleted** from the MCP's provider panel during the previous three months. Although this insert does not need to be prior approved by ODJFS, copies of the insert must be submitted to ODJFS two weeks prior to distribution to members.

Internet Provider Directory

MCPs are required to have an internet-based provider directory available in the same format as their ODJFS-approved printed directory. This internet directory must allow members to electronically search for MCP panel providers based on name, provider type, and geographic proximity, and population (e.g. CFC and/or ABD). If an MCP has one internet-based directory for multiple populations, each provider must include a description of which population they serve.

The internet directory may be updated at any time to include providers who are **not** one of the ODJFS-required provider types listed on the charts included with this appendix. ODJFS-required providers **must** be added to the internet directory within one week of the MCP's notification of ODJFS-approval of the provider via the Provider Verification process. Providers being deleted from the MCP's panel must be deleted from the internet directory within one week of notification from the provider to the MCP. Providers being deleted from the MCP's panel must be posted to the internet directory within one week of notification from the provider to the MCP of the deletion. These deleted providers must be included in the inserts to the MCP's provider directory referenced above.

6. FEDERAL ACCESS STANDARDS

MCPs must demonstrate that they are in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:

In establishing and maintaining their provider panel, MCPs must consider the following:

- The anticipated Medicaid membership.
 - The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCP.
 - The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.
 - The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.
 - MCPs must adequately and timely cover services to an out-of-network provider if the MCP's contracted provider panel is unable to provide the services covered under the MCP's provider agreement. The MCP must cover the out-of-network services for as long as the MCP network is unable to provide the services. MCPs must coordinate with the out-of-network provider with respect to payment and
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ensure that the provider agrees with the applicable requirements.

Contracting providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. MCPs must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. MCPs must establish mechanisms to ensure that panel providers comply with timely access requirements, and must take corrective action if there is failure to comply.

In order to demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP must submit documentation to ODJFS, in a format specified by ODJFS, that demonstrates it offers an appropriate range of preventive, primary care and specialty services adequate for the anticipated number of members in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area.

This documentation of assurance of adequate capacity and services must be submitted to ODJFS no less frequently than at the time the MCP enters into a contract with ODJFS; at any time there is a significant change (as defined by ODJFS) in the MCP's operations that would affect adequate capacity and services (including changes in services, benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCP.

Molina

APPENDIX J

**FINANCIAL PERFORMANCE
CFC ELIGIBLE POPULATION**

1. SUBMISSION OF FINANCIAL STATEMENTS AND REPORTS

MCPs must submit the following financial reports to ODJFS:

- a. The National Association of Insurance Commissioners (NAIC) quarterly and annual Health Statements (hereafter referred to as the “Financial Statements”), as outlined in Ohio Administrative Code (OAC) rule 5101:3-26-09(B). The Financial Statements must include all required Health Statement filings, schedules and exhibits as stated in the NAIC Annual Health Statement Instructions including, but not limited to, the following sections: Assets, Liabilities, Capital and Surplus Account, Cash Flow, Analysis of Operations by Lines of Business, Five-Year Historical Data, and the Exhibit of Premiums, Enrollment and Utilization. The Financial Statements must be submitted to BMHC even if the Ohio Department of Insurance (ODI) does not require the MCP to submit these statements to ODI. A signed hard copy and an electronic copy of the reports in the NAIC-approved format must both be provided to ODJFS;
 - b. Hard copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP or an indirect interest of five percent or more, or a combination of direct and indirect interest equal to five percent or more in the MCP;
 - c. Annual audited Financial Statements prepared by a licensed independent external auditor as submitted to the ODI, as outlined in OAC rule 5101:3-26-09(B);
 - d. Medicaid Managed Care Plan Annual Ohio Department of Job and Family Services (ODJFS) Cost Report and the auditor’s certification of the cost report, as outlined in OAC rule 5101:3-26-09(B);
 - e. Medicaid MCP Annual Restated Cost Report for the prior calendar year. The restated cost report shall be audited upon BMHC request;
 - f. Annual physician incentive plan disclosure statements and disclosure of and changes to the MCP’s physician incentive plans, as outlined in OAC rule 5101:3-26-09(B);
 - g. Reinsurance agreements, as outlined in OAC rule 5101:3-26-09(C);
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- h. Prompt Pay Reports, in accordance with OAC rule 5101:3-26-09(B). A hard copy and an electronic copy of the reports in the ODJFS-specified format must be provided to ODJFS;
- i. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5101:3-26-09.1;
- j. Financial, utilization, and statistical reports, when ODJFS requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5101:3-26-06(D);
- k. In accordance with ORC Section 5111.76 and Appendix C, MCP Responsibilities, MCPs must submit ODJFS-specified franchise fee reports in hard copy and electronic formats pursuant to ODJFS specifications.

2. FINANCIAL PERFORMANCE MEASURES AND STANDARDS

This Appendix establishes specific expectations concerning the financial performance of MCPs. In the interest of administrative simplicity and nonduplication of areas of the ODI authority, ODJFS' emphasis is on the assurance of access to and quality of care. ODJFS will focus only on a limited number of indicators and related standards to monitor plan performance. The three indicators and standards for this contract period are identified below, along with the calculation methodologies. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements.

Report Period: Compliance will be determined based on the annual Financial Statement.

- a. **Indicator:** **Net Worth as measured by Net Worth Per Member**

Definition: Net Worth = Total Admitted Assets minus Total Liabilities divided by TotalMembers across all lines of business

Standard: For the financial report that covers calendar year 2008, a minimum net worth per member of \$172.00, as determined from the annual Financial Statement submitted to ODI and the ODJFS.

The Net Worth Per Member (NWPM) standard is the Medicaid Managed Care Capitation amount paid to the MCP during the preceding calendar year, including delivery payments, but excluding the at-risk amount, expressed as a per-member per-month figure, multiplied by the applicable proportion below:

0.75 if the MCP had a total membership of 100,000 or more during that calendar year

0.90 if the MCP had a total membership of less than 100,000 for that calendar year

If the MCP did not receive Medicaid Managed Care Capitation payments during the preceding calendar year, then the NWPM standard for the MCP is the average Medicaid Managed Care capitation amount paid to Medicaid-contracting MCPs during the preceding calendar year, including delivery payments, but excluding the at-risk amount, multiplied by the applicable proportion above.

b. Indicator: Administrative Expense Ratio

Definition: Administrative Expense Ratio = Administrative Expenses minus Franchise Fees divided by Total Revenue minus Franchise Fees.

Standard: Administrative Expense Ratio not to exceed 15%, as determined from the annual Financial Statement submitted to ODI and ODJFS.

c. Indicator: Overall Expense Ratio

Definition: Overall Expense Ratio = The sum of the Administrative Expense Ratio and the Medical Expense Ratio.

Administrative Expense Ratio = Administrative Expenses minus Franchise Fees divided by Total Revenue minus Franchise Fees.

Medical Expense Ratio = Medical Expenses divided by Total Revenue minus Franchise Fees.

Standard: Overall Expense Ratio not to exceed 100% as determined from the annual Financial Statement submitted to ODI and ODJFS.

Penalty for noncompliance: Failure to meet any standard on 2.a., 2.b., or 2.c. above will result in ODJFS requiring the MCP to complete a corrective action plan (CAP) and specifying the date by which compliance must be demonstrated. Failure to meet the standard or otherwise comply with the CAP by the specified date will result in a new membership freeze unless ODJFS determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If the financial statement is not submitted to ODI by the due date, the MCP

continues to be obligated to submit the report to ODJFS by ODI's originally specified due date unless the MCP requests and is granted an extension by ODJFS.

Failure to submit complete quarterly and annual Financial Statements on a timely basis will be deemed a failure to meet the standards and will be subject to the noncompliance penalties listed for indicators 2.a., 2.b., and 2.c., including the imposition of a new membership freeze. The new membership freeze will take effect at the first of the month following the month in which the determination was made that the MCP was non-compliant for failing to submit financial reports timely.

In addition, ODJFS will review two liquidity indicators if a plan demonstrates potential problems in meeting related administrative requirements or the standards listed above. The two standards, 2.d and 2.e, reflect ODJFS' expected level of performance. At this time, ODJFS has not established penalties for noncompliance with these standards; however, ODJFS will consider the MCP's performance regarding the liquidity measures, in addition to indicators 2.a., 2.b., and 2.c., in determining whether to impose a new membership freeze, as outlined above, or to not issue or renew a contract with an MCP. The source for each indicator will be the NAIC Quarterly and annual Financial Statements.

Long-term investments that can be liquidated without significant penalty within 24 hours, which a plan would like to include in Cash and Short-Term Investments in the next two measurements, must be disclosed in footnotes on the NAIC Reports. Descriptions and amounts should be disclosed. Please note that "significant penalty" for this purpose is any penalty greater than 20%. Also, enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

d. Indicator: Days Cash on Hand

Definition: Days Cash on Hand = Cash and Short-Term Investments divided by (Total Hospital and Medical Expenses plus Total Administrative Expenses) divided by 365.

Standard: Greater than 25 days as determined from the annual Financial Statement submitted to ODI and ODJFS.

e. Indicator: Ratio of Cash to Claims Payable

Definition: Ratio of Cash to Claims Payable = Cash and Short-Term Investments divided by claims Payable (reported and unreported).

Standard: Greater than 0.83 as determined from the annual Financial Statement submitted to ODI and ODJFS.

3. REINSURANCE REQUIREMENTS

Pursuant to the provisions of OAC rule 5101:3-26-09 (C), each MCP must carry reinsurance coverage from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by Medicaid members.

The annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed \$75,000.00, except as provided below. Except for transplant services, and as provided below, this reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of \$75,000.00.

For transplant services, the reinsurance must cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of \$75,000.00.

An MCP may request a higher deductible amount and/or that the reinsurance cover less than 80% of inpatient costs in excess of the deductible amount. If the MCP does not have more than 75,000 members in Ohio, but does have more than 75,000 members between Ohio and other states, ODJFS may consider alternate reinsurance arrangements. However, depending on the corporate structures of the Medicaid MCP, other forms of security may be required in addition to reinsurance. These other security tools may include parental guarantees, letters of credit, or performance bonds. In determining whether or not the request will be approved, the ODJFS may consider any or all of the following:

- a. whether the MCP has sufficient reserves available to pay unexpected claims;
- b. the MCP's history in complying with financial indicators 2.a., 2.b., and 2.c., as specified in this Appendix.
- c. the number of members covered by the MCP;
- d. how long the MCP has been covering Medicaid or other members on a full risk basis.
- e. risk based capital ratio greater than 2.5 calculated from the last annual ODI financial statement.
- f. scatter diagram or bar graph from the last calendar year that shows the number of reinsurance claims that exceeded the current reinsurance deductible.

The MCP has been approved to have a reinsurance policy with a deductible amount of \$400,000 that covers 80% of inpatient costs in excess of the deductible amount for non-transplant services.

Molina has also been approved to delegate the responsibility for maintaining reinsurance coverage for Molina members who are with Children's Hospital and Physician Health Care Network (CHPHN) to CHPHN. Molina must assure that CHPHN maintains a reinsurance policy and that this policy covers at least 70% of inpatient costs incurred by one member in one year, in excess of CHPHN's \$100,000.00 deductible.

Penalty for noncompliance: If it is determined that an MCP failed to have reinsurance coverage, that an MCP's deductible exceeds \$75,000.00 without approval from ODJFS, or that the MCP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODJFS, then the MCP will be required to pay a monetary penalty to ODJFS. The amount of the penalty will be the difference between the estimated amount, as determined by ODJFS, of what the MCP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCP did actually pay while it was out of compliance plus 5%. For example, if the MCP paid \$3,000,000.00 in premiums during the period of non-compliance and would have paid \$5,000,000.00 if the requirements had been met, then the penalty would be \$2,100,000.00.

If it is determined that an MCP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, the MCP will be required to develop a corrective action plan (CAP).

4. PROMPT PAY REQUIREMENTS

In accordance with 42 CFR 447.46, MCPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the MCP and delegated claims processing entities.

The date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or date of electronic payment transmission. A claim means a bill from a provider for health care services that is assigned a unique identifier. A claim does not include an encounter form.

A "claim" can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Clean claims do not include payments made to a provider of service or a third party where the timing of the payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also

does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Penalty for noncompliance: Noncompliance with prompt pay requirements will result in progressive penalties to be assessed on a quarterly basis, as outlined in Appendix N of the Provider Agreement.

5. PHYSICIAN INCENTIVE PLAN DISCLOSURE REQUIREMENTS

MCPs must comply with the physician incentive plan requirements stipulated in 42 CFR 438.6(h) . If the MCP operates a physician incentive plan, no specific payment can be made directly or indirectly under this physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

If the physician incentive plan places a physician or physician group at substantial financial risk [as determined under paragraph (d) of 42 CFR 422.208] for services that the physician or physician group does not furnish itself, the MCP must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of 42 CFR 422.208, and conduct periodic surveys in accordance with paragraph (h) of 42 CFR 422.208.

In accordance with 42 CFR 417.479 and 42 CFR 422.210, MCPs must maintain copies of the following required documentation and submit to ODJFS annually, no later than 30 days after the close of the state fiscal year and upon any modification of the MCP's physician incentive plan:

- a. A description of the types of physician incentive arrangements the MCP has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus must be specified.
 - b. A description of information/data feedback to a physician/group on their: 1) adherence to evidence-based practice guidelines; and 2) positive and/or negative care variances from standard clinical pathways that may impact outcomes or costs. The feedback information may be used by the MCP for activities such as physician performance improvement projects that include incentive programs or the development of quality improvement initiatives.
 - c. A description of the panel size for each physician incentive plan. If patients are pooled, then the pooling method used to determine if substantial financial risk exists must also be specified.
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- d. If more than 25% of the total potential payment of a physician/group is at risk for referral services, the MCP must maintain a copy of the results of the required patient satisfaction survey and documentation verifying that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the threshold amounts, and any coinsurance required for amounts over the threshold.

6. NOTIFICATION OF REGULATORY ACTION

Any MCP notified by the ODI of proposed or implemented regulatory action must report such notification and the nature of the action to ODJFS no later than one working day after receipt from ODI. The ODJFS may request, and the MCP must provide, any additional information as necessary to assure continued satisfaction of program requirements. MCPs may request that information related to such actions be considered proprietary in accordance with established ODJFS procedures. Failure to comply with this provision will result in an immediate membership freeze.

APPENDIX K
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM
AND
EXTERNAL QUALITY REVIEW
CFC ELIGIBLE POPULATION

1. As required by federal regulation, 42 CFR 438.240, each managed care plan (MCP) must have an ongoing Quality Assessment and Performance Improvement Program (QAPI) that is annually prior-approved by the Ohio Department of Job and Family Services (ODJFS). The program must include the following elements:

a. PERFORMANCE IMPROVEMENT PROJECTS

Each MCP must conduct performance improvement projects (PIPs), including those specified by ODJFS. PIPs must achieve, through periodic measurements and intervention, significant and sustained improvement in clinical and non-clinical areas which are expected to have a favorable effect on health outcomes and satisfaction. MCPs must adhere to ODJFS PIP content and format specifications.

All ODJFS-specified PIPs must be prior-approved by ODJFS. As part of the external quality review organization (EQRO) process, the EQRO will assist MCPs with conducting PIPs by providing technical assistance and will annually validate the PIPs. In addition, the MCP must annually submit to ODJFS the status and results of each PIP.

MCPs must initiate the following PIPs:

- i. Non-clinical Topic: Identifying children/members with special health care needs.
- ii. Clinical Topic: Well-child visits during the first 15 months of life.
- iii. Clinical Topic: Percentage of members aged 2-21 years that access dental care services.

Initiation of PIPs will begin in the second year of participation in the Medicaid managed care program.

b. UNDER- AND OVER-UTILIZATION

Each MCP must have mechanisms in place to detect under- and over-utilization of health care services. The MCP must specify the mechanisms used to monitor utilization in its annual submission of the QAPI program to ODJFS.

It should also be noted that pursuant to the program integrity provisions outlined in Appendix I, MCPs must monitor for the potential under-utilization of services by their members in order to assure that all Medicaid-covered services are being provided, as

required. If any under-utilized services are identified, the MCP must immediately investigate and correct the problem(s) which resulted in such under-utilization of services.

In addition the MCP must conduct an ongoing review of service denials and must monitor utilization on an ongoing basis in order to identify services which may be under-utilized.

c. SPECIAL HEALTH CARE NEEDS

Each MCP must have mechanisms in place to assess the quality and appropriateness of care furnished to children/members with special health care needs. The MCP must specify the mechanisms used in its annual submission of the QAPI program to ODJFS.

d. SUBMISSION OF PERFORMANCE MEASUREMENT DATA

Each MCP must submit clinical performance measurement data as required by ODJFS that enables ODJFS to calculate standard measures. Refer to Appendix M "Performance Evaluation" for a more comprehensive description of the clinical performance measures.

Each MCP must also submit clinical performance measurement data as required by ODJFS that uses standard measures as specified by ODJFS. MCPs are required to submit Health Employer Data Information Set (HEDIS) audited data for the following measures:

- i. Well Child Visits in the First 15 Months of Life
- ii. Child Immunization Status

The measures must have received a "report" designation from the HEDIS certified auditor and must be specific to the Medicaid population. Data must be submitted annually and in an electronic format. Data will be used for MCP clinical performance monitoring and will be incorporated into comparative reports developed by the EQRO.

Initiation of submission of performance data will begin in the second year of participation in the Medicaid managed care program.

e. QAPI PROGRAM SUBMISSION

Each MCP must implement an evaluation process to review, revise, and/or update the QAPI program. The MCP must annually submit its QAPI program for review and approval by ODJFS.

2. EXTERNAL QUALITY REVIEW

In addition to the following requirements, MCPs must participate in external quality review activities as outlined in OAC 5101:3-26-07.

a. EQRO ADMINISTRATIVE REVIEWS

The EQRO will conduct annual focused administrative compliance assessments for each MCP which will include, but not be limited to, the following domains as specified by ODJFS: member rights and services, QAPI program, case management, provider networks, grievance system, coordination and continuity of care, and utilization management. In addition, the EQRO will complete a comprehensive administrative compliance assessment every three (3) years as required by 42 CFR 438.358 and specified by ODJFS.

In accordance with 42 CFR 438.360 and 438.362, MCPs with accreditation from a national accrediting organization approved by the Centers for Medicare and Medicaid Services (CMS) may request a non-duplication exemption from certain specified components of the administrative review. Non-duplication exemptions may not be requested for SFY 2008.

b. EXTERNAL QUALITY REVIEW PERFORMANCE

In accordance with OAC 5101: 3-26-07, each MCP must participate in an annual external quality review survey. If the EQRO cites a deficiency in performance, the MCP will be required to complete a Corrective Action Plan (e.g., ODJFS technical assistance session) or Quality Improvement Directives depending on the severity of the deficiency. (An example of a deficiency is if an MCP fails to meet certain clinical or administrative standards as supported by national evidence-based guidelines or best practices.) Serious deficiencies may result in immediate termination or non-renewal of the provider agreement. These quality improvement measures recognize the importance of ongoing MCP performance improvement related to clinical care and service delivery.

APPENDIX L
DATA QUALITY
CFC ELIGIBLE POPULATION

A high level of performance on the data quality measures established in this appendix is crucial in order for the Ohio Department of Job and Family Services (ODJFS) to determine the value of the Medicaid Managed Health Care Program and to evaluate Medicaid consumers' access to and quality of services. Data collected from MCPs are used in key performance assessments such as the external quality review, clinical performance measures, utilization review, care coordination and case management, and in determining incentives. The data will also be used in conjunction with the cost reports in setting the premium payment rates. The following measures, as specified in this appendix, will be calculated per MCP and include all Ohio Medicaid members receiving services from the MCP (i.e., Covered Families and Children (CFC) and Aged, Blind, or Disabled (ABD) membership, if applicable): Incomplete Outpatient Hospital Data, Rejected Encounters, Acceptance Rate, Encounter Data Accuracy, and Generic Provider Number Usage.

Data sets collected from MCPs with data quality standards include: encounter data; case management data; data used in the external quality review; members' PCP data; and appeal and grievance data.

1. ENCOUNTER DATA

For detailed descriptions of the encounter data quality measures below, see *ODJFS Methods for Encounter Data Quality Measures for CFC and ABD*.

1.a. Encounter Data Completeness

Each MCP's encounter data submissions will be assessed for completeness. The MCP is responsible for collecting information from providers and reporting the data to ODJFS in accordance with program requirements established in Appendix C, *MCP Responsibilities*. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with other performance standards.

1.a.i. Encounter Data Volume

Measure: The volume measure for each service category, as listed in Table 2 below, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM).

Report Period: The report periods for the SFY 2008 and SFY 2009 contract periods are listed in Table 1. below.

Table 1. Report Periods for the SFY 2008 and 2009 Contract Periods

<u>Quarterly Report Periods</u>		<u>Data Source: Estimated Encounter Data File Update</u>	<u>Quarterly Report Estimated Issue Date</u>	<u>Contract Period</u>
Qtr 3 & Qtr 4 2004, 2005, 2006 Qtr 1 2007		July 2007	August 2007	SFY 2008
Qtr 3 & Qtr 4 2004, 2005, 2006 Qtr 1, Qtr 2 2007		October 2007	November 2007	
Qtr 4 2004, 2005, 2006 Qtr 1 thru Qtr 3 2007		January 2008	February 2008	
Qtr 1 thru Qtr 4: 2005, 2006, 2007		April 2008	May 2008	
Qtr 2 thru Qtr 4 2005, Qtr 1 thru Qtr 4: 2006, 2007 Qtr 1 2008		July 2008	August 2008	SFY 2009
Qtr 3, Qtr 4: 2005, Qtr 1 thru Qtr 4: 2006, 2007 Qtr 1, Qtr 2 2008		October 2008	November 2008	
Qtr 4: 2005, Qtr 1 thru Qtr 4: 2006, 2007 Qtr 1 thru Qtr 3: 2008		January 2009	February 2009	
Qtr 1 thru Qtr 4: 2006, 2007, 2008		April 2009	May 2009	
Qtr1 = January to March	Qtr2 = April to June	Qtr3 = July to September	Qtr4 = October to December	

Table 2. Standards – Encounter Data Volume (County-Based Approach)

Data Quality Standard, County-Based Approach: The standards in Table 2 apply to the MCP’s county-based results (see *County-Based Approach* below). The utilization rate for all service categories listed in Table 2 must be equal to or greater than the standard established in Table 2 below.

<u>Category</u>	<u>Measure per 1,000/MM</u>	<u>Standard for Dates of Service 7/1/2003 thru 6/30/2004</u>	<u>Standard for Dates of Service 7/1/2004 thru 6/30/2006</u>	<u>Standard for Dates of Service on or after 7/1/2006</u>	<u>Description</u>
Inpatient Hospital	Discharges	5.4	5.0	5.4	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department		51.6	51.4	50.7	Includes physician and hospital emergency department encounters
Dental		38.2	41.7	50.9	Non-institutional and hospital dental visits
Vision	Visits	11.6	11.6	10.6	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		220.1	225.7	233.2	Physician/practitioner and hospital outpatient visits
Ancillary Services		144.7	123.0	133.6	Ancillary visits
Behavioral Health	Service	7.6	8.6	10.5	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	388.5	457.6	492.2	Prescribed drugs

County-Based Approach: All counties with managed care membership as of February 1, 2006, will be included in a county-based encounter data volume measure until regional evaluation is implemented for the county’s applicable region.. Upon implementation of regional-based evaluation for a particular county’s region, the county will be included in the MCP’s regional-based results and will no longer be included in the MCP’s county-based results. County-based results will be determined by MCP (i.e., one utilization rate per service category for all applicable counties) and must be equal to or greater than the standards established in Table 2 above. [Example: The county-based result for MCP AAA, which has contracts in the Central and West Central regions, will include Franklin, Pickaway, Montgomery, Greene and Clark counties (i.e., counties with managed care membership as of February 1, 2006). When the regional-based evaluation is implemented for the Central region, Franklin and Pickaway counties, along with all other counties in the region, will then be included in the Central region results for MCP AAA; Montgomery, Greene, and Clark

counties will remain in the county-based results for MCP AAA until the West Central regional measure is implemented.]

Interim Regional-Based Approach:

Prior to the transition to the regional-based approach, encounter data volume will be evaluated by MCP, by region, using an interim approach. All regions with managed care membership will be included in results for an interim regional-based encounter data volume measure until regional evaluation is implemented for the applicable region (see Regional-Based Approach below). Encounter data volume will be evaluated by MCP (i.e., one utilization rate per service category for all counties in the region). The utilization rate for all service categories listed in Table 3 must be equal to or greater than the standard established in Table 3 below. The standards listed in Table 3 below are based on utilization data for counties with managed care membership as of February 1, 2006, and have been adjusted to accommodate estimated differences in utilization for all counties in a region, including counties that did not have membership as of February 1, 2006.

Prior to implementation of the regional-based approach, an MCP's encounter data volume will be evaluated using the county-based approach and the interim regional-based approach. A county with managed care membership as of February 1, 2006, will be included in both the County-Based approach and the Interim Regional-Based approach until regional evaluation is implemented for the county's applicable region.

Data Quality Standard, Interim Regional-Based Approach: The standards in Table 3 apply to the MCP's interim regional-based results. The utilization rate for all service categories listed in Table 3 must be equal to or greater than the standard established in Table 3 below.

Table 3. Standards – Encounter Data Volume (Interim Regional-Based Approach)

<u>Category</u>	<u>Measure per 1,000/MM</u>	<u>Standard for Dates of Service on or after 7/1/2006</u>	<u>Description</u>
Inpatient Hospital	Discharges	2.7	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department		25.3	Includes physician and hospital emergency department encounters
Dental		25.5	Non-institutional and hospital dental visits
Vision	Visits	5.3	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		116.6	Physician/practitioner and hospital outpatient visits
Ancillary Services		66.8	Ancillary visits
Behavioral Health	Service	5.2	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	246.1	Prescribed drugs

Determination of Compliance: Performance is monitored once every quarter for the entire report period. If the standard is not met for every service category in all quarters of the report period in either the county-based or interim regional-based approach, or both, then the MCP will be determined to be noncompliant for the report period.

Penalty for noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for three consecutive quarters, membership will be frozen. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

Regional-Based Approach: Transition to the regional-based approach will occur by region, after the first four quarters (i.e., full calendar year quarters) of regional membership. Encounter data volume will be evaluated by MCP, by region, after determination of the regional-based data quality standards. ODJFS will use the first four quarters of data (i.e., full calendar year quarters) from all MCPs serving in an active region to determine minimum encounter volume data quality standards for that region.

1.a.ii. Incomplete Outpatient Hospital Data

Since July 1, 1997, MCPs have been required to provide both the revenue code and the HCPCS code on applicable outpatient hospital encounters. ODJFS will be monitoring, on a quarterly basis, the percentage of hospital encounters which contain a revenue code and CPT/HCPCS code. A CPT/HCPCS code must accompany certain revenue center codes. These codes are listed in Appendix B of Ohio Administrative Code rule 5101:3-2-21 (fee-for-service outpatient hospital policies) and in the methods for calculating the completeness measures.

Measure: The percentage of outpatient hospital line items with certain revenue center codes, as explained above, which had an accompanying valid procedure (CPT/HCPCS) code. The measure will be calculated per MCP.

Report Period: For the SFY 2008 and SFY 2009 contract periods, performance will be evaluated using the report periods listed in 1.a.i., Table 1.

Data Quality Standard: The data quality standard is a minimum rate of 95%.

Determination of Compliance: Performance is monitored once every quarter for all report periods.

For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

Penalty for noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent quarterly measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6) of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.a.iii. Incomplete Data For Last Menstrual Period

As outlined in *ODJFS Encounter Data Specifications*, the last menstrual period (LMP) field is a required encounter data field. It is discussed in Item 14 of the "HCFA 1500 Billing Instructions." The date of the LMP is essential for calculating the clinical performance measures and allows the ODJFS to adjust performance expectations for the length of a pregnancy.

The occurrence code and date fields on the UB-92, which are "optional" fields, can also be used to submit the date of the LMP. These fields are described in Items 32a & b, 33a & b, 34a & b, 35a & b of the "Inpatient Hospital" and "Outpatient Hospital UB-92 Claim Form Instructions."

An occurrence code value of '10' indicates that a LMP date was provided. The actual date of the LMP would be given in the 'Occurrence Date' field.

Measure: The percentage of recipients with a live birth during the report period where a "valid" LMP date was given on one or more of the recipient's perinatal claims. If the LMP date is before the date of birth and there is a difference of between 119 and 315 days between the date the recipient gave birth and the LMP date, then the LMP date will be considered a valid date. The measure will be calculated per MCP (i.e., to include the MCP's service area for the CFC).

Report Period: For the SFY 2008 contract period, performance will be evaluated using the January - December 2007 report period. For the SFY 2009 contract period, performance will be evaluated using the January — December 2008 report period.

Data Quality Standard: The data quality standard is a minimum rate of 80%.

Penalty for noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance

instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.a.iv. Rejected Encounters

Encounters submitted to ODJFS that are incomplete or inaccurate are rejected and reported back to the MCPs on the Exception Report. If an MCP does not resubmit rejected encounters, ODJFS' encounter data set will be incomplete.

Measure 1 only applies to MCPs that have had Medicaid membership for more than one year.

Measure 1: The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

Report Period: For the SFY 2008 contract period, performance will be evaluated using the following report periods: April — June 2007; July — September 2007; October — December 2007, January — March 2008, and April – June 2008. For the SFY 2009 contract period, performance will be evaluated using the following report periods: July — September 2008; October — December 2008, January — March 2009, and April – June 2009.

Data Quality Standard for measure 1: Data Quality Standard 1 is a maximum encounter data rejection rate of 10% for each file type in the ODJFS-specified medium per format for encounters submitted in SFY 2004 and thereafter. The measure will be calculated per MCP.

Determination of Compliance: Performance is monitored once every quarter. Compliance determination with the standard applies only to the quarter under consideration and does not include performance in previous quarters.

Penalty for noncompliance with the Data Quality Standard for measure 1: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of one percent of the current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

Measure 2 only applies to MCPs that have had Medicaid membership for one year or less.

Measure 2: The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

Report Period: The report period for Measure 2 is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

Data Quality Standard for measure 2: The data quality standard is a maximum encounter data rejection rate for each file type in the ODJFS-specified medium per format as follows:

Third through sixth months with membership:	50%
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Seventh through twelfth month with membership:	25%
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Files in the ODJFS-specified medium per format that are totally rejected will not be considered in the determination of noncompliance.

Determination of Compliance: Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous quarters.

Penalty for Noncompliance with the Data Quality Standard for measure 2: If the MCP is determined to be noncompliant for either standard, ODJFS will impose a monetary sanction of one percent of the MCP's current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. The monetary sanction will be applied only once per file type per compliance determination period and will not exceed a total of two percent of the MCP's current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. Special consideration will be made for MCPs with less than 1,000 members.

1.a.v. Acceptance Rate

This measure only applies to MCPs that have had Medicaid membership for one year or less.

Measure: The rate of encounters that are submitted to ODJFS and accepted (accepted encounters per 1,000 member months). The measure will be calculated per MCP

Report Period: The report period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

Data Quality Standard: The data quality standard is a monthly minimum accepted rate of encounters for each file type in the ODJFS-specified medium per format as follows:

Third through sixth month with membership:	50 encounters per 1,000 MM for NCPDP 65 encounters per 1,000 MM for NSF 20 encounters per 1,000 MM for UB-92
Seventh through twelfth month of membership:	250 encounters per 1,000 MM for NCPDP 350 encounters per 1,000 MM for NSF 100 encounters per 1,000 MM for UB-92

Determination of Compliance: Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months.

Penalty for Noncompliance: If the MCP is determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one percent of the MCP's current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. The monetary sanction will be applied only once per file type per compliance determination period and will not exceed a total of two percent of the MCP's current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. Special consideration will be made for MCPs with less than 1,000 members.

1.b. Encounter Data Accuracy

As with data completeness, MCPs are responsible for assuring the collection and submission of accurate data to ODJFS. Failure to do so jeopardizes MCPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

1.b.i. Encounter Data Accuracy Studies

Measure 1: The focus of this accuracy study will be on delivery encounters. Its primary purpose will be to verify that MCPs submit encounter data accurately and to ensure only one payment is made per delivery. The rate of appropriate payments will be determined by comparing a sample of delivery payments to the medical record. The measure will be calculated per MCP (i.e., to include the MCP's entire service area for the CFC membership).

Report Period: In order to provide timely feedback on the accuracy rate of encounters, the report period will be the most recent from when the measure is initiated. This measure is conducted annually.

Medical records retrieval from the provider and submittal to ODJFS or its designee is an integral component of the validation process. ODJFS has optimized the sampling to minimize the number of records required. This methodology requires a high record submittal rate. To aid MCPs in achieving

a high submittal rate, ODJFS will give at least an 8 week period to retrieve and submit medical records as a part of the validation process. A record submittal rate will be calculated as a percentage of all records requested for the study.

Data Quality Standard 1 for Measure 1: For results that are finalized during the contract year, the accuracy rate for encounters generating delivery payments is 100%.

Penalty for noncompliance: The MCP must participate in a detailed review of delivery payments made for deliveries during the report period. Any duplicate or unvalidated delivery payments must be returned to ODJFS.

Data Quality Standard 2 for Measure 1: A minimum record submittal rate of 85%.

Penalty for noncompliance: For all encounter data accuracy studies that are completed during this contract period, if an MCP is noncompliant with the standard, ODJFS will impose a non-refundable \$10,000 monetary sanction.

Measure 2: This accuracy study will compare the accuracy and completeness of payment data stored in MCPs' claims systems during the study period to payment data submitted to and accepted by ODJFS. The measure will be calculated per MCP.

Payment information found in MCPs' claims systems for paid claims that does not match payment information found on a corresponding encounter will be counted as omissions.

Report Period: In order to provide timely feedback on the omission rate of encounters, the report period will be the most recent from when the measure is initiated. This measure is conducted annually.

Data Quality Standard for Measure 2: TBD for SFY 2008 and SFY 2009 based on study conducted in SFY 2007 (standard to be released in June, 2007).

Penalty for Noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6) of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.b.ii. Generic Provider Number Usage

Measure: This measure is the percentage of non-pharmacy encounters with the generic provider number. Providers submitting claims which do not have an MMIS provider number must be submitted to ODJFS with the generic provider number 9111115. The measure will be calculated per MCP.

All other encounters are required to have the MMIS provider number of the servicing provider. The report period for this measure is quarterly.

Report Period: For the SFY 2008 and SFY 2009 contract periods, performance will be evaluated using the report periods listed in 1.a.i., Table 1.

Data Quality Standard: A maximum generic provider number usage rate of 10%.

Determination of Compliance: Performance is monitored once every quarter for all report periods. For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

Penalty for noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction.

Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of three percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.c. Timely Submission of Encounter Data

1.c.i. Timeliness

ODJFS recommends submitting encounters no later than thirty-five days after the end of the month in which they were paid. ODJFS does not monitor standards specifically for timeliness, but the minimum claims volume (Section 1.a.i.) and the rejected encounter (Section 1.a.v.) standards are based on encounters being submitted within this time frame.

1.c.ii. Submission of Encounter Data Files in the ODJFS-specified medium per format

Information concerning the proper submission of encounter data may be obtained from the *ODJFS Encounter Data File and Submission Specifications* document. The MCP must submit a letter of certification, using the form required by ODJFS, with each encounter data file in the ODJFS-specified medium per format.

The letter of certification must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

2. CASE MANAGEMENT DATA

ODJFS designed a case management system (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix G, *Coverage and Services*. Each MCP's case management data submissions will be assessed for completeness and accuracy. The MCP is responsible for submitting a case management file every month. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with CSHCN requirements. For detailed descriptions of the case management measures below, see *ODJFS Methods for Case Management Data Quality Measures*.

2.a. Case Management System Data Accuracy

2.a.i. Open Case Management Spans for Disenrolled Members *(this measure will be discontinued as of January 2008)*

Measure: The percentage of the MCP's adult and children case management records in the Screening, Assessment, and Case Management System that have open case management date spans for members who have disenrolled from the MCP.

Report Period: For the third and fourth quarters of SFY 2007, January – March 2007, and April – June 2007 report periods. For the SFY 2008 contract period, July – September 2007, and October – December 2007.

Statewide and Regional Data Quality Standard: A rate of open case management spans for disenrolled members of no more than 1.0%.

For an MCP which had membership as of February 1, 2006: Performance will be evaluated using: 1) region-based results for any active region in which all selected MCPs had at least 10,000 members during each month of the entire report period; and/or 2) the statewide result for all counties that were not included in the region-based results, but in which the MCP had managed care membership as of February 1, 2006.

For any MCP which did not have membership as of February 1, 2006: Performance will begin to be evaluated using region-based results for any active region in which all selected MCPs had at least 10,000 members during each month of the entire report period.

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region.

Penalty for noncompliance: If an MCP is noncompliant with the standard, then the ODJFS will issue a Sanction Advisory informing the MCP that a monetary sanction will be imposed if the MCP is noncompliant for any future report periods. Upon all subsequent semi-annual measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one-half of one percent of the current month's premium payment.

Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

2.b. Timely Submission of Case Management Files

Data Quality Submission Requirement: The MCP must submit Case Management files on a monthly basis according to the specifications established in *ODJFS' Case Management File and Submission Specifications*.

Penalty for noncompliance: See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with this requirement.

3. EXTERNAL QUALITY REVIEW DATA

In accordance with federal law and regulations, ODJFS is required to conduct an independent quality review of contracting managed care plans. The OAC rule 5101:3-26-07(C) requires MCPs to submit data and information as requested by ODJFS or its designee for the annual external quality review.

Two information sources are integral to these studies: encounter data and medical records. Because encounter data is used to draw samples for these studies, quality must be sufficient to ensure valid sampling.

An adequate number of medical records must then be retrieved from providers and submitted to ODJFS or its designee in order to generalize results to all applicable members. To aid MCPs in achieving the required medical record submittal rate, ODJFS will give at least an eight week period to retrieve and submit medical records.

3.a. Independent External Quality Review

Measure: The percentage of requested records for a study conducted by the External Quality Review Organization (EQRO) that are submitted by the managed care plan.

Report Period: The report period is one year. Results are calculated and performance is monitored annually. Performance is measured with each review.

Data Quality Standard: A minimum record submittal rate of 85% for each clinical measure.

Penalty for noncompliance for Data Quality Standard: For each study that is completed during this contract period, if an MCP is noncompliant with the standard, ODJFS will impose a non-refundable \$10,000 monetary sanction.

4. MEMBERS' PCP DATA

The designated PCP is the provider who will manage and coordinate the overall care for CFC members, including those who have case management needs. The MCP must submit a Members' Designated PCP file every month. Specialists may and should be identified as the PCP as appropriate for the member's condition per the specialty types specified for the CFC population in *ODJFS Member's PCP Data File and Submission Specifications*; however, no CFC member may have more than one PCP identified for a given month.

4.a. Timely submission of Member's PCP Data

Data Quality Submission Requirement: The MCP must submit a Members' Designated PCP Data file on a monthly basis according to the specifications established in *ODJFS Member's PCP Data File and Submission Specifications*.

Penalty for noncompliance: See Appendix N, Compliance Assessment System, for the penalty for noncompliance with this requirement.

4.b. Designated PCP for newly enrolled members (only applicable for report periods prior to January 2008)

Measure: The percentage of MCP's newly enrolled members who were designated a PCP by their effective date of enrollment.

Report Periods: For the third and fourth quarters of SFY 2007, performance will be evaluated using the January – March 2007 and April – June 2007 report periods. For the SFY 2008 contract period, performance will be evaluated using the July-September 2007, and October – December 2007 report periods.

Data Quality Standard: SFY 2007 will be informational only. A minimum rate of 75% of new members with PCP designation by their effective date of enrollment for quarter one and quarter two of SFY 2008.

Statewide Approach: MCPs will be evaluated using a statewide result, including all active regions and counties (Mahoning and Trumbull) in which an MCP has CFC membership.

Penalty for noncompliance: If an MCP is noncompliant with the standard, ODJFS will impose a monetary sanction of one-half of one percent the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. As stipulated in OAC rule 5101:3-26-08.2, each new member must have a designated primary care provider (PCP) prior to their effective date of coverage. Therefore, MCPs are subject to additional corrective action measures under Appendix N, Compliance Assessment System, for failure to meet this requirement.

4.b.i. Designated PCP for newly enrolled members (only applicable for report periods after December 2007)

Measure: The percentage of MCP's newly enrolled members who were designated a PCP by their effective date of enrollment.

Statewide Approach: MCPs will be evaluated using their statewide result, including all active regions and counties (Mahoning and Trumbull) in which an MCP has CFC membership.

Report Periods: For the SFY 2009 contract period, performance will be evaluated annually using CY 2008.

Data Quality Standards: For SFY 2009, a minimum rate of 85% of new members with PCP designation by their effective date of enrollment.

Penalty for noncompliance: If an MCP is noncompliant with the standard, ODJFS will impose a monetary sanction of one-half of one percent the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. As stipulated in OAC rule 5101:3-26-08.2, each new member must have a designated primary care provider (PCP) prior to their effective date of coverage. Therefore, MCPs are subject to additional corrective action measures under Appendix N, Compliance Assessment System, for failure to meet this requirement.

5. APPEALS AND GRIEVANCES DATA

Pursuant to OAC rule 5101:3-26-08.4, MCPs are required to submit information at least monthly to ODJFS regarding appeal and grievance activity. ODJFS requires these submissions to be in an electronic data file format pursuant to the *Appeal File and Submission Specifications* and *Grievance File and Submission Specifications*.

The appeal data file and the grievance data file must include all appeal and grievance activity, respectively, for the previous month, and must be submitted by the ODJFS-specified due date. These data files must be submitted in the ODJFS-specified format and with the ODJFS-specified filename in order to be successfully processed.

Penalty for noncompliance: MCPs who fail to submit their monthly electronic data files to the ODJFS by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to penalty as stipulated under the Compliance Assessment System (Appendix N).

6. NOTES

6.a. Penalties, Including Monetary Sanctions, for Noncompliance

Penalties for noncompliance with standards outlined in this appendix, including monetary sanctions, will be imposed as the results are finalized. With the exception of Sections 1.a.i., 1.a.iii., 1.a.v., 1.a.vi., and 1.b.ii, no monetary sanctions described in this appendix will be imposed if the MCP is in its first contract year of Medicaid program participation. Notwithstanding the penalties specified in this Appendix, ODJFS reserves the right to apply the most appropriate penalty to the area of deficiency identified when an MCP is determined to be noncompliant with a standard. Monetary penalties for noncompliance with any individual measure, as determined in this appendix, shall not exceed \$300,000 during each evaluation period.

Refundable monetary sanctions will be based on the premium payment in the month of the cited deficiency and due within 30 days of notification by ODJFS to the MCP of the amount.

Any monies collected through the imposition of such a sanction will be returned to the MCP (minus any applicable collection fees owed to the Attorney General's Office, if the MCP has been delinquent in submitting payment) after the MCP has demonstrated full compliance with the particular program requirement and the violations/deficiencies are resolved to the satisfaction of ODJFS. If an MCP does not comply within two years of the date of notification of noncompliance, then the monies will not be refunded.

6.b. Combined Remedies

If ODJFS determines that one systemic problem is responsible for multiple deficiencies, ODJFS may impose a combined remedy which will address all areas of deficient performance. The total fines assessed in any one month will not exceed 15% of the MCP's monthly premium payment.

6.c. Membership Freezes

MCPs found to have a pattern of repeated or ongoing noncompliance may be subject to a membership freeze.

6.d. Reconsideration

Requests for reconsideration of monetary sanctions and enrollment freezes may be submitted as provided in Appendix N, *Compliance Assessment System*.

6.e. Contract Termination, Nonrenewals, or Denials

Upon termination either by the MCP or ODJFS, nonrenewal, or denial of an MCP provider agreement, all previously collected refundable monetary sanctions will be retained by ODJFS.

APPENDIX M
PERFORMANCE EVALUATION
CFC ELIGIBLE POPULATION

This appendix establishes minimum performance standards for managed care plans (MCPs) in key program areas. The intent is to maintain accountability for contract requirements. Standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks. Performance will be evaluated in the categories of Quality of Care, Access, Consumer Satisfaction, and Administrative Capacity. Each performance measure has an accompanying minimum performance standard. MCPs with performance levels below the minimum performance standards will be required to take corrective action.

With the statewide expansion of the Ohio Medicaid Managed Care Program for the Covered Families and Children (CFC) population nearly complete, evaluation of performance will transition to a statewide approach encompassing all members who meet the criteria specified per the given methodology for each measure (i.e., measures will include members in any county who meet criteria per the given methodology as opposed to only those members with managed care membership as of February 1, 2006).

The statewide approach will be implemented beginning January 1, 2008. Due to differences in data and reporting requirements, transition to statewide measurement will vary by performance measure. Given that the original intent of the *SFY 2007 and SFY 2008 Covered Families and Children Provider Agreements, Appendix M*, was to transition to a regional-based system of evaluation, several performance measures have used regional-based results for performance monitoring. Regional-based performance monitoring will be discontinued for all measures in Appendix M for report periods from January, 2008 onward. Unless otherwise noted, performance measures and standards (see Sections 1, 2, 3 and 4 of this appendix) will be applicable for all counties in which the MCP has membership as of February 1, 2006, until statewide measurement is implemented.

Selected measures in this appendix will be used to determine pay-for-performance (P4P) as specified in Appendix O, *Pay for Performance*.

1. QUALITY OF CARE

1.a. Independent External Quality Review

In accordance with federal law and regulations, state Medicaid agencies must annually provide for an external quality review of the quality outcomes and timeliness of, and access to, services provided by Medicaid-contracting MCPs [(42 CFR 438.204(d))]. The external review assists the state in assuring MCP compliance with program requirements and facilitates the collection of accurate and reliable information concerning MCP performance.

Measure: The independent external quality review covers a review of clinical and non-clinical performance as outlined in Appendix K.

Report Period: Performance will be evaluated using the reviews conducted during SFY 2008.

Action Required for Deficiencies: For all reviews conducted during the contract period, if the EQRO cites a deficiency in performance, the MCP will be required to complete a Corrective Action Plan or Quality Improvement Directive depending on the severity of the deficiency. Serious deficiencies may result in immediate termination or non-renewal of the provider agreement.

1.b. Children with Special Health Care Needs (CSHCN)

In order to ensure state compliance with the provisions of 42 CFR 438.208, the Bureau of Managed Health Care established Children with Special Health Care Needs (CSHCN) basic program requirements in Appendix G, *Coverage and Services*, and corresponding minimum performance standards as described below. The purpose of these measures is to provide appropriate and targeted case management services to CSHCN.

1.b.i. Case Management of Children (*applicable to performance evaluation through December 2007 and P4P through SFY 2009*)

Measure: The average monthly case management rate for children under 21 years of age.

Report Period: For the SFY 2007 contract period, January — March 2007, and April — June 2007 report periods. For the SFY 2008 contract period, July — September 2007, and October — December 2007 report periods.

County-Based Approach: MCPs with managed care membership as of February 1, 2006 will be evaluated using their county-based statewide result until regional evaluation is implemented for the county's applicable region. The county-based statewide result will include data for all counties in which the MCP had membership as of February 1, 2006 that are not included in any regional-based result. Regional-based results will not be used for evaluation until all selected MCPs in an active region have at least 10,000 members during each month of the entire report period. Upon implementation of regional-based evaluation for a particular county's region, the county will be included in the MCP's regional-based result and will no longer be included in the MCP's county-based statewide result. [Example: The county-based statewide result for MCP AAA, which has contracts in the Central and West Central regions, will include Franklin, Pickaway, Montgomery, Greene and Clark counties (i.e., counties in which MCP AAA had managed care membership as of February 1, 2006). When regional-based evaluation is implemented for the Central region, Franklin and Pickaway counties, along with all other counties in the region, will then be included in the Central region results for MCP AAA; Montgomery, Greene, and Clark counties will remain in the county-based statewide result for evaluation of MCP AAA until the West Central regional-based approach is implemented.] The last report period using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 for P4P (*Appendix O*) is April-June 2009.

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region. Performance will begin to be evaluated using regional-based results for any

active region in which all selected MCPs had at least 10,000 members during each month of the entire report period.

County and Regional-Based Minimum Performance Standard: For the third and fourth quarters of SFY 2007, a case management rate of 5.0%. For the first and second quarters of SFY 2008, a case management rate of 5.0%.

Penalty for Noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 5) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for a subsequent quarter, new member selection freezes or a reduction of assignments will occur as outlined in Appendix N of the Provider Agreement. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

1.b.ii. Case Management of Children (*applicable to performance evaluation as of January, 2008*)

Measure: The average monthly case management rate for children under 21 years of age.

Report Period: For the SFY 2008 contract period, January — March 2008, and April — June 2008 report periods. For the SFY 2009 contract period, July — September 2008, October — December 2008, January — March 2009, and April — June 2009 report periods.

Regional-Based Statewide Approach: Performance will be evaluated using a regional-based statewide approach for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership.

Regional-Based Statewide Target: For the third and fourth quarters of SFY 2008, a case management rate of 5.0%. For SFY 2009, a case management rate of 5.0%.

Regional-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a 20% decrease in the difference between the target and the previous report period's results.

Penalty for Noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 5) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for

a subsequent quarter, new member selection freezes or a reduction of assignments will occur as outlined in Appendix N of the Provider Agreement. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

1.b.iii. Case Management of Children with an ODJFS-Mandated Condition *(applicable to performance evaluation through December 2007)*

Measure 1: The percent of children under 21 years of age with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of asthma that are case managed.

Measure 2: The percent of children age 17 and under with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of teenage pregnancy that are case managed.

Measure 3: The percent of children under 21 years of age with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of HIV/AIDS that are case managed.

Report Periods for Measures 1, 2, and 3: For the SFY 2007 contract period, January — March 2007, and April — June 2007 report periods. For the SFY 2008 contract period, and July — September 2007, October — December 2007 report periods.

County-Based Approach: MCPs with managed care membership as of February 1, 2006 will be evaluated using their county-based statewide result until regional evaluation is implemented for the county's applicable region. The county-based statewide result will include data for all counties in which the MCP had membership as of February 1, 2006 that are not included in any regional-based result. Regional-based results will not be used for evaluation until all selected MCPs in an active region have at least 10,000 members during each month of the entire report period. Upon implementation of regional-based evaluation for a particular county's region, the county will be included in the MCP's regional-based result and will no longer be included in the MCP's county-based statewide result. [Example: The county-based statewide result for MCP AAA, which has contracts in the Central and West Central regions, will include Franklin, Pickaway, Montgomery, Greene and Clark counties (i.e., counties in which MCP AAA had managed care membership as of February 1, 2006). When regional-based evaluation is implemented for the Central region, Franklin and Pickaway counties, along with all other counties in the region, will then be included in the Central region results for MCP AAA; Montgomery, Greene, and Clark counties will remain in the county-based statewide result for evaluation of MCP AAA until the West Central regional-based approach is implemented.]

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region. Performance will begin to be evaluated using regional-based results for any active region in which all selected MCPs had at least 10,000 members during each month of the entire report period.

County and Regional-Based Minimum Performance Standard for Measures 1 and 3: For the third and fourth quarters of SFY 2007, a case management rate of 70%. For the first and second quarters of SFY 2008, a case management rate of 70%.

County and Regional-Based Minimum Performance Standard for Measure 2: For the third and fourth quarters of SFY 2007, a case management rate of 60%. For the first and second quarters of SFY 2008, a case management rate of 60%.

Penalty for Noncompliance for Measures 1 and 2: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 5) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for a subsequent quarter, new member selection freezes or a reduction of assignments will occur as outlined in Appendix N of the Provider Agreement. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned. Note: For the first reporting period during which regional results are used to evaluate performance, measures 1, 2, and 3 are reporting-only measures. For SFY 2008, measure 3 is a reporting-only measure.

1.b.iv. Case Management of Children with an ODJFS-Mandated Condition (*applicable to performance evaluation as of January 2008*)

Measure 1: The percent of children under 21 years of age with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of asthma that are case managed.

Measure 2: The percent of children under 21 years of age with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of HIV/AIDS that are case managed.

Report Periods for Measures 1 and 2: For the SFY 2008 contract period, January — March 2008, and April — June 2008 report periods. For the SFY 2009 contract period, July — September 2008, October — December 2008, January — March 2009, and April — June 2009 report periods.

Regional-Based Statewide Approach: Performance will be evaluated using a regional-based statewide approach for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership.

Regional-Based Statewide Target for Measures 1 and 2: For the third and fourth quarters of SFY 2008, a case management rate of 70%. For SFY 2009, a case management rate of 80%.

Regional-Based Statewide Minimum Performance Standard for Measures 1 and 2: The level of improvement must result in at least a 20% decrease in the difference between the target and the previous report period's results.

Penalty for Noncompliance for Measure 1 : The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 5) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for a subsequent quarter, new member selection freezes or a reduction of assignments will occur as outlined in Appendix N of the Provider Agreement. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned. For SFY 2008 and SFY 2009, measure 2 is a reporting-only measure.

1.c. Clinical Performance Measures

MCP performance will be assessed based on the analysis of submitted encounter data for each year. For certain measures, standards are established; the identification of these standards is not intended to limit the assessment of other indicators for performance improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

The clinical performance measures described below closely follow the National Committee for Quality Assurance's Health Plan Employer Data and Information Set (HEDIS). Minor adjustments to HEDIS measures are required to account for the differences between the commercial population and the Medicaid population, such as shorter and interrupted enrollment periods. NCQA may annually change its method for calculating a measure. These changes can make it difficult to evaluate whether improvement occurred from a prior year. For this reason, ODJFS will use the same methods to calculate the baseline results and the results for the period in which the MCP is being held accountable. For example, the same methods were being used to calculate calendar year 2005 results (the baseline period) and calendar year 2006 results. The methods will be updated and a new baseline will be created during 2007 for calendar year 2006 results. These results will then serve as the baseline to evaluate whether improvement occurred from calendar year 2006 to calendar year 2007. Clinical performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runout. For a comprehensive description of the clinical performance measures below, see *ODJFS Methods for Clinical Performance Measures for the CFC Managed Care Program*. Performance standards are subject to change based on the revision or update of NCQA methods or other national standards, methods or benchmarks.

For an MCP which had membership as of February 1, 2006: MCP performance will be evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership

as of February 1, 2006. For reporting periods CY 2007 and CY 2008, targets and performance standards for *Clinical Performance Measures in this Appendix (1.c.i — 1.c.vii)* will be applicable to all counties in which MCPs had membership as of February 1, 2006. The final reporting year for the counties in which an MCP had membership as of February 1, 2006, will be CY 2008.

For any MCP which did not have membership as of February 1, 2006: Performance will be evaluated using a regional-based statewide approach for all active regions and counties (Trumbull and Mahoning) in which the MCP has membership.

Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership.

For measures requiring one year of baseline data, ODJFS will use the first full calendar year of data (CY 2007 — which may be adjusted based on the number of months of managed care membership) from all MCPs serving CFC membership to determine statewide minimum performance standards. CY 2008 will be the first reporting year that MCPs will be held accountable to the statewide performance standards for one year measures, and penalties will be applied for noncompliance.

For measures requiring two years of baseline data, ODJFS will use the first two full calendar years of data (CY 2007 and CY 2008 — which may be adjusted based on the number of months of managed care membership) from all MCPs serving CFC membership to determine statewide minimum performance standards. CY 2009 will be the first reporting year that MCPs will be held accountable to the statewide performance standards for two year measures, and penalties will be applied for noncompliance.

Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runout.

Report Period: In order to adhere to the statewide expansion timeline, reporting periods may be adjusted based on the number of months of managed care membership. For the SFY 2007 contract period, performance will be evaluated using the January — December 2006 report period. For the SFY 2008 contract period, performance will be evaluated using the January — December 2007 report period. For the SFY 2009 contract period, performance will be evaluated using the January — December 2008 report period.

1.c.i. Perinatal Care — Frequency of Ongoing Prenatal Care

Measure: The percentage of enrolled women with a live birth during the year who received the expected number of prenatal visits. The number of observed versus expected visits will be adjusted for length of enrollment.

County-Based Statewide Target: At least 80% of the eligible population must receive 81% or more of the expected number of prenatal visits.

County-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous report period's results.

(For example, if last year's results were 20%, then the difference between the target and last year's results is 60%. In this example, the standard is an improvement in performance of 10% of this difference or 6%. In this example, results of 26% or better would be compliant with the standard.)

Regional-Based Statewide Target: TBD

Regional-Based Statewide Minimum Performance Standard: TBD

Action Required for Noncompliance: Beginning SFY 2007, if the standard is not met and the results are below 42% (44% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 42% (44% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.ii. Perinatal Care — Initiation of Prenatal Care

Measure: The percentage of enrolled women with a live birth during the year who had a prenatal visit within 42 days of enrollment or by the end of the first trimester for those women who enrolled in the MCP during the early stages of pregnancy.

County-Based Statewide Target: At least 90% of the eligible population initiate prenatal care within the specified time.

County-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous year's results.

Regional-Based Statewide Target: TBD

Regional-Based Statewide Minimum Performance Standard: TBD

Action Required for Noncompliance: Beginning SFY 2007, if the standard is not met and the results are below 71% (74% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 71% (74% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.iii. Perinatal Care — Postpartum Care

Measure: The percentage of women who delivered a live birth who had a postpartum visit on or between 21 days and 56 days after delivery.

County-Based Statewide Target: At least 80% of the eligible population must receive a postpartum visit.

County-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a 5% decrease in the difference between the target and the previous year's results.

Regional-Based Statewide Target: TBD

Regional-Based Statewide Minimum Performance Standard: TBD

Action Required for Noncompliance: Beginning SFY 2007, if the standard is not met and the results are below 48% (50% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 48% (50% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.iv. Preventive Care for Children — Well-Child Visits

Measure: The percentage of children who received the expected number of well-child visits adjusted by age and enrollment. The expected number of visits is as follows:

Children who turn 15 months old: six or more well-child visits.

Children who were 3, 4, 5, or 6, years old: one or more well-child visits.

Children who were 12 through 21 years old: one or more well-child visits.

County-Based Statewide Target: At least 80% of the eligible children receive the expected number of well-child visits.

County-Based Statewide Minimum Performance Standard for Each of the Age Groups: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous year's results.

Regional-Based Statewide Target: TBD

Regional-Based Statewide Minimum Performance Standard for Each of the Age Groups: TBD

Action Required for Noncompliance (15 month old age group): Beginning SFY 2007, if the standard is not met and the results are below 34% (42% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 34% (42% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

Action Required for Noncompliance (3-6 year old age group): Beginning SFY 2007, if the standard is not met and the results are below 50% (57% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 50% (57% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

Action Required for Noncompliance (12-21 year old age group): Beginning SFY 2007, if the standard is not met and the results are below 30% (33% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 30% (33% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.v. Use of Appropriate Medications for People with Asthma

Measure: The percentage of members with persistent asthma who were enrolled for at least 11 months with the plan during the year and who received prescribed medications acceptable as primary therapy for long-term control of asthma.

County-Based Statewide Target: At least 95% of the eligible population must receive the recommended medications.

County-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous year's results.

Regional-Based Statewide Target: TBD

Regional-Based Statewide Minimum Performance Standard: TBD

Action Required for Noncompliance: Beginning SFY 2007, if the standard is not met and the results are below 83% (84% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 83% (84% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.vi. Annual Dental Visits

Measure: The percentage of enrolled members age 4 through 21 who were enrolled for at least 11 months with the plan during the year and who had at least one dental visit during the year.

County-Based Statewide Target: At least 60% of the eligible population receive a dental visit.

County-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous year's results.

Regional-Based Statewide Target: TBD

Regional-Based Statewide Minimum Performance Standard: TBD

Action Required for Noncompliance: Beginning SFY 2007, if the standard is not met and the results are below 40% (42% for SFY 2009), the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 40% (42% for SFY 2009), ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.vii. Lead Screening

Measure: The percentage of one and two year olds who received a blood lead screening by age group.

County-Based Statewide Target: At least 80% of the eligible population receive a blood lead screening.

County-Based Statewide Minimum Performance Standard for Each of the Age Groups: The level of improvement must result in at least a 10% decrease in the difference between the target and the previous year's results.

Regional-Based Statewide Target: TBD

Regional-Based Statewide Minimum Performance Standard for Each of the Age Groups: TBD

Action Required for Noncompliance (1 year olds): Beginning SFY 2007, if the standard is not met and the results are below 45% the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 45%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

Action Required for Noncompliance (2 year olds): Beginning SFY 2007, if the standard is not met and the results are below 28% the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above 28%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

2. ACCESS

Performance in the Access category will be determined by the following measures: Primary Care Provider (PCP) Turnover, Children's Access to Primary Care, Adults' Access to Preventive/Ambulatory Health Services, and Members' Access to Designated PCP. For a comprehensive description of the access performance measures below, see *ODJFS Methods for Access Performance Measures for the CFC Managed Care Program*.

2.a. PCP Turnover

A high PCP turnover rate may affect continuity of care and may signal poor management of providers. However, some turnover may be expected when MCPs end contracts with providers who

are not adhering to the MCP's standard of care. Therefore, this measure is used in conjunction with the children and adult access measures to assess performance in the access category.

Measure: The percentage of primary care providers affiliated with the MCP as of the beginning of the measurement year who were not affiliated with the MCP as of the end of the year.

For an MCP which had membership as of February 1, 2006: MCP performance will be evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The minimum performance standard in this *Appendix (2.a)* will be applicable to the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting year using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 for performance evaluation is CY 2007; the last reporting year using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 for P4P (*Appendix O*) is CY 2008.

For any MCP which did not have membership as of February 1, 2006: Performance will be evaluated using a regional-based statewide approach for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership.

Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all regions and counties (Mahoning and Trumbull) in which the MCP has membership. ODJFS will use the first full calendar year of data (CY 2007 — which may be adjusted based on the number of months of managed care membership) from all MCPs serving CFC membership as a baseline to determine a statewide minimum performance standard. CY 2008 will be the first reporting year that MCPs will be held accountable to the statewide performance standard for statewide reporting, and penalties will be applied for noncompliance.

Report Period: In order to adhere to the statewide expansion timeline, reporting periods may be adjusted based on the number of months of managed care membership. For the SFY 2007 contract period, performance will be evaluated using the January — December 2006 report period. For the SFY 2008 contract period, performance will be evaluated using the January — December 2007 report period. For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period.

County-Based Statewide Minimum Performance Standard: A maximum PCP Turnover rate of 18%.

Regional-Based Statewide Minimum Performance Standard: TBD

Action Required for Noncompliance: MCPs are required to perform a causal analysis of the high PCP turnover rate and assess the impact on timely access to health services, including continuity of care. If access has been reduced or coordination of care affected, then the MCP must develop and implement a corrective action plan to address the findings.

2.b. Children's Access to Primary Care

This measure indicates whether children aged 12 months to 11 years are accessing PCPs for sick or well-child visits.

Measure: The percentage of members age 12 months to 11 years who had a visit with an MCP PCP-type provider.

For an MCP which had membership as of February 1, 2006: MCP performance will be evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The minimum performance standard in this *Appendix (2.b)* will be applicable to the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting year using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 is CY 2008.

For any MCP which did not have membership as of February 1, 2006: Performance will be evaluated using a regional-based statewide approach for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership.

Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership. ODJFS will use the first two full calendar years of data (CY 2007 and CY 2008 — which may be adjusted based on the number of months of managed care membership) from all MCPs serving CFC membership as a baseline to determine a statewide minimum performance standard. CY 2009 will be the first reporting year that MCPs will be held accountable to the statewide performance standard for statewide reporting, and penalties will be applied for noncompliance. Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runoff.

Report Period: In order to adhere to the statewide expansion timeline, reporting periods may be adjusted based on the number of months of managed care membership. For the SFY 2007 contract period, performance will be evaluated using the January — December 2006 report period. For the SFY 2008 contract period, performance will be evaluated using the January — December 2007 report period. For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period.

County-Based Statewide Minimum Performance Standards:

CY 2006 report period — 70% of children must receive a visit.

CY 2007 report period — 71% of children must receive a visit

CY 2008 report period — 74% of children must receive a visit

Regional-Based Statewide Minimum Performance Standards: TBD

Penalty for Noncompliance: If an MCP is noncompliant with the Minimum Performance Standard, then the MCP must develop and implement a corrective action plan.

2.c. Adults' Access to Preventive/Ambulatory Health Services

This measure indicates whether adult members are accessing health services.

Measure: The percentage of members age 20 and older who had an ambulatory or preventive-care visit.

For an MCP which had membership as of February 1, 2006: MCP performance will be evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The minimum performance standard in this *Appendix (2.c)* will be applicable to the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting year using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 for performance evaluation is CY 2007; the last reporting year using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 for P4P (*Appendix O*) is CY 2008.

For any MCP which did not have membership as of February 1, 2006: Performance will be evaluated using a regional-based statewide approach for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership.

Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership. ODJFS will use the first full calendar year of data (CY 2007 — which may be adjusted based on the number of months of managed care membership) from all MCPs serving CFC membership as a baseline to determine a statewide minimum performance standard. CY 2008 will be the first reporting year that MCPs will be held accountable to the statewide performance standard for statewide reporting, and penalties will be applied for noncompliance. Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runoff.

Report Period: In order to adhere to the statewide expansion timeline, reporting periods may be adjusted based on the number of months of managed care membership. For the SFY 2007 contract period, performance will be evaluated using the January — December 2006 report period. For the SFY 2008 contract period, performance will be evaluated using the January — December 2007 report period. For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period.

County-Based Statewide Minimum Performance Standards :

CY 2006 report period — 63% of adults must receive a visit.

CY 2007 report period — 63% of adults must receive a visit.

CY 2008 report period — 63% of adults must receive a visit.

Regional-Based Statewide Minimum Performance Standards: TBD

Penalty for Noncompliance: If an MCP is noncompliant with the Minimum Performance Standard, then the MCP must develop and implement a corrective action plan.

2.d. Members' Access to Designated PCP

The MCP must encourage and assist CFC members without a designated primary care provider (PCP) to establish such a relationship, so that a designated PCP can coordinate and manage a member's health care needs. This measure is to be used to assess MCPs' performance in the access category.

Measure: The percentage of members who had a visit through members' designated PCPs.

Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership. ODJFS will use the first full calendar year of data (CY 2007 — which may be adjusted based on the number of months of managed care membership) from all MCPs serving CFC membership as a baseline to determine a statewide minimum performance standard. CY 2008 will be the first reporting year that MCPs will be held accountable to the performance standard and penalties will be applied for noncompliance. Statewide performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runoff.

Report Period: For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report period.

Regional-Based Statewide Minimum Performance Standard: TBD

Penalty for Noncompliance: If an MCP is noncompliant with the Minimum Performance Standard, then the MCP must develop and implement a corrective action plan.

3. CONSUMER SATISFACTION

In accordance with federal requirements and in the interest of assessing enrollee satisfaction with MCP performance, ODJFS annually conducts independent consumer satisfaction surveys. Results are used to assist in identifying and correcting MCP performance overall and in the areas of access, quality of care, and member services. For SFY 2007 and SFY 2008, performance in this category will be determined by the overall satisfaction score. For a comprehensive description of the Consumer Satisfaction performance measure below, see *ODJFS Methods for the Consumer Satisfaction Performance Measure for the CFC Program*.

Measure: Overall Satisfaction with MCP: The average rating of the respondents to the Consumer Satisfaction Survey who were asked to rate their overall satisfaction with their MCP. The results of this measure are reported annually.

For an MCP which had membership as of February 1, 2006: MCP performance will be evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership

as of February 1, 2006. The minimum performance standard in this *Appendix (3.)* will be applicable to the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. For performance evaluation, the last year to use the county-based statewide approach for the counties in which the MCP had membership as of February 1, 2006 will be SFY 2008, using CY 2008 data. For P4P (*Appendix O*), the last year to use the county-based statewide approach for the counties in which the MCP had membership as of February 1, 2006 will be SFY 2009, using CY 2009 data.

For any MCP which did not have membership as of February 1, 2006: Performance will be evaluated using a regional-based statewide approach for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership.

Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership. ODJFS will use the first full calendar year of data (CY 2008 adult and child survey results) from all MCPs serving CFC membership as a baseline to establish a measure and determine a minimum statewide performance standard. For performance evaluation, the first year to use the statewide regional-based approach will be SFY 2009, using CY 2009 data. For P4P (*Appendix O*), the first year to use the statewide regional-based approach will be SFY 2010, using CY 2010 data.

Report Period: For the SFY 2007 contract period, performance will be evaluated using the results from the CY 2007 consumer satisfaction survey. For the SFY 2008 contract period, performance will be evaluated using the results from the CY 2008 consumer satisfaction survey. For the SFY 2009 contract period, performance will be evaluated using the results from the CY 2009 consumer satisfaction survey.

County-Based Statewide Minimum Performance Standard: An average score of no less than 7.0.

Regional-Based Statewide Minimum Performance Standard: TBD

Penalty for noncompliance: If an MCP is determined noncompliant with the Minimum Performance Standard, then the MCP must develop a corrective action plan and provider agreement renewals may be affected.

4. ADMINISTRATIVE CAPACITY

The ability of an MCP to meet administrative requirements has been found to be both an indicator of current plan performance and a predictor of future performance. Deficiencies in administrative capacity make the accurate assessment of performance in other categories difficult, with findings uncertain. Performance in this category will be determined by the Compliance Assessment System, and the emergency department diversion program. For a comprehensive description of the Administrative Capacity performance measures below, see *ODJFS Methods for the Administrative Capacity Performance Measure for the CFC Managed Care Program*.

4.a. Compliance Assessment System

Measure: The number of points accumulated during a rolling 12-month period through the *Compliance Assessment System*.

Report Period: For the SFY 2008 and SFY 2009 contract periods, performance will be evaluated using a rolling 12-month report period.

Performance Standard: A maximum of 15 points

Penalty for Noncompliance: Penalties for points are established in Appendix N, *Compliance Assessment System*.

4.b. Emergency Department Diversion (*applicable to performance evaluation through SFY 2008 and P4P through SFY 2007*)

Managed care plans must provide access to services in a way that assures access to primary and urgent care in the most effective settings and minimizes inappropriate utilization of emergency department (ED) services. MCPs are required to identify high utilizers of ED services and implement action plans designed to minimize inappropriate ED utilization.

Measure: The percentage of members who had four or more ED visits during the six month reporting period.

For an MCP which had membership as of February 1, 2006: MCP performance will be evaluated using an MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The minimum performance standard and the target in this *Appendix (4.b)* will be applicable to the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting period using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 for performance evaluation is July-December 2007; the last reporting period using the MCP's county-based statewide result for the counties in which the MCP had membership as of February 1, 2006 for P4P (*Appendix O*) is July-December 2006.

Report Period: For the SFY 2007 contract period, a baseline level of performance will be set using the January — June 2006 report period. Results will be calculated for the reporting period of July - December 2006 and compared to the baseline results to determine if the minimum performance standard is met. For the SFY 2008 contract period, a baseline level of performance will be set using the January — June 2007 report period. Results will be calculated for the reporting period of July — December 2007 and compared to the baseline results to determine if the minimum performance standard is met

County-Based Statewide Target: A maximum of 0.70% of the eligible population will have four or more ED visits during the reporting period.

County-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a 10% decrease in the difference between the target and the baseline period results.

Penalty for Noncompliance: If the standard is not met and the results are above 1.1%, then the MCP must develop a corrective action plan, for which ODJFS may direct the MCP to develop the components of their EDD program as specified by ODJFS. If the standard is not met and the results are at or below 1.1%, then the MCP must develop a Quality Improvement Directive.

4.b.i. Emergency Department Diversion (*applicable to performance evaluation as of SFY 2009*)

Managed care plans must provide access to services in a way that assures access to primary and urgent care in the most effective settings and minimizes inappropriate utilization of emergency department (ED) services. MCPs are required to identify high utilizers of targeted ED services and implement action plans designed to minimize inappropriate, preventable and/or primary care sensitive ED utilization.

Measure: The percentage of members who had TBD or more targeted ED visits during the twelve month reporting period.

Regional-Based Statewide Approach: MCPs will be evaluated statewide, using results for all active regions and counties (Mahoning and Trumbull) in which the MCP has membership. ODJFS will use the first full calendar year of data (CY 2007 — which may be adjusted based on the number of months of managed care membership) from all MCPs serving CFC membership as the first baseline reporting year for statewide reporting and to determine a statewide minimum performance standard and target. CY 2008 will be the first reporting year that MCPs will be held accountable to the performance standard and penalties will be applied for noncompliance.

Report Period: For the SFY 2009 contract period, January — December 2008.

Regional-Based Statewide Target: A maximum of TBD of the eligible population will have TBD or more targeted ED visits during the reporting period.

Regional-Based Statewide Minimum Performance Standard: The level of improvement must result in at least a TBD decrease in the difference between the target and the baseline period results.

Penalty for Noncompliance: If the standard is not met and the results are above TBD%, then the MCP must develop a corrective action plan, for which ODJFS may direct the MCP to develop the components of their EDD program as specified by ODJFS. If the standard is not met and the results are at or below TBD%, then the MCP must develop a Quality Improvement Directive.

5. NOTES

Given that unforeseen circumstances (e.g., revision or update of applicable national standards, methods or benchmarks, or issues related to program implementation) may impact performance assessment as specified in Sections 1 through 4, ODJFS reserves the right to apply the most

appropriate penalty to the area of deficiency identified with any individual measure, notwithstanding the penalties specified in this Appendix.

5.a. Report Periods

Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's performance level for that contract period.

5.b. Monetary Sanctions

Penalties for noncompliance with individual standards in this appendix will be imposed as the results are finalized. Penalties for noncompliance with individual standards for each period of compliance, as determined in this appendix, will not exceed \$250,000.

Refundable monetary sanctions will be based on the capitation payment in the month of the cited deficiency and due within 30 days of notification by ODJFS to the MCP of the amount. Any monies collected through the imposition of such a sanction would be returned to the MCP (minus any applicable collection fees owed to the Attorney General's Office, if the MCP has been delinquent in submitting payment) after they have demonstrated improved performance in accordance with this appendix. If an MCP does not comply within two years of the date of notification of noncompliance, then the monies will not be refunded.

5.c. Combined Remedies

If ODJFS determines that one systemic problem is responsible for multiple deficiencies, ODJFS may impose a combined remedy which will address all areas of deficient performance. The total fines assessed in any one month will not exceed 15% of the MCP's monthly capitation.

5.d. Enrollment Freezes

MCPs found to have a pattern of repeated or ongoing noncompliance may be subject to an enrollment freeze.

5.e. Reconsideration

Requests for reconsideration of monetary sanctions and enrollment freezes may be submitted as provided in Appendix N, *Compliance Assessment System*.

5.f. Contract Termination, Nonrenewals or Denials

Upon termination, nonrenewal or denial of an MCP contract, all monetary sanctions collected under this appendix will be retained by ODJFS. The at-risk amount paid to the MCP under the current provider agreement will be returned to ODJFS in accordance with Appendix P, *Terminations*, of the provider agreement.

APPENDIX N
COMPLIANCE ASSESSMENT SYSTEM
CFC ELIGIBLE POPULATION

I. General Provisions of the Compliance Assessment System

- A. The Compliance Assessment System (CAS) is designed to improve the quality of each managed care plan's (MCP's) performance through actions taken by the Ohio Department of Job and Family Services (ODJFS) to address identified failures to meet program requirements. This appendix applies to the MCP specified in the baseline of this MCP Provider Agreement (hereinafter referred to as the Agreement).
- B. The CAS assesses progressive remedies with specified values (e.g., points, fines, etc.) assigned for certain documented failures to satisfy the deliverables required by Ohio Administrative Code (OAC) rule or the Agreement. Remedies are progressive based upon the severity of the violation, or a repeated pattern of violations. The CAS allows the accumulated point total to reflect patterns of less serious violations as well as less frequent, more serious violations.
- C. The CAS focuses on clearly identifiable deliverables and sanctions/remedial actions are only assessed in documented and verified instances of noncompliance. The CAS does not include categories which require subjective assessments or which are not within the MCPs control.
- D. The CAS does not replace ODJFS' ability to require corrective action plans (CAPs) and program improvements, or to impose any of the sanctions specified in OAC rule 5101:3-26-10, including the proposed termination, amendment, or nonrenewal of the MCP's Provider Agreement.
- E. As stipulated in OAC rule 5101:3-26-10(F), regardless of whether ODJFS imposes a sanction, MCPs are required to initiate corrective action for any MCP program violations or deficiencies as soon as they are identified by the MCP or ODJFS.
- F. In addition to the remedies imposed in Appendix N, remedies related to areas of financial performance, data quality, and performance management may also be imposed pursuant to Appendices J, L, and M respectively, of the Agreement.
- G. If ODJFS determines that an MCP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act which are not specifically identified within the CAS, ODJFS may, pursuant to the provisions of OAC rule 5101:3-26-10(A), notify the MCP's members that they may terminate from the MCP without cause and/or
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suspend any further new member selections.

H. For purposes of the CAS, the date that ODJFS first becomes aware of an MCP's program violation is considered the date on which the violation occurred. Therefore, program violations that technically reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODJFS first becomes aware of this noncompliance.

I. In cases where an MCP contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODJFS will not assess points if: (1) the MCP can document that they provided sufficient notification/education to providers of applicable program requirements and prohibited activities; and (2) the MCP takes immediate and appropriate action to correct the problem and to ensure that it does not happen again to the satisfaction of ODJFS. Repeated incidents will be reviewed to determine if the MCP has a systemic problem in this area, and if so, sanctions/remedial actions may be assessed, as determined by ODJFS.

J. All notices of noncompliance will be issued in writing via email and facsimile to the identified MCP contact.

II. Types of Sanctions/Remedial Actions

ODJFS may impose the following types of sanctions/remedial actions, including, but not limited to, the items listed below. The following are examples of program violations and their related penalties. This list is not all inclusive. As with any instance of noncompliance, ODJFS retains the right to use their sole discretion to determine the most appropriate penalty based on the severity of the offense, pattern of repeated noncompliance, and number of consumers affected. Additionally, if an MCP has received any previous written correspondence regarding their duties and obligations under OAC rule or the Agreement, such notice may be taken into consideration when determining penalties and/or remedial actions.

A. Corrective Action Plans (CAPs) — A CAP is a structured activity/process implemented by the MCP to improve identified operational deficiencies.

MCPs may be required to develop CAPs for any instance of noncompliance, and CAPs are not limited to actions taken in this Appendix. All CAPs requiring ongoing activity on the part of an MCP to ensure their compliance with a program requirement remain in effect for twenty-four months.

In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a CAP, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" CAP.

In situations where a penalty is assessed for a violation an MCP has previously been assessed a CAP (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

B. Quality Improvement Directives (QIDs) — A QID is a general instruction that directs the MCP to implement a quality improvement initiative to improve identified administrative or clinical deficiencies. All QIDs remain in effect for twelve months from the date of implementation.

MCPs may be required to develop QIDs for any instance of noncompliance.

In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a QID, ODJFS may require the MCP to comply with an ODJFS-developed or “directed” QID.

In situations where a penalty is assessed for a violation an MCP has previously been assessed a QID (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

C. Points — Points will accumulate over a rolling 12-month schedule. Each month, points that are more than 12-months old will expire. Points will be tracked and monitored separately for each Agreement the MCP concomitantly holds with the BMHC, beginning with the commencement of this Agreement (i.e., the MCP will have zero points at the onset of this Agreement).

No points will be assigned for any violation where an MCP is able to document that the precipitating circumstances were completely beyond their control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike blows a computer system, etc.).

C.1. 5 Points — Failures to meet program requirements, including but not limited to, actions which could impair the member’s ability to obtain correct **information** regarding services or which could impair a consumer’s or member’s rights, as determined by ODJFS, will result in the assessment of 5 points. Examples include, but are not limited to, the following:

- Violations which result in a member’s MCP selection or termination based on inaccurate provider panel information from the MCP.
 - Failure to provide member materials to new members in a timely manner.
 - Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a member of their right to a state hearing when the MCP proposes to deny, reduce, suspend or
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terminate a Medicaid-covered service.

- Failure to staff 24-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to health care providers, the MCP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODJFS or members of provider panel terminations.
- Failure to update website provider directories as required.

C.2. 10 Points — Failures to meet program requirements, including but not limited to, actions which could affect the ability of the MCP to deliver or the **consumer to access** covered services, as determined by ODJFS. Examples include, but are not limited to, the following:

- Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a member in accessing needed services in a timely manner after request from the member.
- Failure to provide medically-necessary Medicaid covered services to members.
- Failure to process prior authorization requests within the prescribed time frames.

D. Fines — Refundable or nonrefundable fines may be assessed as a penalty separate to or in combination with other sanctions/remedial actions.

D.1. Unless otherwise stated, all fines are nonrefundable.

D.2. Pursuant to procedures as established by ODJFS, refundable and nonrefundable monetary sanctions/assurances must be remitted to ODJFS within thirty (30) days of receipt of the invoice by the MCP. In addition, per Ohio Revised Code Section 131.02, payments not received within forty-five (45) days will be certified to the Attorney General's (AG's) office. MCP payments certified to the AG's office will be assessed the appropriate collection fee by the AG's office.

D.3. Monetary sanctions/assurances imposed by ODJFS will be based on the most recent premium payments.

D.4. Any monies collected through the imposition of a refundable fine will be returned to the MCP (minus any applicable collection fees owed to the Attorney General's Office if the MCP has been delinquent in submitting payment) after they have demonstrated full compliance, as determined by ODJFS, with the particular program requirement. If an MCP does not comply within one (1) year of the date of notification of noncompliance involving issues of case management and two (2) years of the date of notification of noncompliance in issues involving encounter data, then the monies will not be refunded.

D.5. MCPs are required to submit a written request for refund to ODJFS at the time they believe is appropriate before a refund of monies will be considered.

E. Combined Remedies — Notwithstanding any other action ODJFS may take under this Appendix, ODJFS may impose a combined remedy which will address all areas of noncompliance if ODJFS determines, in its sole discretion, that (1) one systemic problem is responsible for multiple areas of noncompliance and/or (2) that there are a number of repeated instances of noncompliance with the same program requirement.

F. Progressive Remedies — Progressive remedies will be based on the number of points accumulated at the time of the most recent incident. Unless specifically otherwise indicated in this appendix, all fines are nonrefundable. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	Corrective Action Plan (CAP)
16-25 Points	CAP + \$5,000 fine
26-50 Points	CAP + \$10,000 fine
51-70 Points	CAP + \$20,000 fine
71-100 Points	CAP + \$30,000 fine
100+ Points	Proposed Contract Termination

G. New Member Selection Freezes — Notwithstanding any other penalty or point assessment that ODJFS may impose on the MCP under this Appendix, ODJFS may prohibit an MCP from receiving new membership through consumer initiated selection or the assignment process if: (1) the MCP has accumulated a total of 51 or more points during a rolling 12-month period; (2) or the MCP fails to fully implement a CAP within the designated time frame; or (3) circumstances exist which potentially jeopardize the MCP's members' access to care. [Examples of circumstances that ODJFS may consider

as jeopardizing member access to care include:

- the MCP has been found by ODJFS to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- the MCP has been found by ODJFS to be noncompliant with the provider panel requirements specified in Appendix H of the Agreement;
- the MCP’s refusal to comply with a program requirement after ODJFS has directed the MCP to comply with the specific program requirement; or
- the MCP has received notice of proposed or implemented adverse action by the Ohio Department of Insurance.]

Payments provided for under the Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.730.

H. Reduction of Assignments — ODJFS has sole discretion over how member auto-assignments are made. ODJFS may reduce the number of assignments an MCP receives to assure program stability within a region or if ODJFS determines that the MCP lacks sufficient capacity to meet the needs of the increased volume in membership. Examples of circumstances which ODJFS may determine demonstrate a lack of sufficient capacity include, but are not limited to an MCP’s failure to: maintain an adequate provider network; repeatedly provide new member materials by the member’s effective date; meet the minimum call center requirements; meet the minimum performance standards for identifying and assessing children with special health care needs and members needing case management services; and/or provide complete and accurate appeal/grievance, member’s PCP and CAMS data files.

I. Termination, Amendment, or Nonrenewal of MCP Provider Agreement - ODJFS can at any time move to terminate, amend or deny renewal of a provider agreement. Upon such termination, nonrenewal, or denial of an MCP provider agreement, all previously collected monetary sanctions will be retained by ODJFS.

J. Specific Pre-Determined Penalties

I.1. Adequate network-minimum provider panel requirements — Compliance with provider panel requirements will be assessed quarterly. Any deficiencies in the MCP’s provider network as specified in Appendix H of the Agreement or by ODJFS, will result in the assessment of a \$1,000 nonrefundable fine for each category (practitioners, PCP capacity, hospitals), for each county, and for each population (e.g., ABD, CFC). For example if the MCP did not meet the following minimum panel requirements, the MCP would be assessed (1) a \$3,000

nonrefundable fine for the failure to meet CFC panel requirements; and, (2) a \$1,000 nonrefundable fine for the failure to meet ABD panel requirements).

- practitioner requirements in Franklin county for the CFC population
- practitioner requirements in Franklin county for the ABD population
- hospital requirements in Franklin county for the CFC population
- PCP capacity requirements in Fairfield county for the CFC population

In addition to the pre-determined penalties, ODJFS may assess additional penalties pursuant to this Appendix (e.g. CAPs, points, fines) if member specific access issues are identified resulting from provider panel noncompliance.

J.2. Geographic Information System — Compliance with the Geographic Information System (GIS) requirements will be assessed semi-annually. Any failure to meet GIS requirements as specified in Appendix H of the Agreement will result a \$1,000 nonrefundable fine for each county and for each population (e.g., ABD, CFC, etc.). For example if the MCP did not meet GIS requirements in the following counties, the MCP would be assessed (1) a nonrefundable \$2,000 fine for the failure to meet GIS requirements for the CFC population and (2) a \$1,000 nonrefundable fine for the failure to meet GIS requirements for the ABD population.

- GIS requirements in Franklin county for the CFC population
- GIS requirements in Fairfield county for the CFC population
- GIS requirements in Franklin county for the ABD population

J.3. Late Submissions — All required submissions/data and documentation requests must be received by their specified deadline and must represent the MCP in an honest and forthright manner. Failure to provide ODJFS with a required submission or any data/documentation requested by ODJFS will result in the assessment of a nonrefundable fine of \$100 per day, unless the MCP requests and is granted an extension by ODJFS. Assessments for late submissions will be done monthly. Examples of such program violations include, but are not limited to:

- Late required submissions
 - Annual delegation assessments
 - Call center report
 - Franchise fee documentation
 - Reinsurance information (e.g., prior approval of changes)
 - State hearing notifications
 - Late required data submissions
 - Appeals and grievances, case management, or PCP data
 - Late required information requests
 - Automatic call distribution reports
 - Information/resolution regarding consumer or provider complaint
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- o Just cause or other coordination care request from ODJFS
- o Provider panel documentation
- o Failure to provide ODJFS with a required submission after ODJFS has notified the MCP that the prescribed deadline for that submission has passed

If an MCP determines that they will be unable to meet a program deadline or data/documentation submission deadline, the MCP must submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM EST on the date of the deadline in question. Extension requests should only be submitted in situations where unforeseeable circumstances have occurred which make it impossible for the MCP to meet an ODJFS-stipulated deadline and all such requests will be evaluated upon this standard. Only written approval as may be granted by ODJFS of a deadline extension will preclude the assessment of compliance action for untimely submissions.

J.4. Noncompliance with Claims Adjudication Requirements — If ODJFS finds that an MCP is unable to (1) electronically accept and adjudicate claims to final status and/or (2) notify providers of the status of their submitted claims, as stipulated in Appendix C of the Agreement, ODJFS will assess the MCP with a monetary sanction of \$20,000 per day for the period of noncompliance.

If ODJFS has identified specific instances where an MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement for (1) failing to notify non-contracting providers of procedures for claims submissions when requested and/or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP will be assessed 5 points per incident of noncompliance.

J.5. Noncompliance with Prompt Payment: — Noncompliance with the prompt pay requirements as specified in Appendix J of the Agreement will result in progressive penalties. The first violation during a rolling 12-month period will result in the submission of quarterly prompt pay and monthly status reports to ODJFS until the next quarterly report is due. The second violation during a rolling 12-month period will result in the submission of monthly status reports and a refundable fine equal to 5% of the MCP's monthly premium payment or \$300,000, whichever is less. The refundable fine will be applied in lieu of a nonrefundable fine and the money will be refunded by ODJFS only after the MCP complies with the required standards for two (2) consecutive quarters. Subsequent violations will result in an enrollment freeze.

If an MCP is found to have not been in compliance with the prompt pay requirements for any time period for which a report and signed attestation have been submitted representing the MCP as being in compliance, the MCP will be subject to an enrollment freeze of not less than three (3) months duration.

J.6. Noncompliance with Franchise Fee Assessment Requirements — In accordance with ORC Section 5111.176, and in addition to the imposition of any other penalty, occurrence or points under this Appendix, an MCP that does not pay the franchise permit fee in full by the due date is subject to any or all of the following:

- A monetary penalty in the amount of \$500 for each day any part of the fee remains unpaid, except the penalty will not exceed an amount equal to 5 % of the total fee that was due for the calendar quarter for which the penalty was imposed;
- Withholdings from future ODJFS capitation payments. If an MCP fails to pay the full amount of its franchise fee when due, or the full amount of the imposed penalty, ODJFS may withhold an amount equal to the remaining amount due from any future ODJFS capitation payments. ODJFS will return all withheld capitation payments when the franchise fee amount has been paid in full;
- Proposed termination or non-renewal of the MCP's Medicaid provider agreement may occur if the MCP:
 - a. Fails to pay its franchise permit fee or fails to pay the fee promptly;
 - b. Fails to pay a penalty imposed under this Appendix or fails to pay the penalty promptly;
 - c. Fails to cooperate with an audit conducted in accordance with ORC Section 5111.176.

J.7. Noncompliance with Clinical Laboratory Improvement Amendments - Noncompliance with CLIA requirements as specified by ODJFS will result in the assessment of a nonrefundable \$1,000 fine for each violation.

J.8. Noncompliance with Abortion and Sterilization Payment — Noncompliance with abortion and sterilization requirements as specified by ODJFS will result in the assessment of a nonrefundable \$2,000 fine for each documented violation. Additionally, MCPs must take all appropriate action to correct each ODJFS-documented violation.

J.9. Refusal to Comply with Program Requirements — If ODJFS has instructed an MCP that they must comply with a specific program requirement and the MCP refuses, such refusal constitutes documentation that the MCP is no longer operating in the best interests of the MCP's members or the state of Ohio and ODJFS will move to terminate or nonrenew the MCP's provider agreement.

III. Request for Reconsiderations

MCPs may request a reconsideration of remedial action taken under the CAS for penalties that include points, fines, reductions in assignments and/or selection freezes. Requests for reconsideration must be submitted on the ODJFS required form as follows:

- A. MCPs notified of ODJFS' imposition of remedial action taken under the CAS will have ten (10) working days from the date of receipt of the facsimile to request reconsideration, although ODJFS will impose enrollment freezes based on an access to care concern concurrent with initiating notification to the MCP. Any information that the MCP would like reviewed as part of the reconsideration request must be submitted at the time of submission of the reconsideration request, unless ODJFS extends the time frame in writing.
 - B. All requests for reconsideration must be submitted by either facsimile transmission or overnight mail to the Chief, Bureau of Managed Health Care, and received by ODJFS by the tenth business day after receipt of the faxed notification of the imposition of the remedial action by ODJFS.
 - C. The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests for reconsideration must explain in detail why the specified remedial action should not be imposed. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP. The Bureau Chief will review all correspondence and materials related to the violation in question in making the final reconsideration decision.
 - D. Final decisions or requests for additional information will be made by ODJFS within ten (10) business days of receipt of the request for reconsideration.
 - E. If additional information is requested by ODJFS, a final reconsideration decision will be made within three (3) business days of the due date for the submission. Should ODJFS require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.
 - F. If a reconsideration request is decided, in whole or in part, in favor of the MCP, both the penalty and the points associated with the incident, will be rescinded or reduced, in the sole discretion of ODJFS. The MCP may still be required to submit a CAP if ODJFS, in its sole discretion, believes that a CAP is still warranted under the circumstances.
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APPENDIX O
PAY-FOR PERFORMANCE (P4P)
CFC ELIGIBLE POPULATION

This Appendix establishes P4P for managed care plans (MCPs) to improve performance in specific areas important to the Medicaid MCP members. P4P include the at-risk amount included with the monthly premium payments (see Appendix F, *Rate Chart*), and possible additional monetary rewards up to \$250,000.

To qualify for consideration of any P4P, MCPs must meet minimum performance standards established in Appendix M, *Performance Evaluation* on selected measures, and achieve P4P standards established for selected Clinical Performance Measures. For qualifying MCPs, higher performance standards for three measures must be reached to be awarded a portion of the at-risk amount and any additional P4P (see Sections 1 and 2). An excellent and superior standard is set in this Appendix for each of the three measures. Qualifying MCPs will be awarded a portion of the at-risk amount for each excellent standard met. If an MCP meets all three excellent and superior standards, they may be awarded additional P4P (see Section 3).

Prior to the transition to a regional-based statewide P4P system (SFY 2006 through SFY 2009), the county-based statewide P4P system (sections 1 and 2 of this Appendix) will apply to MCPs with membership as of February 1, 2006. Only counties with membership as of February 1, 2006 will be used to calculate performance levels for the county-based statewide P4P system.

1. SFY 2007 P4P

1.a. Qualifying Performance Levels

To qualify for consideration of the SFY 2007 P4P, an MCP's performance level must:

- 1) Meet the minimum performance standards set in Appendix M, *Performance Evaluation*, for the measures listed below; and
- 2) Meet the P4P standards established for the Emergency Department Diversion and Clinical Performance Measures below.

A detailed description of the methodologies for each measure can be found on the BMHC page of the ODJFS website.

Measures for which the minimum performance standard for SFY 2007 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of P4P are as follows:

1. PCP Turnover (Appendix M, Section 2.a.)

Report Period: CY 2006

2. Children's Access to Primary Care (Appendix M, Section 2.b.)

Report Period: CY 2006

3. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2006

4. Overall Satisfaction with MCP (Appendix M, Section 3.)

Report Period: The most recent consumer satisfaction survey completed prior to the end of the SFY 2007 contract period.

For the EDD performance measure, the MCP must meet the P4P standard for the report period of July - December, 2006 to be considered for SFY 2007 P4P. The MCP meets the P4P standard if one of two criteria are met. The P4P standard is a performance level of either:

- 1) The minimum performance standard established in Appendix M, Section 4.b.; or
- 2) The Medicaid benchmark of a performance level at or below 1.1%.

For each clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2007 P4P. The MCP meets the P4P standard if one of two criteria are met. The P4P standard is a performance level of either:

- 1) The minimum performance standard established in Appendix M, *Performance Evaluation*, for seven of the nine clinical performance measures listed below; or
- 2) The Medicaid benchmarks for seven of the nine clinical performance measures listed below. The Medicaid benchmarks are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

Clinical Performance Measure	Medicaid Benchmark
1. Perinatal Care — Frequency of Ongoing Prenatal Care	42%
2. Perinatal Care — Initiation of Prenatal Care	71%
3. Perinatal Care — Postpartum Care	48%
4. Well-Child Visits — Children who turn 15 months old	34%
5. Well-Child Visits — 3, 4, 5, or 6, years old	50%
6. Well-Child Visits — 12 through 21 years old	30%
7. Use of Appropriate Medications for People with Asthma	83%
8. Annual Dental Visits	40%
9. Blood Lead — 1 year olds	45%

1.b. Excellent and Superior Performance Levels

For qualifying MCPs as determined by Section 2.a., performance will be evaluated on the measures below to determine the status of the at-risk amount or any additional P4P that may be awarded. Excellent and Superior standards are set for the three measures described below. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the BMHC page of the ODJFS website.

1. Case Management of Children (Appendix M, Section 1.b.ii.)

Report Period: April — June 2007

Excellent Standard: 5.5%

Superior Standard: 6.5%

2. Use of Appropriate Medications for People with Asthma (Appendix M, Section 1.c.vi.)

Report Period: CY 2006

Excellent Standard: 86%

Superior Standard: 88%

3. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2006

Excellent Standard: 76%

Superior Standard: 83%

1.c. Determining SFY 2007 P4P

MCPs reaching the minimum performance standards described in Section 1.a. herein, will be considered for P4P including retention of the at-risk amount and any additional P4P. For each Excellent standard established in Section 1.b. herein, that an MCP meets, one-third of the at-risk amount may be retained. For MCPs meeting all of the Excellent and Superior standards established in Section 1.b. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund (see section 2.) will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs

receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is \$250,000. An MCP may receive up to \$500,000 should both of the MCP's ABD and CFC programs achieve the Superior Performance Levels.

2. SFY 2008 P4P

2.a. Qualifying Performance Levels

To qualify for consideration of the SFY 2008 P4P, an MCP's performance level must meet the minimum performance standards set in Appendix M, *Performance Evaluation*, for the measures listed below. A detailed description of the methodologies for each measure can be found on the BMHC page of the ODJFS website.

Measures for which the minimum performance standard for SFY 2008 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of P4P are as follows:

1. PCP Turnover (Appendix M, Section 2.a.)

Report Period: CY 2007

2. Children's Access to Primary Care (Appendix M, Section 2.b.)

Report Period: CY 2007

3. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2007

4. Overall Satisfaction with MCP (Appendix M, Section 3.)

Report Period: The most recent consumer satisfaction survey completed prior to the end of the SFY2008.

For each clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2008 P4P. The MCP meets the P4P standard if one of two criteria are met. The P4P standard is a performance level of either:

1) The minimum performance standard established in Appendix M, *Performance Evaluation*, for seven of the nine clinical performance measures listed below; or

2) The Medicaid benchmarks for seven of the nine clinical performance measures listed below. The Medicaid benchmarks are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

Clinical Performance Measure	Medicaid Benchmark
1. Perinatal Care — Frequency of Ongoing Prenatal Care	42%
2. Perinatal Care — Initiation of Prenatal Care	71%
3. Perinatal Care — Postpartum Care	48%
4. Well-Child Visits — Children who turn 15 months old	34%
5. Well-Child Visits — 3, 4, 5, or 6, years old	50%
6. Well-Child Visits — 12 through 21 years old	30%
7. Use of Appropriate Medications for People with Asthma	83%
8. Annual Dental Visits	40%
9. Blood Lead — 1 year olds	45%

2.b. Excellent and Superior Performance Levels

For qualifying MCPs as determined by Section 2.a., performance will be evaluated on the measures below to determine the status of the at-risk amount or any additional P4P that may be awarded. Excellent and Superior standards are set for the three measures described below. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the BMHC page of the ODJFS website.

1. Case Management of Children (Appendix M, Section 1.b.i.)

Report Period: April — June 2008

Excellent Standard: 5.5%

Superior Standard: 6.5%

2. Use of Appropriate Medications for People with Asthma (Appendix M, Section 1.c.v.)

Report Period: CY 2007

Excellent Standard: 86%

Superior Standard: 88%

3. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2007

Excellent Standard: 76%

Superior Standard: 84%

2.c. Determining SFY 2008 P4P

MCP's reaching the minimum performance standards described in Section 2.a. herein, will be considered for P4P including retention of the at-risk amount and any additional P4P. For each Excellent standard established in Section 2.b. herein, that an MCP meets, one-third of the at-risk amount may be retained. For MCPs meeting all of the Excellent and Superior standards established in Section 2.b. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund (see Section 3.) will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is \$250,000. An MCP may receive up to \$500,000 should both of the MCP's ABD and CFC programs achieve the Superior Performance Levels.

3. NOTES

3.a. Transition from a county-based statewide to a regional-based statewide P4P system.

The current county-based statewide P4P system will transition to a regional-based statewide system as managed care expands statewide. The regional-based statewide approach will be fully phased in no later than SFY 2010. The regional-based statewide P4P system will be modeled after the county-based statewide system with adjustments to performance standards where appropriate.

3.a.i. County-based statewide P4P system

For MCPs in their first twenty-four months of Ohio Medicaid CFC Managed Care Program participation, the status of the at-risk amount will not be determined because compliance with many of the standards cannot be determined in an MCP's first two contract years (see Appendix F., *Rate Chart*). In addition, MCPs in their first two contract years are not eligible for the additional P4P amount awarded for superior performance.

Starting with the twenty-fifth month of participation in the program, a new MCP's at-risk amount will be included in the P4P system. The determination of the status of this at-risk amount will be after at least three full calendar years of membership as many of the performance standards require three full calendar years to determine an MCP's performance level. Because of this requirement, more than 12 months of at-risk dollars may be included in an MCP's first at-risk status determination depending on when an MCP starts with the program relative to the calendar year.

During the transition to a regional-based statewide system (SFY 2006 through SFY 2009), MCPs with membership as of February 1, 2006 will continue in the county-based statewide P4P system until the transition is complete. These MCPs will be put at-risk for a portion of the premiums received for members in counties they are serving as of February 1, 2006.

3.a.ii. Regional-based statewide P4P system

All MCPs will be included in the regional-based statewide P4P system. The at-risk amount will be determined separately for each region an MCP serves.

The status of the at-risk amount for counties not included in the county-based statewide P4P system will not be determined for the first twenty-four months of regional membership. Starting with the twenty-fifth month of regional membership, the MCP's at-risk amount will be included in the P4P system. The determination of the status of this at-risk amount will be after at least three full calendar years of regional membership as many of the performance standards require three full calendar years to determine an MCP's performance level. Given that statewide expansion was not complete by December 31, 2006, ODJFS may adjust performance measure reporting periods based on the number of months an MCP has had regional membership. Because of this requirement, more than 12 months of at-risk dollars may be included in an MCP's first regional at-risk status determination depending on when regional membership starts relative to the calendar year. Regional premium payments for months prior to July 2009 for members in counties included in the county-based statewide P4P system for the SFY 2009 P4P determination, will be excluded from the at-risk dollars included in the first regional-based statewide P4P determination.

3.b. Determination of at-risk amounts and additional P4P payments

For MCPs that have participated in the Ohio Medicaid Managed Care Program long enough to calculate performance levels for all of the performance measures included in the P4P system, determination of the status of an MCP's at-risk amount will occur within six months of the end of the contract period. Determination of additional P4P payments will be made at the same time the status of an MCP's at-risk amount is determined.

3.c. Contract Termination, Nonrenewals, or Denials

Upon termination, nonrenewal or denial of an MCP contract, the at-risk amount paid to the MCP under the current provider agreement will be returned to ODJFS in accordance with Appendix P., *Terminations/Nonrenewals/Amendments*, of the provider agreement.

Additionally, in accordance with Article XI of the provider agreement, the return of the at-risk amount paid to the MCP under the current provider agreement will be a condition necessary for ODJFS' approval of a provider agreement assignment.

3.d. Report Periods

The report period used in determining the MCP's performance levels varies for each measure depending on the frequency of the report and the data source. Unless otherwise noted, the most recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.

PROVIDER AGREEMENT

BETWEEN

STATE OF OHIO

DEPARTMENT OF JOB AND FAMILY SERVICES

AND

MOLINA HEALTHCARE OF OHIO, INC

Amendment No. 1

Pursuant to Article IX. A. the Provider Agreement between the State of Ohio, Department of Job and Family Services, (hereinafter referred to as "ODJFS") and MOLINA HEALTHCARE OF OHIO INC (hereinafter referred to as "MCP") for the Aged, Blind or Disabled (hereinafter referred to as "ABD") population dated July 1, 2007, is hereby amended as follows:

1. Appendices C, D, E, F, G, H, J, K, L, M, N and O are modified as attached.
2. All other terms of the provider agreement are hereby affirmed.

The amendment contained herein shall be effective January 1, 2008.

MOLINA HEALTHCARE OF OHIO, INC:

BY: /s/ KATHIE MANCINI
KATHIE MANCINI, PRESIDENT

DATE: 12/20/07

On behalf of Kathie Mancini

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES:

BY: /s/ HELEN E. JONES-KELLEY
HELEN E. JONES-KELLEY, DIRECTOR

DATE: 12/26/07

APPENDIX C
MCP RESPONSIBILITIES
ABD ELIGIBLE POPULATION

The MCP must meet on an ongoing basis, all program requirements specified in Chapter 5101:3-26 of the Ohio Administrative Code (OAC) and the Ohio Department of Job and Family Services (ODJFS) — MCP Provider Agreement. The following are MCP responsibilities that are not otherwise specifically stated in OAC rule provisions or elsewhere in the MCP provider agreement, but are required by ODJFS.

General Provisions

1. The MCP agrees to implement program modifications as soon as reasonably possible or no later than the required effective date, in response to changes in applicable state and federal laws and regulations.
 2. The MCP must submit a current copy of their Certificate of Authority (COA) to ODJFS within 30 days of issuance by the Ohio Department of Insurance.
 3. The MCP must designate the following:
 - a. A primary contact person (the Medicaid Coordinator) who will dedicate a majority of their time to the Medicaid product line and coordinate overall communication between ODJFS and the MCP. ODJFS may also require the MCP to designate contact staff for specific program areas. The Medicaid Coordinator will be responsible for ensuring the timeliness, accuracy, completeness and responsiveness of all MCP submissions to ODJFS.
 - b. A provider relations representative for each service area included in their ODJFS provider agreement. This provider relations representative can serve in this capacity for only one service area (as specified in Appendix H).

If an MCP serves both the CFC and ABD populations, they are not required to designate a separate provider relations representative or Medicaid Coordinator for each population group.
 4. All MCP employees are to direct all day-to-day submissions and communications to their ODJFS-designated Contract Administrator unless otherwise notified by ODJFS.
 5. The MCP must be represented at all meetings and events designated by ODJFS as requiring mandatory attendance.
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Appendix C

Aged, Blind or Disabled (ABD) population

Page 2

6. The MCP must have an administrative office located in Ohio.
 7. Upon request by ODJFS, the MCP must submit information on the current status of their company's operations not specifically covered under this Agreement (for example, other product lines, Medicaid contracts in other states, NCQA accreditation, etc.) unless otherwise excluded by law.
 8. The MCP must have all new employees trained on applicable program requirements, and represent, warrant and certify to ODJFS that such training occurs, or has occurred.
 9. If an MCP determines that it does not wish to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, it must immediately notify ODJFS to coordinate the implementation of this change. MCPs will be required to notify their members of this change at least thirty (30) days prior to the effective date. The MCP's member handbook and provider directory, as well as all marketing materials, will need to include information specifying any such services that the MCP will not provide.
 10. For any data and/or documentation that MCPs are required to maintain, ODJFS may request that MCPs provide analysis of this data and/or documentation to ODJFS in an aggregate format, such format to be solely determined by ODJFS.
 11. The MCP is responsible for determining medical necessity for services and supplies requested for their members as specified in OAC rule 5101:3-26-03. Notwithstanding such responsibility, ODJFS retains the right to make the final determination on medical necessity in specific member situations.
 12. In addition to the timely submission of medical records at no cost for the annual external quality review as specified in OAC rule 5101:3-26-07, the MCP may be required for other purposes to submit medical records at no cost to ODJFS and/or designee upon request.
 13. The MCP must notify the BMHC of the termination of an MCP panel provider that is designated as the primary care provider for 100 or more of the MCP's ABD members. The MCP must provide notification within one working day of the MCP becoming aware of the termination.
 14. Upon request by ODJFS, MCPs may be required to provide written notice to members of any significant change(s) affecting contractual requirements, member services or access to providers.
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15. MCPs may elect to provide services that are in addition to those covered under the Ohio Medicaid fee-for-service program. Before MCPs notify potential or current members of the availability of these services, they must first notify ODJFS and advise ODJFS of such planned services availability. If an MCP elects to provide additional services, the MCP must ensure to the satisfaction of ODJFS that the services are readily available and accessible to members who are eligible to receive them.
 - a. MCPs are **required** to make transportation available to any member requesting transportation when they must travel thirty (30) miles or more from their home to receive a medically-necessary Medicaid-covered service. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may not be counted toward this trip limit.
 - b. Additional benefits may not vary by county within a region except out of necessity for transportation arrangements (e.g., bus versus cab). MCPs approved to serve consumers in more than one region may vary additional benefits between regions.
 - c. MCPs must give ODJFS and members ninety (90) days prior notice when decreasing or ceasing any additional benefit(s). When it is beyond the control of the MCP, as demonstrated to ODJFS' satisfaction, ODJFS must be notified within one (1) working day.
 16. MCPs must comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff adheres to such laws when furnishing services to its members. MCPs shall include a requirement in its contracts with affiliated providers that such providers also adhere to applicable Federal and State laws when providing services to members.
 17. MCPs must comply with any other applicable Federal and State laws (such as Title VI of the Civil rights Act of 1964, etc.) and other laws regarding privacy and confidentiality, as such may be applicable to this Agreement.
 18. Upon request, the MCP will provide members and potential members with a copy of their practice guidelines.
 19. The MCP is responsible for promoting the delivery of services in a culturally competent manner, as solely determined by ODJFS, to all members, including those with limited English proficiency (LEP) and diverse cultural and ethnic backgrounds.
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All MCPs must comply with the requirements specified in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08 and 5101:3-26-08.2 for providing assistance to LEP members and eligible individuals. In addition, MCPs must provide written translations of certain MCP materials in the prevalent non-English languages of members and eligible individuals in accordance with the following:

- a. When 10% or more of the ABD eligible individuals in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved marketing materials into the primary language of that group. The MCP must monitor changes in the eligible population on an ongoing basis and conduct an assessment no less often than annually to determine which, if any, primary language groups meet the 10% threshold for the eligible individuals in each service area. When the 10% threshold is met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their marketing materials, and make these marketing materials available to eligible individuals. MCPs must submit to ODJFS, upon request, their prevalent non English language analysis of eligible individuals and the results of this analysis.
 - b. When 10% or more of an MCP's ABD members in the MCP's service area have a common primary language other than English, the MCP must translate all ODJFS-approved member materials into the primary language of that group. The MCP must monitor their membership and conduct a quarterly assessment to determine which, if any, primary language groups meet the 10% threshold. When the 10% threshold is met, the MCP must report this information to ODJFS, in a format as requested by ODJFS, translate their member materials, and make these materials available to their members. MCPs must submit to ODJFS, upon request, their prevalent non-English language member analysis and the results of this analysis.
20. The MCP must utilize a centralized database which records the special communication needs of all MCP members (i.e., those with limited English proficiency, limited reading proficiency, visual impairment, and hearing impairment) and the provision of related services (i.e., MCP materials in alternate format, oral interpretation, oral translation services, written translations of MCP materials, and sign language services). This database must include all MCP member primary language information (PLI) as well as all other special communication needs information for MCP members, as indicated above, when identified by any source including but not limited to ODJFS, ODJFS selection services entity, MCP staff, providers, and members. This centralized database must be readily available to MCP staff and be used in coordinating communication and services to members, including the selection of a PCP who speaks the primary language of an LEP member, when such a provider is available. MCPs must share member specific communication needs information with their providers [e.g., PCPs, Pharmacy Benefit
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Managers (PBMs), and Third Party Administrators (TPAs)], as applicable. MCPs must submit to ODJFS, upon request, detailed information regarding the MCP's members with special communication needs, which could include individual member names, their specific communication need, and any provision of special services to members (i.e., those special services arranged by the MCP as well as those services reported to the MCP which were arranged by the provider).

Additional requirements specific to providing assistance to hearing-impaired, vision-impaired, limited reading proficient (LRP), and LEP members and eligible individuals are found in OAC rules 5101:3-26-03.1, 5101:3-26-05(D), 5101:3-26-05.1(A), 5101:3-26-08, and 5101:3-26-08.2.

21. The MCP is responsible for ensuring that all member materials use easily understood language and format. The determination of what materials comply with this requirement is in the sole discretion of ODJFS.
 22. Pursuant to OAC rules 5101:3-26-08 and 5101:3-26-08.2, the MCP is responsible for ensuring that all MCP marketing and member materials are prior approved by ODJFS before being used or shared with members. Marketing and member materials are defined as follows:
 - a. Marketing materials are those items produced in any medium, by or on behalf of an MCP, including gifts of nominal value (i.e., items worth no more than \$15.00), which can reasonably be interpreted as intended to market to eligible individuals.
 - b. Member materials are those items developed, by or on behalf of an MCP, to fulfill MCP program requirements or to communicate to all members or a group of members. Member health education materials that are produced by a source other than the MCP and which do not include any reference to the MCP are not considered to be member materials.
 - c. All MCP marketing and member materials must represent the MCP in an honest and forthright manner and must not make statements which are inaccurate, misleading, confusing, or otherwise misrepresentative, or which defraud eligible individuals or ODJFS.
 - d. All MCP marketing cannot contain any assertion or statement (whether written or oral) that the MCP is endorsed by CMS, the Federal or State government or similar entity.
 - e. MCPs must establish positive working relationships with the CDJFS offices and must not aggressively solicit from local Directors, MCP County Coordinators, or
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other staff. Furthermore, MCPs are prohibited from offering gifts of nominal value (i.e. clipboards, pens, coffee mugs, etc.) to CDJFS offices or managed care enrollment center (MCEC) staff, as these may influence an individual's decision to select a particular MCP.

23. Advance Directives – All MCPs must comply with the requirements specified in 42 CFR 422.128. At a minimum, the MCP must:

- a. Maintain written policies and procedures that meet the requirements for advance directives, as set forth in 42 CFR Subpart I of part 489.
- b. Maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care by or through the MCP to ensure that the MCP:
 - i. Provides written information to all adult members concerning:
 - a. the member's rights under state law to make decisions concerning their medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives. (In meeting this requirement, MCPs must utilize form JFS 08095 entitled *You Have the Right*, or include the text from JFS 08095 in their ODJFS-approved member handbook).
 - b. the MCP's policies concerning the implementation of those rights including a clear and precise statement of any limitation regarding the implementation of advance directives as a matter of conscience;
 - c. any changes in state law regarding advance directives as soon as possible but no later than ninety (90) days after the proposed effective date of the change; and
 - d. the right to file complaints concerning noncompliance with the advance directive requirements with the Ohio Department of Health.
 - ii. Provides for education of staff concerning the MCP's policies and procedures on advance directives;
 - iii. Provides for community education regarding advance directives directly or in concert with other providers or entities;



- iv. Requires that the member's medical record document whether or not the member has executed an advance directive; and
- v. Does not condition the provision of care, or otherwise discriminate against a member, based on whether the member has executed an advance directive.

24. New Member Materials

Pursuant to OAC rule 5101:3-26-08.2 (B)(3), MCPs must provide to each member or assistance group, as applicable, an MCP identification (ID) card, a new member letter, a member handbook, a provider directory, and information on advance directives.

- a. MCPs must use the model language specified by ODJFS for the new member letter.
- b. The ID card and new member letter must be mailed together to the member via a method that will ensure their receipt prior to the member's effective date of coverage.
- c. The member handbook, provider directory and advance directives information may be mailed to the member separately from the ID card and new member letter. MCPs will meet the timely receipt requirement for these materials if they are mailed to the member within (twenty-four) 24 hours of the MCP receiving the ODJFS produced monthly membership roster (MMR). This is provided the materials are mailed via a method with an expected delivery date of no more than five (5) days. If the member handbook, provider directory and advance directives information are mailed separately from the ID card and new member letter and the MCP is unable to mail the materials within twenty-four (24) hours, the member handbook, provider directory and advance directives information must be mailed via a method that will ensure receipt by no later than the effective date of coverage. If the MCP mails the ID card and new member letter with the other materials (e.g., member handbook, provider directory, and advance directives), the MCP must ensure that all materials are mailed via a method that will ensure their receipt prior to the member's effective date of coverage.
- d. MCPs must designate two (2) MCP staff members to receive a copy of the new member materials on a monthly basis in order to monitor the timely receipt of these materials. At least one of the staff members must receive the materials at their home address.

25. Call Center Standards

The MCP must provide assistance to members through a member services toll-free call-in system pursuant to OAC rule 5101:3-26-08.2(A)(1). MCP member services staff must be available nationwide to provide assistance to members through the toll-free call-in system every Monday through Friday, at all times during the hours of 7:00 am to 7:00 pm

Eastern Time, except for the following major holidays:

- New Year's Day
- Martin Luther King's Birthday
- Memorial Day
- Independence Day
- Labor Day
- Thanksgiving Day
- Christmas Day
- 2 optional closure days: These days can be used independently or in combination with any of the major holiday closures but cannot both be used within the same closure period. Before announcing any optional closure dates to members and/or staff, MCPs must receive ODJFS prior-approval which verifies that the optional closure days meet the specified criteria.

If a major holiday falls on a Saturday, the MCP member services line may be closed on the preceding Friday. If a major holiday falls on a Sunday, the member services line may be closed on the following Monday. MCP member services closure days must be specified in the MCP's member handbook, member newsletter, or other some general issuance to the MCP's members at least thirty (30) days in advance of the closure.

The MCP must also provide access to medical advice and direction through a centralized twenty-four-hour, seven day, toll-free call-in system, available nationwide, pursuant to OAC rule 5101:3-26-03.1(A)(6). The twenty-four (24)/7 hour call-in system must be staffed by appropriately trained medical personnel. For the purposes of meeting this requirement, trained medical professionals are defined as physicians, physician assistants, licensed practical nurses, and registered nurses.

MCPs must meet the current American Accreditation HealthCare Commission/URAC-designed Health Call Center Standards (HCC) for call center abandonment rate, blockage rate and average speed of answer. By the 10th of each month, MCPs must self-report their prior month performance in these three areas for their member services and twenty-four (24) hour toll-free call-in systems to ODJFS. ODJFS will inform the MCPs of any changes/updates to these URAC call center standards.

MCPs are not permitted to delegate grievance/appeal functions [Ohio Administrative Code (OAC) rule 5101:3-26-08.4(A)(9)]. Therefore, the member services call center requirement may not be met through the execution of a Medicaid Delegation Subcontract Addendum or Medicaid Combined Services Subcontract Addendum.

26. Notification of Optional MCP Membership

In order to comply with the terms of the ODJFS State Plan Amendment for the managed care program (i.e., 42 CFR 438.50), MCPs in mandatory membership service areas must inform new members, as applicable, that MCP membership is optional for certain populations. Specifically, MCPs must inform any applicable pending member or member that the following ABD population is not required to select an MCP in order to receive their Medicaid healthcare benefit and what steps they need to take if they do not wish to be a member of an MCP:

- Indians who are members of federally-recognized tribes, except as permitted under 42 C.F.R 438.50(d)(21).

27. HIPAA Privacy Compliance Requirements

The Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulations at 45 CFR. § 164.502(e) and § 164.504(e) require ODJFS to have agreements with MCPs as a means of obtaining satisfactory assurance that the MCPs will appropriately safeguard all personal identified health information. Protected Health Information (PHI) is information received from or on behalf of ODJFS that meets the definition of PHI as defined by HIPAA and the regulations promulgated by the United States Department of Health and Human Services, specifically 45 CFR 164.501, and any amendments thereto. MCPs must agree to the following:

- a. MCPs shall not use or disclose PHI other than is permitted by this Agreement or required by law.
 - b. MCPs shall use appropriate safeguards to prevent unauthorized use or disclosure of PHI.
 - c. MCPs shall report to ODJFS any unauthorized use or disclosure of PHI of which it becomes aware. Any breach by the MCP or its representatives of protected health information (PHI) standards shall be immediately reported to the State HIPAA Compliance Officer through the Bureau of Managed Health Care. MCPs must provide documentation of the breach and complete all actions ordered by the HIPAA Compliance Officer.
 - d. MCPs shall ensure that all its agents and subcontractors agree to these same PHI conditions and restrictions.
 - e. MCPs shall make PHI available for access as required by law.
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- f. MCP shall make PHI available for amendment, and incorporate amendments as appropriate as required by law.
 - g. MCPs shall make PHI disclosure information available for accounting as required by law.
 - h. MCPs shall make its internal PHI practices, books and records available to the Secretary of Health and Human Services (HHS) to determine compliance.
 - i. Upon termination of their agreement with ODJFS, the MCPs, at ODJFS' option, shall return to ODJFS, or destroy, all PHI in its possession, and keep no copies of the information, except as requested by ODJFS or required by law.
 - j. ODJFS will propose termination of the MCP's provider agreement if ODJFS determines that the MCP has violated a material breach under this section of the agreement, unless inconsistent with statutory obligations of ODJFS or the MCP .
28. Electronic Communications – MCPs are required to purchase/utilize Transport Layer Security (TLS) for all e-mail communication between ODJFS and the MCP. The MCP's e-mail gateway must be able to support the sending and receiving of e-mail using Transport Layer Security (TLS) and the MCP's gateway must be able to enforce the sending and receiving of email via TLS.
29. MCP Membership acceptance, documentation and reconciliation
- a. Selection Services Contractor: The MCP shall provide to the MCEC ODJFS prior-approved MCP materials and directories for distribution to eligible individuals who request additional information about the MCP.
 - b. Monthly Reconciliation of Membership and Premiums: The MCP shall reconcile member data as reported on the MCEC produced consumer contact record (CCR) with the ODJFS-produced monthly member roster (MMR) and report to the ODJFS any difficulties in interpreting or reconciling information received. Membership reconciliation questions must be identified and reported to the ODJFS prior to the first of the month to assure that no member is left without coverage. The MCP shall reconcile membership with premium payments reported on the monthly remittance advice (RA).
- The MCP shall work directly with the ODJFS, or other ODJFS-identified entity, to resolve any difficulties in interpreting or reconciling premium information. Premium reconciliation questions must be identified within thirty (30) days of receipt of the RA.
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- c. Monthly Premiums: The MCP must be able to receive monthly premiums in a method specified by ODJFS. (ODJFS monthly prospective premium issue dates are provided in advance to the MCPs.) Various retroactive premium payments and recovery of premiums paid (e.g., retroactive terminations of membership, deferments, etc.,) may occur via any ODJFS weekly remittance.
- d. Hospital/Inpatient Facility Deferment: When an MCP learns of a currently hospitalized member's intent to disenroll through the CCR or the 834, the disenrolling MCP must notify the hospital/inpatient facility and treating providers as well as the enrolling MCP of the change in enrollment within five (5) business days of receipt of the CCR or 834. The disenrolling MCP must notify the inpatient facility that it will remain responsible for the inpatient facility charges through the date of discharge; and must notify the treating providers that it will remain responsible for provider charges through the date of disenrollment.

When the enrolling MCP learns through the disenrolling MCP, through ODJFS or other means, that a new member who was previously enrolled with another MCP was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall contact the hospital/inpatient facility within five (5) business days of learning of the hospitalization. The enrolling MCP shall verify that it is responsible for all medically necessary Medicaid covered services from the effective date of MCP membership, including treating provider services related to the inpatient stay; the enrolling MCP must reiterate that the admitting/disenrolling MCP remains responsible for the hospital/inpatient facility charges through the date of discharge. The enrolling MCP shall work with the hospital/inpatient facility to facilitate discharge planning and authorize services as needed.

When an MCP learns that a new member who was previously on Medicaid fee for service was admitted prior to the effective date of enrollment and remains an inpatient on the effective date of enrollment, the enrolling MCP shall notify the hospital/ inpatient facility and treating providers that the MCP may not be the payer. The MCP shall work with hospital/inpatient facility, treating providers and the ODJFS to assure that discharge planning assures continuity of care and accurate payment. Notwithstanding the MCP's right to request a hospital deferment up to six (6) months following the member's effective date, when the enrolling MCP learns of a deferment-eligible hospitalization, the MCP shall notify the ODJFS **and** request the deferment within five (5) business days of learning of the potential deferment.

- e. Just Cause Requests: The MCP shall follow procedures as specified by ODJFS in assisting the ODJFS in resolving member requests for member-initiated requests affecting membership.
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- f. Eligible Individuals: If an eligible individual contacts the MCP, the MCP must provide any MCP-specific managed care program information requested. The MCP must not attempt to assess the eligible individual's health care needs. However, if the eligible individual inquires about continuing/transitioning health care services, MCPs shall provide an assurance that all MCPs must cover all medically necessary Medicaid-covered health care services and assist members with transitioning their health care services.

- g. Pending Member

If a pending member (i.e., an eligible individual subsequent to plan selection or assignment, but prior to their membership effective date) contacts the selected MCP, the MCP must provide any membership information requested, including but not limited to, assistance in determining whether the current medications require prior authorization. The MCP must also ensure that any care coordination (e.g., PCP selection, prescheduled services and transition of services) information provided by the pending member is logged in the MCP's system and forwarded to the appropriate MCP staff for processing as required. MCPs may confirm any information provided on the CCR at this time. Such communication does not constitute confirmation of membership. MCPs are prohibited from initiating contact with a pending member. Upon receipt of the 834, the MCP may contact a pending member to confirm information provided on the CCR or the 834, assist with care coordination and transition of care, and inquire if the pending member has any membership questions.

- h. Transition of Fee-For-Service Members

Providing care coordination, access to preventive and specialized care, case management, member services, and education with minimal disruption to members' established relationships with providers and existing care treatment plans is critical for members transitioning from Medicaid fee-for-service to managed care. MCPs must develop and implement a transition plan that outlines how the MCP will effectively address the unique care coordination issues of members in their first three months of MCP membership and how the various MCP departments will coordinate and share information regarding these new members. The transition plan must include at a minimum:

- i. An effective outreach process to identify each new member's existing and/or potential health care needs that results in a new member profile that includes, but is not limited to identification of:
 - a. Health care needs, including those services received through state
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sub-recipient agencies [e.g., the Ohio Department of Mental Health (ODMH), the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD), the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Aging (ODA)];

- b. Existing sources of care (i.e., primary physicians, specialists, case manager(s), ancillary and other care givers); and
 - c. Current care therapies for all aspects of health care services, including scheduled health care appointments, planned and/or approved surgeries (inpatient or outpatient), ancillary or medical therapies, prescribed drugs, home health care services, private duty nursing (PDN), scheduled lab/radiology tests, necessary durable medical equipment, supplies and needed/approved transportation arrangements.
- ii. Strategies for how each new member will obtain care therapies from appropriate sources of care as an MCP member. The MCP's strategies must include at a minimum:
- a. Allowing their new members that are transitioning from Medicaid fee-for-service to receive services from out-of-panel providers if the member or provider contacts the MCP to discuss the scheduled health services in advance of the service date and one of the following applies:
 - i. The member has appointments within the initial three months of the MCP membership with a primary care provider_or specialty physician that was scheduled prior to the effective date of the MCP membership;
 - ii. The member is in her third trimester of pregnancy and has an established relationship with an obstetrician and/or delivery hospital;
 - iii. The member has been scheduled for an inpatient or outpatient surgery and has been prior-approved and/or precertified pursuant to OAC rule 5101:3-2-40 (surgical procedures would also include follow-up care as appropriate);
 - iv. The member is receiving ongoing chemotherapy or radiation treatment; or
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- v. The member has been released from the hospital within thirty (30) days prior to MCP enrollment and is following a treatment plan. If contacted by the member, the MCP must contact the provider's office as expeditiously as the situation warrants to confirm that the service(s) meets the above criteria.
 - b. Allowing their new members that are transitioning from Medicaid fee-for-service to continue receiving home care services (i.e., nursing, aide, and skilled therapy services) and private duty nursing (PDN) services if the member or provider contacts the MCP to discuss the health services in advance of the service date. These services must be covered from the date of the member or provider contact at the current service level, and with the current provider, whether a panel or out-of-panel provider, until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1. As soon as the MCP becomes aware of the member's current home care services, the MCP must initiate contact with the current provider and member as applicable to ensure continuity of care and coordinate a transfer of services to a panel provider, if appropriate.
 - c. Honoring any current fee-for-service prior authorization to allow their new members that are transitioning from Medicaid fee-for-service to receive services from the authorized provider, whether a panel or out-of-panel provider, for the following approved services:
 - i. an organ, bone marrow, or hematopoietic stem cell transplant pursuant to OAC rule 5101:3-2-07.1;
 - ii. dental services that have not yet been received;
 - iii. vision services that have not yet been received;
 - iv. durable medical equipment (DME) that has not yet been received. Ongoing DME services and supplies are to be covered by the MCP as previously-authorized until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.
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- v. private duty nursing (PDN) services. PDN services must be covered at the previously-authorized service level until the MCP conducts a medical necessity review and renders an authorization decision pursuant to OAC rule 5101:3-26-03.1.

As soon as the MCP becomes aware of the member's current fee-for-service authorization approval, the MCP must initiate contact with the authorized provider and member as applicable to ensure continuity of care. The MCP must implement a plan to meet the member's immediate and ongoing medical needs and, with the exception of organ, bone marrow, or hematopoietic stem cell transplants, coordinate the transfer of services to a panel provider, if appropriate.

When an MCP medical necessity review results in a decision to reduce, suspend, or terminate services previously authorized by fee-for-service Medicaid, the MCP must notify the member of their state hearing rights no less than 15 calendar days prior to the effective date of the MCP's proposed action, per rule 5101:3-26-08.4 of the Administrative Code.

- d. Reimbursing out-of-panel providers that agree to provide the transition services at 100% of the current Medicaid fee-for-service provider rate for the service(s) identified in Section 29.h.ii.(a., b., and c.) of this appendix.
 - e. Documenting the provision of transition services identified in Section 29.h.ii.(a., b., and c.) of this appendix as follows:
 - i. For non-panel providers, notification to the provider confirming the provider's agreement/disagreement to provide the service and accept 100% of the current Medicaid fee-for-service rate as payment. If the provider agrees, the distribution of the MCP's materials as outlined in Appendix G.4.e.
 - ii. Notification to the member of the non-panel provider's agreement /disagreement to provide the service. If the provider disagrees, notification to the member of the
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MCP's availability to assist with locating a provider as expeditiously as the member's health condition warrants.

iii. For panel providers, notification to the provider and member confirming the MCP's responsibility to cover the service.

MCPs must use the ODJFS-specified model language for the provider and member notices and maintain documentation of all member and/or provider contacts relating to such services.

f. Implementing a drug transition of care process that prevents drug access problems for new members that are transitioning from Medicaid fee-for-service (FFS). Such a process would involve the MCP covering at least one prescription fill or refill without prior authorization (PA) of any covered prescription drug not requiring PA by FFS. For new members that are transitioning from FFS who utilize ongoing medications for chronic conditions the MCP must educate the member about how to continue to access drugs for their chronic condition before the MCP may implement PA requirements for that member's specific ongoing medication. The MCP's process for covering the prescription fill or refill without PA must be based on one of the following approaches:

i. the MCP covers without PA all prescriptions written within the two months prior to the effective date of MCP enrollment that do not require PA by Medicaid fee-for-service; or

ii. the MCP covers without PA for at least the initial 30 days of the member's MCP membership all prescriptions that do not require PA by Medicaid fee-for-service.

For any new member transitioning from FFS who utilizes ongoing medications for chronic conditions the MCP may require subsequent PA for those drugs once the MCP has educated the member about the importance of working with their physician to discuss initiating a PA request to continue the current medication and the option of using alternative medications that may be available without PA. Written member notices must use ODJFS-specified model language and be ODJFS-approved. Verbal member education may be done in place of written education but must contain the same information as a written notice and must follow a call script that contains ODJFS-specified model language and be ODJFS-approved.

For those new members who are not utilizing ongoing medications for chronic conditions, no additional drug PA education is required beyond the MCP's general new member education that includes what drugs require MCP PA.

MCPs must receive ODJFS approval prior to implementing their transition of care drug PA process. An MCP's proposal must document how the MCP will:

- i. implement one of the above options to ensure that members transitioning from FFS receive at least one prescription fill or refill without PA of any covered prescription drug not requiring PA by FFS; and
- ii. identify new members that are transitioning from FFS who utilize ongoing medications for chronic conditions and provide timely education to the member about how to continue to access drugs for their chronic condition before the MCP will implement PA requirements for that member's specific ongoing medication.

MCPs who have not received ODJFS approval for their transition of care drug PA process must not require PA of any prescription drug that does not require PA by Medicaid fee-for-service for the initial three months of a member's MCP membership.

- g. Covering antipsychotic medications for new members as well as current members as stipulated in Appendix G(3)(a)(i).

30. Health Information System Requirements

The ability to develop and maintain information management systems capacity is crucial to successful plan performance. ODJFS therefore requires MCPs to demonstrate their ongoing capacity in this area by meeting several related specifications.

- a. Health Information System
 - i. As required by 42 CFR 438.242(a), each MCP must maintain a health information system that collects, analyzes, integrates, and reports data. The system must provide information on areas including, but not limited to, utilization, grievances and appeals, and MCP membership terminations for other than loss of Medicaid eligibility.
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- ii. As required by 42 CFR 438.242(b)(1), each MCP must collect data on member and provider characteristics and on services furnished to its members.
- iii. As required by 42 CFR 438.242(b)(2), each MCP must ensure that data received from providers is accurate and complete by verifying the accuracy and timeliness of reported data; screening the data for completeness, logic, and consistency; and collecting service information in standardized formats to the extent feasible and appropriate.
- iv. As required by 42 CFR 438.242(b)(3), each MCP must make all collected data available upon request by ODJFS or the Center for Medicare and Medicaid Services (CMS).
- v. Acceptance testing of any data that is electronically submitted to ODJFS is required:
 - a. Before an MCP may submit production files
 - b. Whenever an MCP changes the method or preparer of the electronic media; and/or
 - c. When the ODJFS determines an MCP's data submissions have an unacceptably high error rate.

MCPs that change or modify information systems that are involved in producing any type of electronically submitted files, either internally or by changing vendors, are required to submit to ODJFS for review and approval a transition plan including the submission of test files in the ODJFS-specified formats. Once an acceptable test file is submitted to ODJFS, as determined solely by ODJFS, the MCP can return to submitting production files. ODJFS will inform MCPs in writing when a test file is acceptable. Once an MCP's new or modified information system is operational, that MCP will have up to ninety (90) days to submit an acceptable test file and an acceptable production file.

Submission of test files can start before the new or modified information system is in production. ODJFS reserves the right to verify any MCP's capability to report elements in the minimum data set prior to executing the provider agreement for the next contract period. Penalties for noncompliance with this requirement are specified in Appendix N, Compliance Assessment System of the Provider Agreement.

b. Electronic Data Interchange and Claims Adjudication Requirements

Claims Adjudication

The MCP must have the capacity to electronically accept and adjudicate all claims to final status (payment or denial). Information on claims submission procedures must be provided to non-contracting providers within thirty (30) days of a request. MCPs must inform providers of its ability to electronically process and adjudicate claims and the process for submission. Such information must be initiated by the MCP and not only in response to provider requests.

The MCP must notify providers who have submitted claims of claims status [paid, denied, pended (suspended)] within one month of receipt. Such notification may be in the form of a claim payment/remittance advice produced on a routine monthly, or more frequent, basis.

Electronic Data Interchange

The MCP shall comply with all applicable provisions of HIPAA including electronic data interchange (EDI) standards for code sets and the following electronic transactions:

Health care claims;
Health care claim status request and response;
Health care payment and remittance status;
Standard code sets; and

National Provider Identifier (NPI).

Each EDI transaction processed by the MCP shall be implemented in conformance with the appropriate version of the transaction implementation guide, as specified by applicable federal rule or regulation.

The MCP must have the capacity to accept the following transactions from the Ohio Department of Job and Family services consistent with EDI processing specifications in the transaction implementation guides and in conformance with the 820 and 834 Transaction Companion Guides issued by ODJFS:

ASC X12 820 — Payroll Deducted and Other Group Premium Payment for Insurance Products; and

ASC X12 834 — Benefit Enrollment and Maintenance.

The MCP shall comply with the HIPAA mandated EDI transaction standards and

code sets no later than the required compliance dates as set forth in the federal regulations.

Documentation of Compliance with Mandated EDI Standards

The capacity of the MCP and/or applicable trading partners and business associates to electronically conduct claims processing and related transactions in compliance with standards and effective dates mandated by HIPAA must be demonstrated, to the satisfaction of ODJFS, as outlined below.

Verification of Compliance with HIPAA (Health Insurance Portability and Accountability Act of 1995)

MCPs shall comply with the transaction standards and code sets for sending and receiving applicable transactions as specified in 45 CFR Part 162 – Health Insurance Reform: Standards for Electronic Transactions (HIPAA regulations) In addition the MCP must enter into the appropriate trading partner agreement and implemented standard code sets. If the MCP has obtained third-party certification of HIPAA compliance for any of the items listed below, that certification may be submitted in lieu of the MCP's written verification for the applicable item(s).

- i. Trading Partner Agreements
- ii. Code Sets
- iii. Transactions
 - a. Health Care Claims or Equivalent Encounter Information (ASC X12N 837 & NCPDP 5.1)
 - b. Eligibility for a Health Plan (ASC X12N 270/271)
 - c. Referral Certification and Authorization (ASC X12N 278)
 - d. Health Care Claim Status (ASC X12N 276/277)
 - e. Enrollment and Disenrollment in a Health Plan (ASC X12N 834)
 - f. Health Care Payment and Remittance Advice (ASC X12N 835)
 - g. Health Plan Premium Payments (ASC X12N 820)
 - h. Coordination of Benefits

Trading Partner Agreement with ODJFS

MCPs must complete and submit an EDI trading partner agreement in a format specified by the ODJFS. Submission of the copy of the trading partner agreement prior to entering into this Agreement may be waived at the discretion of ODJFS; if submission prior to entering into the Agreement is waived, the trading partner agreement must be submitted at a subsequent date determined by ODJFS.

Noncompliance with the EDI and claims adjudication requirements will result in the imposition of penalties, as outlined in Appendix N, Compliance Assessment System, of the Provider Agreement.

c. Encounter Data Submission Requirements

General Requirements

Each MCP must collect data on services furnished to members through an encounter data system and must report encounter data to the ODJFS. MCPs are required to submit this data electronically to ODJFS on a monthly basis in the following standard formats:

- Institutional Claims — UB92 flat file
- Noninstitutional Claims — National standard format
- Prescription Drug Claims — NCPDP

ODJFS relies heavily on encounter data for monitoring MCP performance. The ODJFS uses encounter data to measure clinical performance, conduct access and utilization reviews, reimburse MCPs for newborn deliveries and aid in setting

MCP capitation rates. For these reasons, it is important that encounter data is timely, accurate, and complete. Data quality, performance measures and standards are described in the Agreement.

An encounter represents all of the services, including medical supplies and medications, provided to a member of the MCP by a particular provider, regardless of the payment arrangement between the MCP and the provider. (For example, if a member had an emergency department visit and was examined by a physician, this would constitute two encounters, one related to the hospital provider and one related to the physician provider. However, for the purposes of calculating a utilization measure, this would be counted as a single emergency department visit. If a member visits their PCP and the PCP examines the member and has laboratory procedures done within the office, then this is one encounter between the member and their PCP.)

If the PCP sends the member to a lab to have procedures performed, then this is two encounters; one with the PCP and another with the lab. For pharmacy encounters, each prescription filled is a separate encounter.

Encounters include services paid for retrospectively, through fee-for-service payment arrangements, and prospectively, through capitated arrangements. Only encounters with services (line items) that are paid by the MCP, fully or in part, and for which no further payment is anticipated, are acceptable encounter data submissions.

All other services that are unpaid or paid in part and for which the MCP anticipates further payment (e.g., unpaid services rendered during a delivery of a newborn) may not be submitted to ODJFS until they are paid. Penalties for noncompliance with this requirement are specified in Appendix N, Compliance Assessment System of the Agreement.

Acceptance Testing

The MCP must have the capability to report all elements in the Minimum Data Set as set forth in the ODJFS Encounter Data Specifications and must submit a test file in the ODJFS-specified medium in the required formats prior to contracting or prior to an information systems replacement or update.

Acceptance testing of encounter data is required as specified in Section 29(a)(v) of this Appendix.

Encounter Data File Submission Procedures

A certification letter must accompany the submission of an encounter data file in the ODJFS-specified medium. The certification letter must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

Timing of Encounter Data Submissions

ODJFS recommends that MCPs submit encounters no more than thirty-five (35) days after the end of the month in which they were paid. (For example, claims paid in January are due March 5.) ODJFS recommends that MCPs submit files in the ODJFS-specified medium by the 5th of each month. This will help to ensure that the encounters are included in the ODJFS master file in the same month in which they were submitted.

d. Information Systems Review

ODJFS or its designee may review the information system capabilities of each MCP before ODJFS enters into a provider agreement with a new MCP, when a participating MCP undergoes a major information system upgrade or change, when there is identification of significant information system problems, or at ODJFS' discretion. Each MCP must participate in the review. The review will assess the extent to which MCPs are capable of maintaining a health information system including producing valid encounter data, performance measures, and other data necessary to support quality assessment and improvement, as well as managing the care delivered to its members.

The following activities, at a minimum, will be carried out during the review. ODJFS or its designee will:

- i. Review the Information Systems Capabilities Assessment (ISCA) forms, as developed by CMS; which the MCP will be required to complete.
 - ii. Review the completed ISCA and accompanying documents;
 - iii. Conduct interviews with MCP staff responsible for completing the ISCA, as well as staff responsible for aspects of the MCP's information systems function;
 - iv. Analyze the information obtained through the ISCA, conduct follow-up interviews with MCP staff, and write a statement of findings about the MCP's information system.
 - v. Assess the ability of the MCP to link data from multiple sources;
 - vi. Examine MCP processes for data transfers;
 - vii. If an MCP has a data warehouse, evaluate its structure and reporting capabilities;
 - viii. Review MCP processes, documentation, and data files to ensure that they comply with state specifications for encounter data submissions; and
 - ix. Assess the claims adjudication process and capabilities of the MCP.
31. If the MCP will be using the Internet functions that will allow approved users to access member information (e.g., eligibility verification), the MCP must receive prior written approval from ODJFS that verifies that the proper safeguards, firewalls, etc., are in place to protect member data.
 32. MCPs must receive prior written approval from ODJFS before adding any information to their website that would require ODJFS prior approval in hard copy form (e.g., provider listings, member handbook information).
 33. Pursuant to 42 CFR 438.106(b), the MCP acknowledges that it is prohibited from holding a member liable for services provided to the member in the event that the ODJFS fails to make payment to the MCP.
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34. In the event of an insolvency of an MCP, the MCP, as directed by ODJFS, must cover the continued provision of services to members until the end of the month in which insolvency has occurred, as well as the continued provision of inpatient services until the date of discharge for a member who is institutionalized when insolvency occurs.

35. Franchise Fee Assessment Requirements

- a. Each MCP is required to pay a franchise permit fee to ODJFS for each calendar quarter as required by ORC Section 5111.176. The current fee to be paid is an amount equal to 4¹/₂ percent of the managed care premiums, minus Medicare premiums that the MCP received from any payer in the quarter to which the fee applies. Any premiums the MCP returned or refunded to members or premium payers during that quarter are excluded from the fee.
- b. The franchise fee is due to ODJFS in the ODJFS-specified format on or before the 30th day following the end of the calendar quarter to which the fee applies.
- c. At the time the fee is submitted, the MCP must also submit to ODJFS a completed form and any supporting documentation pursuant to ODJFS specifications.
- d. Penalties for noncompliance with this requirement are specified in Appendix N, Compliance Assessment System of the Provider Agreement and in ORC Section 5111.176.

36. Information Required for MCP Websites

- a. On-line Provider Directory – MCPs must have an internet-based provider directory available in the same format as their ODJFS-approved provider directory, that allows members to electronically search for the MCP panel providers based on name, provider type, geographic proximity, and population (as specified in Appendix H). MCP provider directories must include all MCP-contracted providers [except as specified by ODJFS] as well as certain ODJFS non-contracted providers.
 - b. On-line Member Website – MCPs must have a secure internet-based website which is regularly updated to include the most current ODJFS approved materials. The website at a minimum must include: (1) a list of the counties that are covered in their service area; (2) the ODJFS-approved MCP member handbook, recent newsletters/announcements, MCP contact information including member services hours and closures; (3) the MCP provider directory as referenced in section 36(a) of this appendix; (4) the MCP's current preferred drug list (PDL),
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including an explanation of the list, which drugs require prior authorization (PA), and the PA process; (5) the MCP's current list of drugs covered only with PA, the PA process, and the MCP's policy for covering generic for brand-name drugs; and (6) the ability for members to submit questions/comments/grievances/appeals/etc. and receive a response (members must be given the option of a return e-mail or phone call). Responses regarding questions or comments are expected within one working day of receipt, whereas responses regarding grievances and appeals must be within the timeframes specified in OAC rule 5101:3-26-08.4. MCPs must ensure that all member materials designated specifically for CFC and/or ABD consumers (i.e. the MCP member handbook) are clearly labeled as such. The MCP's member website cannot be used as the only means to notify members of new and/or revised MCP information (e.g., change in holiday closures, change in additional benefits, revisions to approved member materials etc.). ODJFS may require MCPs to include additional information on the member website, as needed.

- c. On-line Provider Website – MCPs must have a secure internet-based website for contracting providers where they will be able to confirm a consumer's MCP enrollment and through this website (or through e-mail process) allow providers to electronically submit and receive responses to prior authorization requests. This website must also include: (1) a list of the counties that are covered in their service area; (2) the MCP's provider manual;(3) MCP contact information; (4) a link to the MCP's on-line provider directory as referenced in section 37(a) of this appendix; (5) the MCP's current PDL list, including an explanation of the list, which drugs require PA, and the PA process; (6) the MCP's current list of drugs covered only with PA, the PA process, and the MCP's policy for covering generic for brand-name drugs. MCPs must ensure that all provider materials designated specifically for CFC and/or ABD consumers (i.e. the MCP's provider manual) are clearly labeled as such; and (7) information regarding the availability of expedited prior authorization requests, as well as the information that is required from that provider in order to substantiate an expedited prior authorization request.

ODJFS may require MCPs to include additional information on the provider website, as needed.

38. MCPs must provide members with a printed version of their PDL and PA lists, upon request.
39. MCPs must not use, or propose to use , any offshore programming or call center services in fulfilling the program requirements.
-

40. PCP Feedback – The MCP must have the administrative capacity to offer feedback to individual providers on their: 1) adherence to evidence-based practice guidelines; and 2) positive and negative care variances from standard clinical pathways that may impact outcomes or costs. In addition, the feedback information may be used by the MCP for activities such as provider performance improvement projects that include incentive programs or the development of quality improvement programs.

41. Coordination of Benefits

When a claim is denied due to third party liability, the managed care plan must timely share appropriate and available information regarding the third party to the provider for the purposes of coordination of benefits, including, but not limited to third party liability information received from the Ohio Department of Job and Family Services.

APPENDIX D
ODJFS RESPONSIBILITIES
ABD ELIGIBLE POPULATION

The following are ODJFS responsibilities or clarifications that are not otherwise specifically stated in OAC Chapter 5101: 3-26 or elsewhere in the ODJFS-MCP provider agreement.

General Provisions

1. ODJFS will provide MCPs with an opportunity to review and comment on the rate-setting time line and proposed rates, and proposed changes to the OAC program rules or the provider agreement.
 2. ODJFS will notify MCPs of managed care program policy and procedural changes and, whenever possible, offer sufficient time for comment and implementation.
 3. ODJFS will provide regular opportunities for MCPs to receive program updates and discuss program issues with ODJFS staff.
 4. ODJFS will provide technical assistance sessions where MCP attendance and participation is required. ODJFS will also provide optional technical assistance sessions to MCPs, individually or as a group.
 5. ODJFS will provide MCPs with an annual MCP Calendar of Submissions outlining major submissions and due dates.
 6. ODJFS will identify contact staff, including the Contract Administrator, selected for each MCP.
 7. ODJFS will recalculate the minimum provider panel specifications if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population.
 8. ODJFS will recalculate the geographic accessibility standards, using the geographic information systems (GIS) software, if ODJFS determines that significant changes have occurred in the availability of specific provider types and the number and composition of the eligible population and/or the ODJFS provider panel specifications.
 9. On a monthly basis, ODJFS will provide MCPs with an electronic file containing their MCP's provider panel as reflected in the ODJFS Provider Verification System (PVS) database, or other designated system.
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10. On a monthly basis, ODJFS will provide MCPs with an electronic Master Provider File containing all the Ohio Medicaid fee-for-service providers, which includes their Medicaid Provider Number, as well as all providers who have been assigned a provider reporting number for current encounter data purposes.
 11. It is the intent of ODJFS to utilize electronic commerce for many processes and procedures that are now limited by HIPAA privacy concerns to FAX, telephone, or hard copy. The use of TLS will mean that private health information (PHI) and the identification of consumers as Medicaid recipients can be shared between ODJFS and the contracting MCPs via e-mail such as reports, copies of letters, forms, hospital claims, discharge records, general discussions of member-specific information, etc. ODJFS may revise data/information exchange policies and procedures for many functions that are now restricted to FAX, telephone, and hard copy, including, but not limited to, monthly membership and premium payment reconciliation requests, newborn reporting, Just Cause disenrollment requests, information requests etc. (as specified in Appendix C).
 12. ODJFS will immediately report to Center for Medicare and Medicaid Services (CMS) any breach in privacy or security that compromises protected health information (PHI), when reported by the MCP or ODJFS staff.
 13. Service Area Designation Membership in a service area is mandatory unless ODJFS approves membership in the service area for consumer initiated selections only. It is ODJFS' current intention to implement a mandatory managed care program in service areas wherever choice and capacity allow and the criteria in 42 CFR 438.50(a) are met.
 14. Consumer information
 - a. ODJFS, or its delegated entity, will provide membership notices, informational materials, and instructional materials relating to members and eligible individuals in a manner and format that may be easily understood. At least annually, ODJFS or designee will provide MCP eligible individuals, including current MCP members, with a Consumer Guide. The Consumer Guide will describe the managed care program and include information on the MCP options in the service area and other information regarding the managed care program as specified in 42 CFR 438.10.
 - b. ODJFS will notify members or ask MCPs to notify members about significant changes affecting contractual requirements, member services or access to providers.
 - c. If an MCP elects not to provide, reimburse, or cover a counseling service or referral service due to an objection to the service on moral or religious grounds, ODJFS will provide coverage and reimbursement for these services for the MCP's members.
-

ODJFS will provide information on what services the MCP will not cover and how and where the MCP's members may obtain these services in the applicable Consumer Guides.

15. Membership Selection and Premium Payment

- a. The managed care enrollment center (MCEC): The ODJFS-contracted MCEC will provide unbiased education, selection services, and community outreach for the Medicaid managed care program. The MCEC shall operate a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

The MCEC shall distribute the most current Consumer Guide that includes the managed care program information as specified in 42 CFR 438.10, as well as ODJFS prior-approved MCP materials, such as solicitation brochures and provider directories, to consumers who request additional materials.

- b. Auto-Assignment Limitations – In order to promote market and program stability, ODJFS may limit an MCP's auto-assignments if they meet any of the following enrollment thresholds:
- 40% of **statewide** Aged, Blind, or Disabled (ABD) managed care eligibles; and/or
 - 60% of the ABD managed care eligibles in **any region with two MCPs**; and/or
 - 40% of the ABD managed care eligibles in **any region with three MCPs**.

Once an MCP meets one of these enrollment thresholds, the MCP will only be permitted to receive the additional new membership (in the region or statewide, as applicable) through: (1) consumer-initiated enrollment; and (2) auto-assignments which are based on previous enrollment in that MCP or an historical provider relationship with a provider who is not on the panel of any other MCP in that region. In the event that an MCP in a region meets one or more of these enrollment thresholds, ODJFS, may not impose the auto-assignment limitation and auto-assign members to the MCPs in that region as ODJFS deems appropriate.

- c. Consumer Contact Record (CCR): ODJFS or their designated entity shall forward CCRs to MCPs on no less than a weekly basis. The CCRs are a record of each consumer-initiated MCP enrollment, change, or termination, and each MCEC
-

initiated MCP assignment processed through the MCEC. The CCR contains information that is not included on the monthly member roster.

- d. Monthly member roster (MR): ODJFS verifies managed care plan enrollment on a monthly basis via the monthly membership roster. ODJFS or its designated entity provides a full member roster (F) and a change roster (C) via HIPAA 834 compliant transactions.
 - e. Monthly Premiums: ODJFS will remit payment to the MCPs via an electronic funds transfer (EFT), or at the discretion of ODJFS, by paper warrant.
 - f. Remittance Advice: ODJFS will confirm all premium payments paid to the MCP during the month via a monthly remittance advice (RA), which is sent to the MCP the week following state cut-off. ODJFS or its designated entity provides a record of each payment via HIPAA 820 compliant transactions.
 - g. MCP Reconciliation Assistance: ODJFS will work with an MCP-designated contact(s) to resolve the MCP's member and newborn eligibility inquiries, and premium inquiries/discrepancies and to review/approve hospital deferment requests.
16. ODJFS will make available a website which includes current program information.
17. ODJFS will regularly provide information to MCPs regarding different aspects of MCP performance including, but not limited to, information on MCP-specific and statewide external quality review organization surveys, focused clinical quality of care studies, consumer satisfaction surveys and provider profiles.
18. ODJFS will periodically review a random sample of online and printed directories to assess whether MCP information is both accessible and updated.
19. Communications
- a. ODJFS/BMHC: The Bureau of Managed Health Care (BMHC) is responsible for the oversight of the MCPs' provider agreements with ODJFS. Within the BMHC, a specific Contract Administrator (CA) has been assigned to each MCP. Unless expressly directed otherwise, MCPs shall first contact their designated CA for questions/assistance related to Medicaid and/or the MCP's program requirements /responsibilities. If their CA is not available and the MCP needs immediate assistance, MCP staff should request to speak to a supervisor within the Contract Administration
-

Section. MCPs should take all necessary and appropriate steps to ensure all MCP staff are aware of, and follow, this communication process.

- b. ODJFS contracting entities: ODJFS-contracting entities should never be contacted by the MCPs unless the MCPs have been specifically instructed by ODJFS to contact the ODJFS contracting entity directly.
 - c. MCP delegated entities: In that MCPs are ultimately responsible for meeting program requirements, the BMHC will not discuss MCP issues with the MCPs' delegated entities unless the applicable MCP is also participating in the discussion. MCP delegated entities, with the applicable MCP participating, should only communicate with the specific CA assigned to that MCP.
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APPENDIX E
RATE METHODOLOGY
ABD ELIGIBLE POPULATION



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December 12, 2007

Mr. Jon Barley, Ph.D., Bureau Chief
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Columbus, OH 43215

RE: CY 2008 CAPITATION RATE DEVELOPMENT — AGED, BLIND, OR DISABLED

Dear Jon:

Milliman, Inc. (Milliman) was retained by the State of Ohio, Department of Job and Family Services (ODJFS) to develop the calendar year 2008 actuarially sound capitation rates for the Aged, Blind, or Disabled (ABD) Risk Based Managed Care (RBMC) program. This letter provides the documentation for the actuarially sound capitation rates.

LIMITATIONS

The information contained in this letter, including the enclosures, has been prepared for the State of Ohio, Department of Job and Family Services and their consultants and advisors. It is our understanding that the information contained in this letter may be utilized in a public document. To the extent that the information contained in this letter is provided to third parties, the letter should be distributed in its entirety. Any user of the data must possess a certain level of expertise in actuarial science and healthcare modeling so as not to misinterpret the data presented.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the capitation rates, assumptions, and trends.

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The information contained in this letter was prepared as documentation of the actuarially sound capitation rates for Medicaid managed care organization health plans in the State of Ohio. The information may not be appropriate for any other purpose.

SUMMARY OF METHODOLOGY

ODJFS contracted with Milliman to develop the CY 2008 ABD actuarially sound capitation rates. The actuarially sound capitation rates were developed from historical claims and enrollment data for the fee for service (FFS) population. The FFS population is considered a comparable population to the population to be enrolled with the health plans. The historical experience was converted to a per member per month (PMPM) basis and stratified by region and category of service. The historical experience was trended forward using projected trend rates to a center point of July 1, 2008 for the 2008 calendar year contract period. The historical experience was adjusted to reflect adjustments to the utilization and average cost per service that would be expected in a managed care environment.

Appendix 1 contains a chart outlining the methodology that was used to develop the CY 2008 capitation rates for the ABD populations.

Appendix 2 contains the actuarial certification regarding the actuarial soundness of the capitation rates.

Appendix 3 contains the CY 2008 capitation rates by region, including the segmentation of the administrative cost allowance between guaranteed and at-risk components.

DETAILS OF METHODOLOGY**I. COVERED POPULATION**

The CY 2008 ABD capitation rates have been developed using historical experience from the FFS population. The historical experience was developed for the population eligible for managed care enrollment based on age and program assignment. The program assignments shown in Table 1 were included in the development of the capitation rates.

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Table 1
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Summary of Managed Care Eligible Population

Program Assignment	Description
AGED	Aged
RAGED	Aged as defined on RMF
BLIND	Blind
RBLIND	Blind as defined on RMF
DISABLED	Disabled
RDISABLED	Disabled as defined on RMF
RESMED	Residential State Supplement & Medicaid

Milliman extracted the eligible population information from historical data. The eligible population includes the adult ABD population excluding: retro-active periods, back-dated periods, institutionalized, waiver, spend-down, Medicare dual-eligibles, and long-term nursing facility recipients. Adults are defined based on age greater than or equal to 21 during the base experience period. Long-term nursing facility was defined as stays lasting past the last day of the month following the admission to the nursing facility.

If a member was ineligible during a month, all claims and eligibility for the month were excluded from the actuarial models.

II. CATEGORY OF SERVICE DEFINITIONS

The categories of service listed in Table 2 describe the actuarial model service groupings. The units associated with the categories have been indicated. Further, the primary method of classifying the claims has been provided.

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Table 2
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Categories of Service

Type of Service	Service Category	Utilization Units	Classification Basis
<i>Inpatient Hospital</i>	Medical/Surgical	Admits/Days	COS, DRG
	MH/SA	Admits/Days	
	Maternity Delivery	Admits/Days	
	Well Newborn	Admits/Days	
	Maternity Non-Deliveries	Admits/Days	
	Nursing Facility	Admits/Days	
	Other Inpatient	Admits/Days	
<i>Outpatient Hospital</i>	Emergency Room	Claims	COS, Revenue Code
	Surgery/ASC	Services	
	Cardiovascular	Services	
	PT/ST/OT	Services	
	Clinic	Services	
	Other	Services	
<i>Professional</i>	Inpatient/Outpatient Surgery	Services	COS, Provider Type, Procedure, Modifier
	Anesthesia	Line Items	
	Obstetrics	Services	
	Office Visits/Consults	Services	
	Hospital Inpatient Visits	Services	
	Emergency Room Visits	Services	
	Immunizations & Injections	Services	
	Physical Medicine	Services	
	Miscellaneous Services	Line Items, Services	
<i>Rad/Path/Lab</i>	Radiology	Services	COS, Revenue Code, Provider Type, Procedure
	Pathology/Laboratory	Services	
<i>Ancillaries</i>	MH/SA	Services	COS, Provider Type, Procedure
	FQHC/RHF/OP Health Facility	Services	COS
	Pharmacy	Line Items	COS
	Dental	Services	COS
	Vision	Services	COS, Provider Type, Procedure
	Home Health	Line Items	COS
	Non-Emergent Transportation	Line Items	COS
	Ambulance	Line Items	COS, Procedure Code
	Supplies and DME	Line Items	COS, Provider Type, Procedure
	Miscellaneous Services	Line Items	COS

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The CY 2008 ABD capitation rates will be risk adjusted using the Chronic Illness and Disability Payment System (CDPS). As such, the ABD capitation rates are provided in one single rate group. Further information regarding the CDPS risk adjustment is contained in a later section as well as documented in detail in other correspondence provided by Milliman.

IV. DEVELOPMENT OF CY 2006 ADJUSTED FFS DATA

As discussed in other sections of this document, several adjustments were applied to the base FFS data to develop the CY 2008 capitation rates. The following outlines each of the adjustments applied to the base FFS data.

a. Historical Data Summaries

The CY 2008 ABD capitation rates were developed using FFS claims for two state fiscal year (SFY) periods:

- SFY 2005 (Incurred during the 12 months ending June 30, 2005 paid through May 31, 2007).
- SFY 2006 (Incurred during the 12 months ending June 30, 2006 paid through May 31, 2007).

The claims data was provided by ODJFS from the data warehouse. The experience was stratified into geographic region based on the member's county of residence.

The reimbursement amounts captured on the FFS actuarial models reflect the amount paid by ODJFS, net of third party liability recoveries and member co-payment amounts. The reimbursement amounts have not been adjusted for payments made outside the claims processing system. These amounts are discussed later in the documentation.

The FFS historical experience was adjusted to include only those services that are included in the capitation payment. Services that are not covered under the capitation payment have been excluded from the experience. The excluded services were identified by the state-assigned Category of Service field, as shown in Table 3.

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Table 3
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
FFS Claim Exclusions

COS Field Value	Description
08	PACE
13	ICF/MR Public
18	ICF/MR Private
35	Core Services
36	Home Care Facilitator Services
41	Mental Health Services
42	Mental Retardation
46	Model 50 Waiver Services
58	HMO Services
59	Mental Health Support Services
60	Mental Retardation Support Services
63	PPO Services
64	Passport
66	Passport Waiver III
67	OBRA MR/DD Waiver
80	Alcohol and Drug Abuse
82	Department of Education
84	ODADAS

b. Completion Factors

Milliman utilized 24 months of claims experience for the FFS population that was incurred through June 2006 and paid through May 2007 (eleven months of run-out). Milliman applied claim completion factors to the twelve months of fiscal year 2005 and twelve months of fiscal year 2006 claims experience. The claim completion factors were developed by service category based on claims experience for the FFS population incurred and paid through May 2007.

c. Historical Program Adjustments

The base experience data represents a historical time period from which projections were developed. Certain program changes have occurred during and subsequent to the base data time period. The program adjustments were estimated and applied to the portion of the base experience data prior to the program change effective date. For example, a program change implemented on January 1, 2006 will only be reflected in the second half of SFY 2006. As such, an adjustment was applied to all of SFY 2005 and half of SFY 2006 to include the program change in all periods of the base experience data.

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ODJFS has provided a listing of all program changes impacting the base experience data. Table 4 summarizes the historical program changes that were reflected in the development of the CY 2008 capitation rates.

Table 4
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Historical Program Adjustments — FFS

Program Adjustment	Effective Date	Service Category(s)
Inpatient Market Basket Increase	1/1/2005	Inpatient Hospital
Dental Fee Schedule Reduction	1/1/2006	Dental
Inpatient Recalibration and Outlier Policy	1/1/2006	Inpatient
Pharmacy Co-pay (\$2 Per Brand Prescription)	1/1/2006	Pharmacy
Dental Co-pay (\$3 Per Date of Service)	1/1/2006	Dental
Vision Exam Co-Pay (\$2 Per Exam)	1/1/2006	Vision / Optometric
Vision Hardware Co-Pay (\$1 Per Item)	1/1/2006	Vision / Optometric
ER Co-Pay (\$3 Per Non-Emergency Visit)	1/1/2006	Emergency Room
Dental Benefit Reduction	1/1/2006	Dental

d. Third-Party Liability

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. The paid amounts reflect a reduction for the amounts paid by third party carriers. Additionally, Milliman reduced the FFS experience to reflect third party liability recoveries following payment of claims. The reduction represents the average third party liability recovery rate received by the state under the “pay-and-chase” recovery program for each base year. It is expected that the health plans will collect the third party liability recoveries for managed care enrolled individuals.

e. Fraud and Abuse

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. Milliman reduced the FFS experience to reflect fraud and abuse recoveries following payment of claims. The reduction represents the average fraud and abuse recovery rate received by the state for each base year. It is expected that the health plans will pursue fraud and abuse detection activities for managed care enrolled individuals.

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FINAL and CONFIDENTIAL**f. Gross Adjustments**

The FFS experience was calculated using the net paid claim data from the FFS data provided by ODJFS. Milliman adjusted the FFS experience to reflect payments/refunds occurring outside of normal claim adjudication. Milliman received a “gross adjustments” file from ODJFS containing the additional adjustments.

g. Non-State Plan Services

CMS requires removal of non-state plan services from rate-setting. The FFS data does not contain any such services. As such, no adjustment was applied to the base FFS data for non-state plan services.

h. Trends/Inflation to CY 2006

Milliman developed trend rates to progress the historical experience from state fiscal years 2005 and 2006 forward to a common center point (CY 2006). Milliman reviewed historical experience and performed linear regression on the experience data to develop trend rates by category of service for both utilization and unit cost. Additionally, Milliman reviewed the resulting trends with internal data sources to develop the trends used to develop the CY 2008 ABD capitation rates.

The base experience data was normalized for artificial program adjustments prior to the trend rate development. Milliman did not consider items such as fee schedule changes or benefit modifications as standard components of trend. Removing the impact of historical changes allows for transparent inclusion of prospective program changes for future periods.

i. Blend Base Experience Years

Each of the base experience years was trended to CY 2006. At this point, each base year was on a comparable basis and could be aggregated. The weighting was developed with the intention of placing more credibility on the most recent experience and is consistent with the CY 2007 methodology. Specifically, SFY 2005 received a weight of 30% and SFY 2006 received a weight of 70%.

j. Managed Care Adjustments

Utilization and cost per service adjustments were developed for each service category and region.

Utilization

Milliman adjusted the FFS utilization and cost per service to reflect the managed care environment. After reviewing utilization benchmarks in the Milliman Medicaid Guidelines (*Guidelines*) as well as other

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sources, Milliman calculated percentage adjustments to reflect the utilization differential between an economic and efficiently managed plan and the FFS base experience.

Cost Per Service

Milliman adjusted the average reimbursement rates to reflect changes in the mix / intensity of services due to the management of health care. The reimbursement rate changes were also developed following a review of benchmarks in the *Guidelines* as well as other sources.

In addition to the intensity adjustments applied to the cost per service amounts, Milliman also included adjustments to reflect the health plan contracted rates with providers in the managed care adjustments.

V. CY 2006 ADJUSTED BASE DATA TO CY 2008 CAPITATION RATES

The adjusted CY 2006 utilization and cost per service rates are trended forward to CY 2008 and adjusted for prospective program changes that will be effective for the CY 2008 contract period. The resulting PMPM, after trend and prospective program changes establishes the regional adjusted claim cost for the health plans in CY 2008. The administrative cost allowance and franchise fee components are applied to the adjusted claim cost to develop the CY 2008 capitation rate.

a. Trend to CY 2008

The trend rates that were used to progress the CY 2006 experience forward to the CY 2008 rating period were developed from the historical experience, the experience from other Medicaid managed care programs, and our actuarial judgment. The trend rates include a component for utilization and unit cost by major category of service.

b. Prospective Program Adjustments

The SFY 2008/2009 Budget contains several program changes that impacted the development of the capitation rates. The program changes include items such as provider fee changes, benefit changes, and administrative changes. Adjustments to the CY 2006 experience were developed for each item based on its expected impact to the prospective claims cost. Table 5 lists the program changes that were included in the CY 2008 capitation rate development.

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Table 5

**STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Prospective Program Adjustments**

Program Adjustment	Effective Date	Service Category(s)
Nursing Facility Fee Increase	7/1/2007 7/1/2008	Nursing Facility
Chiropractor Benefit Restoration	1/1/2008	Miscellaneous Services
Independent Psychologists Benefit Restoration	1/1/2008	Mental Health / Substance Abuse
Occupational Therapy-Independent Provider Status	1/1/2008	Miscellaneous Services
Improved TPL Management	1/1/2008	All Service Categories
Prior Authorization Policy Change	1/1/2008	Pharmacy
Prior Authorization of Atypical Anti-Psychotic Medication	1/1/2008	Pharmacy

c. Prospective Selection Adjustment

Milliman adjusted the CY 2006 experience to reflect the expected penetration of managed care in CY 2008. Table 6 provides the target managed care penetration used in the development of the CY 2008 capitation rates.

Table 6

**STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Prospective Selection Adjustments**

Region	June 2007 MC Penetration	Target MC Penetration
Central	89.5%	93%
East Central	88.8%	93%
Northeast	89.7%	93%
Northeast Central	0.0%	93%
Northwest	87.6%	93%
Southeast	92.3%	93%
Southwest	86.0%	93%
West Central	87.7%	93%

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d. Administrative Allowance

Milliman included an administrative cost allowance in the development of the actuarially sound capitation rates for CY 2008. The administrative cost allowance contains provision for administrative expenses, profit/contingency, and surplus contribution and was calculated as a percentage of the capitation rate prior to the franchise fee. As such, the pre-franchise fee capitation rate will be determined by dividing the projected managed care claim cost by one minus the administrative cost allowance. By determining the pre-franchise fee capitation rate in this manner, the administrative allowance may be expressed as a percentage of the pre-franchise fee capitation rate. Milliman developed the administrative cost allowance following a review of cost information from other representative Medicaid managed care organizations.

For health plans in plan year 3 or later, 1% of the administrative component will be at-risk and contingent upon performance requirements defined in the ODJFS provider agreements. Table 7 provides the administrative cost allowance for each plan year.

Table 7
STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Administrative Cost Allowance

Plan Year	Guaranteed %	At-Risk %	Total %
Plan Year 1 (1-12 Months)	11.5%	0.0%	11.5%
Plan Year 2 (13-24 Months)	10.5%	0.0%	10.5%
Plan Year 3 (25 + Months)	9.5%	1.0%	10.5%

The administrative cost allowance percentages contained in Table 7 reflect a change from the 2007 methodology.

e. Franchise Fee

Milliman included a franchise fee component in the development of the actuarially sound capitation rates for CY 2008. The franchise fee was calculated as a percentage of the capitation rates. Therefore, the capitation rate will be determined by dividing the pre-franchise fee capitation rate by one minus the franchise fee component. By determining the pre-franchise fee capitation rate in this manner, the franchise fee may be expressed as a percentage of the capitation rate. The franchise fee component is 4.5% of the capitation rate.

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.



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VI. CDPS RISK ADJUSTMENT

The methodology described in this correspondence was used to develop the base capitation rates for CY 2008 for each region. Milliman will then apply the Chronic Illness and Disability Payment System (CDPS) to adjust the actuarially sound base capitation rates for the ABD population on a regional basis for each health plan. The CDPS risk adjustment will be updated each six month period for existing regions and plans. For the initial period of managed care within a region and plan, a monthly risk score will be developed for the first three months.

The next anticipated risk score update will be January 1, 2008. The CDPS risk scores will be developed for ABD recipients enrolled in managed care during December 2007 using diagnosis information from claims incurred in calendar year 2006 with paid dates between January 1, 2006 and June 30, 2007. Health plan and region specific prevalence reports will be provided with the updated risk scores.

DATA RELIANCE

In developing the CY 2008 ABD capitation rates, we have relied upon certain data and information from ODJFS. While limited review was performed for reasonableness, the data and information was accepted without audit. To the extent that the data and information was not accurate or complete, the values shown in this letter will need to be revised.



If you have any questions regarding the enclosed information, please do not hesitate to contact me at (317) 524-3512.

Sincerely,

Robert M. Damler, FSA, MAAA
Principal and Consulting Actuary

RMD/mle

cc: Dan Hecht (ODJFS)

Mitali Ghatak (ODJFS)

Robert Monks (ODJFS)

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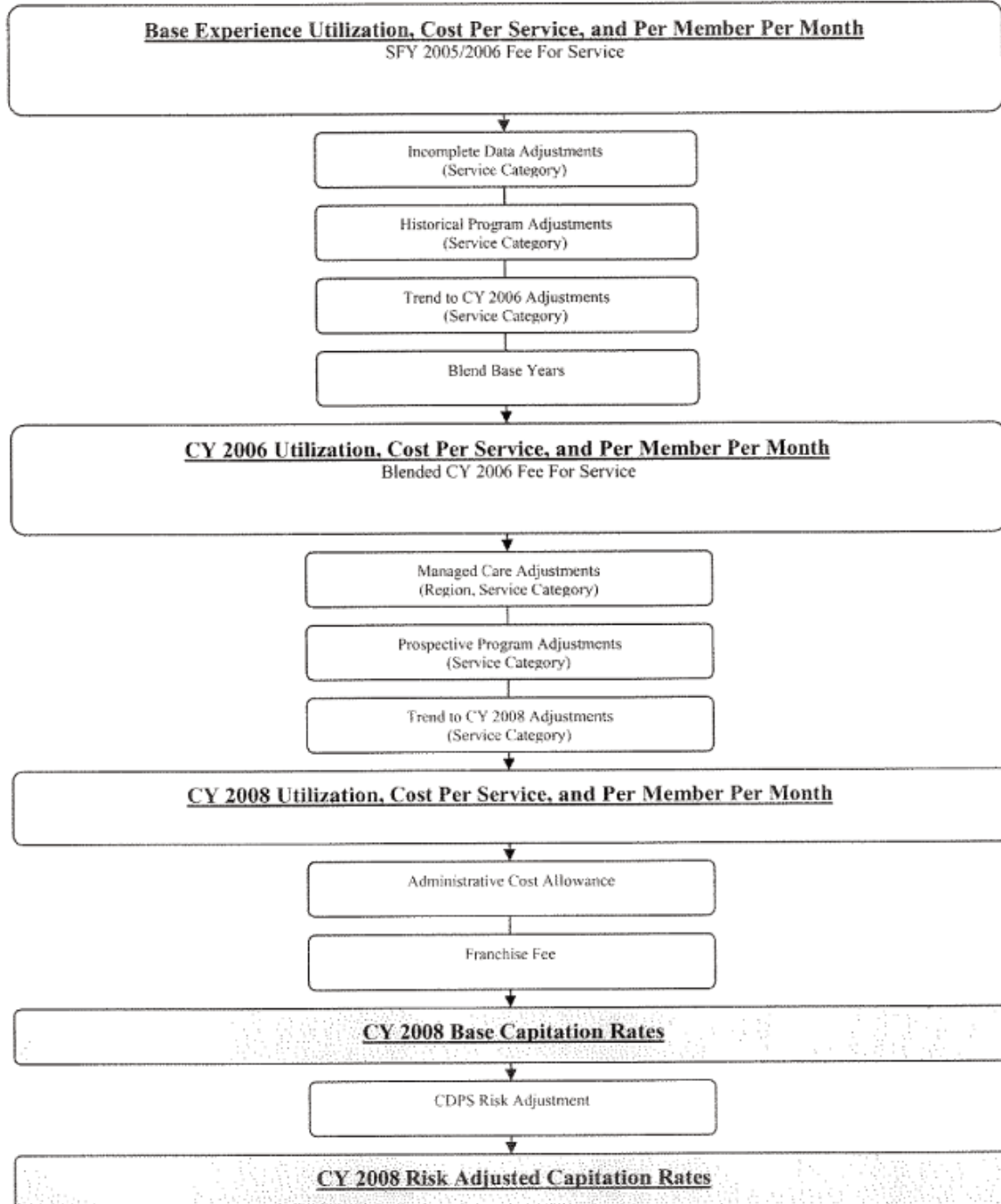
APPENDIX 1

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Illustration of Rate Development Methodology

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APPENDIX 2

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**STATE OF OHIO
DEPARTMENT OF JOB AND FAMILY SERVICES
Aged, Blind, or Disabled — CY 2008 Capitation Rates**

Actuarial Certification

I, Robert M. Damler, am a Principal and Consulting Actuary with the firm of Milliman, Inc. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I was retained by the State of Ohio, Department of Job and Family Services to perform an actuarial review and certification regarding the development of the capitation rates to be effective for calendar year 2008. The capitation rates were developed for the Aged, Blind, or Disabled managed care eligible populations. I have experience in the examination of financial calculations for Medicaid programs and meet the qualification standards for rendering this opinion.

I reviewed the historical claims experience for reasonableness and consistency. I have developed certain actuarial assumptions and actuarial methodologies regarding the projection of healthcare expenditures into future periods. I have complied with the elements of the rate setting checklist CMS developed for its Regional Offices regarding 42 CFR 438.6(c) for capitated Medicaid managed care plans.

The capitation rates provided with this certification are effective for a one-year rating period beginning January 1, 2008 through December 31, 2008. At the end of the one-year period, the capitation rates will be updated for calendar year 2009. The update may be based on fee-for-service experience, managed care utilization and trend experience, policy and procedure changes, and other changes in the health care market. A separate certification will be provided with the updated rates.

The capitation rates provided with this certification are considered actuarially sound, defined as:

- the capitation rates have been developed in accordance with generally accepted actuarial principles and practices;
- the capitation rates are appropriate for the populations to be covered, and the services to be furnished under the contract; and,
- the capitation rates meet the requirements of 42 CFR 438.6(c).

This actuarial certification has been based on the actuarial methods, considerations, and analyses promulgated from time to time through the Actuarial Standards of Practice by the Actuarial Standards Board.

Robert M. Damler, FSA
Member, American Academy of Actuaries

December 4, 2007

Date

Milliman makes no representations or warranties regarding the contents of this letter to third parties. Likewise, third parties are instructed that they are to place no reliance upon this letter prepared for ODJFS by Milliman that would result in the creation of any duty or liability under any theory of law by Milliman or its employees to third parties. Other parties receiving this letter must rely upon their own experts in drawing conclusions about the information presented.



APPENDIX 3

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State of Ohio
Department of Job and Family Services
CY2008 ABD Capitation Rate Development

Region	Projected CY 2008 Member Months	CY 2008 Guaranteed Rate	CY 2008 At Risk Rate	CY 2008 Rate
Central	284,169	\$ 1,101.26	\$ 10.62	\$ 1,111.88
East Central	149,045	1,091.21	10.52	1,101.73
Northeast	287,103	1,099.46	10.60	1,110.06
Northeast Central	85,309	1,098.34	10.59	1,108.93
Northwest	137,407	1,107.94	10.68	1,118.62
Southeast	152,735	981.68	9.47	991.15
Southwest	174,390	1,120.61	10.80	1,131.41
West Central	123,260	1,133.13	10.93	1,144.06
Statewide	1,393,418	\$ 1,092.43	\$ 10.53	\$ 1,102.96

Appendix F

PREMIUM RATES WITHOUT THE AT-RISK PAYMENT AMOUNTS FOR 01/01/08 THROUGH 06/30/08

MCP's premiums will be at-risk starting the 25th month of the ABD Medicaid Managed Care Program participation.

MCP: Molina Healthcare of Ohio, Inc.

Service Enrollment Area	Risk Adjusted Rate	At-Risk Amounts
Central Region	\$1,057.00	\$0.00
Southeast Region	\$962.08	\$0.00
Southwest Region	\$1,075.63	\$0.00
West Central	\$1,094.20	\$0.00

List of Eligible Assistance Groups (AGs)

Aged, Blind or Disabled: MA-A Aged
MA-B Blind
MA-D Disabled

APPENDIX G
COVERAGE AND SERVICES
ABD ELIGIBLE POPULATION

1. Basic Benefit Package

Pursuant to OAC rule 5101:3-26-03(A), with limited exclusions (see section G.2 of this appendix), MCPs must ensure that members have access to medically-necessary services covered by the Ohio Medicaid fee-for-service (FFS) program. For information on Medicaid-covered services, MCPs must refer to the ODJFS website. The following is a general list of the benefits pertinent to the ABD population covered by the MCPs:

- Inpatient hospital services
 - Outpatient hospital services
 - Rural health clinics (RHCs) and Federally qualified health centers (FQHCs)
 - Physician services whether furnished in the physician's office, the covered person's home, a hospital, or elsewhere
 - Laboratory and x-ray services
 - Family planning services and supplies
 - Home health and private duty nursing services
 - Podiatry
 - Physical therapy, occupational therapy, and speech therapy
 - Nurse-midwife, certified family nurse practitioner, and certified pediatric nurse practitioner services
 - Prescription drugs
 - Ambulance and ambulette services
 - Dental services
 - Durable medical equipment and medical supplies
 - Vision care services, including eyeglasses
-

- Nursing facility stays as specified in OAC rule 5101:3-26-03
- Hospice care
- Behavioral health services (see section G.2.b.iii of this appendix)
- Chiropractic services

2. Exclusions, Limitations and Clarifications

a. Exclusions

MCPs are not required to pay for Ohio Medicaid FFS program (Medicaid) non-covered services. For information regarding Medicaid noncovered services, MCPs must refer to the ODJFS website. The following is a general list of the services not covered by the Ohio Medicaid fee-for-service program:

- Services or supplies that are not medically necessary
 - Experimental services and procedures, including drugs and equipment, not covered by Medicaid
 - Organ transplants that are not covered by Medicaid
 - Abortions, except in the case of a reported rape, incest, or when medically necessary to save the life of the mother
 - Infertility services for males or females
 - Voluntary sterilization if under 21 years of age or legally incapable of consenting to the procedure
 - Reversal of voluntary sterilization procedures
 - Plastic or cosmetic surgery that is not medically necessary*
 - Immunizations for travel outside of the United States
 - Services for the treatment of obesity unless medically necessary*
 - Custodial or supportive care not covered by Medicaid
 - Sex change surgery and related services
 - Sexual or marriage counseling
-

- Acupuncture and biofeedback services
- Services to find cause of death (autopsy)
- Comfort items in the hospital (e.g., TV or phone)
- Paternity testing

MCPs are also not required to pay for non-emergency services or supplies received without members following the directions in their MCP member handbook, unless otherwise directed by ODJFS.

*These services could be deemed medically necessary if medical complications/conditions in addition to the obesity or physical imperfection are present.

b. Limitations & Clarifications

i. Member Cost-Sharing

As specified in OAC rules 5101:3-26-05(D) and 5101:3-26-12, MCPs are permitted to impose the applicable member co-payment amount(s) for dental services, vision services, non-emergency emergency department services, or prescription drugs, other than generic drugs. MCPs must notify ODJFS if they intend to impose a co-payment. ODJFS must approve the notice to be sent to the MCP's members and the timing of when the co-payments will begin to be imposed. If ODJFS determines that an MCP's decision to impose a particular co-payment on their members would constitute a significant change for those members, ODJFS may require the effective date of the co-payment to coincide with the "Open Enrollment" month.

Notwithstanding the preceding paragraph, MCPs must provide an ODJFS-approved notice to all their members 90 days in advance of the date that the MCP will impose the co-payment. With the exception of member co-payments the MCP has elected to implement in accordance with OAC rules 5101:3-26-05(D) and 5101:3-26-12, the MCP's payment constitutes payment in full for any covered services and their subcontractors must not charge members or ODJFS any additional co-payment, cost sharing, down-payment, or similar charge, refundable or otherwise.

ii. Abortion and Sterilization

The use of federal funds to pay for abortion and sterilization services is prohibited unless the specific criteria found in 42 CFR 441 and OAC rules 5101:3-17-01 and 5101:3-21-01 are met. MCPs must verify that all of the information on the required forms (JFS 03197, 03198, and 03199) is provided and that the service meets the required criteria before any such claim is paid.

Additionally, payment must not be made for associated services such as anesthesia, laboratory tests, or hospital services if the abortion or sterilization itself does not qualify for payment. MCPs are responsible for educating their providers on the requirements; implementing internal procedures including systems edits to ensure that claims are only paid once the MCP has determined if the applicable forms are completed and the required criteria are met, as confirmed by the appropriate certification/consent forms; and for maintaining documentation to justify any such claim payments.

iii. Behavioral Health Services

Coordination of Services: MCPs must have a process to coordinate benefits of and referrals to the publicly funded community behavioral health system. MCPs must ensure that members have access to all medically-necessary behavioral health services covered by the Ohio Medicaid FFS program and are responsible for coordinating those services with other medical and support services. MCPs must notify members via the member handbook and provider directory of where and how to access behavioral health services, including the ability to self-refer to mental health services offered through ODMH community mental health centers (CMHCs) as well as substance abuse services offered through Ohio Department of Alcohol and Drug Addiction Services (ODADAS)-certified Medicaid providers. Pursuant to ORC Section 5111.16, alcohol, drug addiction and mental health services covered by Medicaid are not to be paid by the managed care program when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than ODJFS. MCPs are also not responsible for providing mental health services to persons between 22 and 64 years of age while residing in an institution for mental disease (IMD) as defined in Section 1905(i) of the Social Security Act.

MCPs must provide Medicaid-covered behavioral health services for members who are unable to timely access services or unwilling

to access services through community providers.

Mental Health Services: There are a number of Medicaid-covered mental health (MH) services available through ODMH CMHCs.

Where an MCP is responsible for providing MH services for their members, the MCP is responsible for ensuring access to counseling and psychotherapy, physician/psychiatrist services, outpatient clinic services, general hospital outpatient psychiatric services, pre-hospitalization screening, diagnostic assessment (clinical evaluation), crisis intervention, psychiatric hospitalization in general hospitals (for all ages), and Medicaid-covered prescription drugs and laboratory services. MCPs are not required to cover partial hospitalization, or inpatient psychiatric care in a private or public free-standing psychiatric hospital. However, MCPs are required to cover the payment of physician services in a private or public free-standing psychiatric hospital when such services are billed independent of the hospital.

Substance Abuse Services: There are a number of Medicaid-covered substance abuse services available through ODADAS-certified Medicaid providers.

Where an MCP is responsible for providing substance abuse services for their members, the MCP is responsible for ensuring access to alcohol and other drug (AOD) urinalysis screening, assessment, counseling, physician/psychiatrist AOD treatment services, outpatient clinic AOD treatment services, general hospital outpatient AOD treatment services, crisis intervention, inpatient detoxification services in a general hospital, and Medicaid-covered prescription drugs and laboratory services. MCPs are not required to cover outpatient detoxification and methadone maintenance.

Financial Responsibility for Behavioral Health Services: MCPs are responsible for the following:

- payment of Medicaid-covered prescription drugs prescribed by an ODMH CMHC or ODADAS-certified provider when obtained through an MCP's panel pharmacy;
 - payment of Medicaid-covered services provided by an MCP's panel laboratory when referred by an ODMH CMHC or ODADAS-certified provider;
 - payment of all other Medicaid-covered behavioral health services obtained through providers other than those who are ODMH CMHCs or ODADAS-certified providers when
-

arranged/authorized by the MCP.

Limitations:

- Pursuant to ORC Section 5111.16, alcohol, drug addiction and mental health services covered by Medicaid are not to be paid by the managed care program when the nonfederal share of the cost of those services is provided by a board of alcohol, drug addiction, and mental health services or a state agency other than ODJFS. As part of this limitation:
 - MCPs are not responsible for paying for behavioral health services provided through ODMH CMHCs and ODADAS-certified Medicaid providers;
 - MCPs are not responsible for payment of partial hospitalization (mental health), inpatient psychiatric care in a private or public free-standing inpatient psychiatric hospital, outpatient detoxification, intensive outpatient programs (IOP) (substance abuse) or methadone maintenance.
 - However, MCPs are required to cover the payment of physician services in a private or public free-standing psychiatric hospital when such services are billed independent of the hospital.

- iv. Pharmacy Benefit: In providing the Medicaid pharmacy benefit to their members, MCPs must cover the same drugs covered by the Ohio Medicaid fee-for-service program.

MCPs may establish a preferred drug list for members and providers which includes a listing of the drugs that they prefer to have prescribed. Preferred drugs requiring prior authorization approval must be clearly indicated as such. Pursuant to ORC §5111.172, ODJFS may approve MCP-specific pharmacy program utilization management strategies (see appendix G.3.a).

- v. Organ Transplants: MCPs must ensure coverage for organ transplants and related services in accordance with OAC 5101-3-2-07.1 (B)(4)&(5). Coverage for all organ transplant services, except kidney transplants, is contingent upon review and recommendation by the “Ohio Solid Organ Transplant Consortium” based on criteria established by Ohio organ transplant surgeons and authorization from the ODJFS prior authorization unit. Reimbursement for bone marrow transplant and hematopoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the “Ohio
-

Hematopoietic Stem Cell Transplant Consortium” again based on criteria established by Ohio experts in the field of bone marrow transplant. While MCPs may require prior authorization for these transplant services, the approval criteria would be limited to confirming the consumer is being considered and/or has been recommended for a transplant by either consortium and authorized by ODJFS. Additionally, in accordance with OAC 5101:3-2-03 (A)(4) all services related to organ donations are covered for the donor recipient when the consumer is Medicaid eligible.

3. Care Coordination

a. Utilization Management Programs

General Provisions — Pursuant to OAC rule 5101:3-26-03.1(A)(7), MCPs must implement a utilization management (UM) program to maximize the effectiveness of the care provided to members and may develop other UM programs, subject to prior approval by ODJFS. For the purposes of this requirement, the specific UM programs which require ODJFS prior-approval are an MCP’s general pharmacy program, a controlled substances and member management program, and any other program designed by the MCP with the purpose of redirecting or restricting access to a particular service or service location.

- i. Pharmacy Programs — Pursuant to ORC Sec. 5111.172 and OAC rule 5101:3-26-03(A) and (B), MCPs may, subject to ODJFS prior-approval, implement strategies for the management of pharmacy utilization. Pharmacy utilization management strategies may include developing preferred drug lists, requiring prior authorization for certain drugs, placing limitations on the type of provider and locations where certain medications may be administered, and developing and implementing a specialized pharmacy program to address the utilization of controlled substances, as defined in section 3719.01 of the Ohio Revised Code.

Drug Prior Authorizations: MCPs must receive prior approval from ODJFS for the medications that they wish to cover through prior authorization. MCPs must establish their prior authorization system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services. As outlined in paragraph 29(i)(ii)(f) of Appendix C, MCPs must adhere to specific prior-authorization limitations to assist with the transition of new ABD members from FFS Medicaid. MCPs must make their approved list of drugs covered only with prior authorization available to members and providers, as outlined in paragraphs 36(b) and (c) of Appendix C.

Beginning January 1, 2008, MCPs may require prior authorization for the coverage of antipsychotic drugs with ODJFS approval. MCPs must, however, allow any member to continue receiving a specific antipsychotic drug if the member is stabilized on that particular medication. The MCP must continue to cover that specific drug for the stabilized member for as long as that medication continues to be effective for the member. MCPs may also implement a drug utilization review program designed to promote the appropriate clinical prescribing of antipsychotic drugs. This can be accomplished through the MCP's retrospective analysis of drug claims to identify potential inappropriate use and provide education to those providers who are outliers to acceptable standards for prescribing/dispensing antipsychotic drugs.

MCPs must comply with the provisions of 1927(d)(5) of the Social Security Act, 42 USC 1396r-8(k)(3), and OAC rule 5101:3-26-03.1 regarding the timeframes for prior authorization of covered outpatient drugs.

Controlled Substances and Member Management Programs: MCPs may also, with ODJFS prior approval, develop and implement Controlled Substances and Member Management (CSMM) programs designed to address use of controlled substances. Utilization management strategies may include prior authorization as a condition of obtaining a controlled substance, as defined in section 3719.01 of the Ohio Revised Code. CSMM strategies may also include processes for requiring MCP members at high risk for fraud or abuse involving controlled substances to have their narcotic medications prescribed by a designated provider/providers and filled by a pharmacy, medical provider, or health care facility designated by the program.

- ii. Emergency Department Diversion (EDD) — MCPs must provide access to services in a way that assures access to primary, specialist and urgent care in the most appropriate settings and that minimizes frequent, preventable utilization of emergency department (ED) services. OAC rule 5101:3-26-03.1(A)(7)(d) requires MCPs to implement the ODJFS-required emergency department diversion (EDD) program for frequent utilizers.

Each MCP must establish an ED diversion (EDD) program with the goal of minimizing frequent ED utilization. The MCP's EDD program must include the monitoring of ED utilization, identification of frequent ED utilizers, and targeted approaches designed to reduce avoidable ED utilization. MCP EDD programs must, at a minimum, address those ED visits which could have been prevented through improved education,

access, quality or care management approaches.

Although there is often an assumption that frequent ED visits are solely the result of a preference on the part of the member and education is therefore the standard remedy, it is also important to ensure that a member's frequent ED utilization is not due to problems such as their PCP's lack of accessibility or failure to make appropriate specialist referrals. The MCP's EDD program must therefore also include the identification of providers who serve as PCPs for a substantial number of frequent ED utilizers and the implementation of corrective action with these providers as so indicated.

This requirement does not replace the MCP's responsibility to inform and educate all members regarding the appropriate use of the ED.

MCPs must also implement the ODJFS-required emergency department diversion (EDD) program for frequent users. In that ODJFS has developed the parameters for an MCP's EDD program, it therefore does not require ODJFS prior approval (Moved).

b. Integration of Member Care

The MCP must ensure that a discharge plan is in place to meet a member's health care needs following discharge from a nursing facility, and integrated into the member's continuum of care. The discharge plan must address the services to be provided for the member and must be developed prior to the date of discharge from the nursing facility. The MCP must ensure follow-up contact occurs with the member, or authorized representative, within thirty (30) days of the member's discharge from the nursing facility to ensure that the member's health care needs are being met.

c. Care Coordination with ODJFS-Designated Providers

Per OAC rule 5101:3-26-03.1(A)(4), MCPs are required to share specific information with certain ODJFS-designated non-contracting providers in order to ensure that these providers have been supplied with specific information needed to coordinate care for the MCP's members. Within the first month of operation, after an MCP has obtained a provider agreement, the MCP must provide to the ODJFS-designated providers (i.e., ODMH Community Mental Health Centers, ODADAS-certified Medicaid providers, FQHCs/RHCs, QFPs, CNMs, CNPs [if applicable], and hospitals) a quick reference information packet which includes the following:

- i. A brief cover letter explaining the purpose of the mailing; and
-

ii. A brief summary document that includes the following information:

- Claims submission information including the MCP's Medicaid provider number for each region;
- The MCP's prior authorization and referral procedures or the MCP's website;
- A picture of the MCP's member identification card (front and back);
- Contact numbers and/or website location for obtaining information for eligibility verification, claims processing, referrals/prior authorization, and information regarding the MCP's behavioral health administrator;
- A listing of the MCP's major pharmacy chains and the contact number for the MCP's pharmacy benefit administrator (PBM);
- A listing of the MCP's laboratories and radiology providers; and
- A listing of the MCP's contracting behavioral health providers and how to access services through them (this information is only to be provided to non-contracting community mental health and substance abuse providers).

d. Care coordination with Non-Contracting Providers

Per OAC rule 5101:3-26-05(A)(9), MCPs authorizing the delivery of services from a provider who does not have an executed subcontract must ensure that they have a mutually agreed upon compensation amount for the authorized service and notify the provider of the applicable provisions of paragraph D of OAC rule 5101:3-26-05. This notice is provided when an MCP authorizes a non-contracting provider to furnish services on a one-time or infrequent basis to an MCP member and must include required ODJFS-model language and information. This notice must also be included with the transition of services form sent to providers as outlined in paragraph 29.h. of Appendix C.

4. Case Management

In accordance with 5101:3-26-03.1(A)(8), MCPs must offer and provide comprehensive case management services which coordinate and monitor the care of members with specific diagnoses, or who require high-cost and/or extensive services.

- a. Each MCP must inform all members and contracting providers of the MCP's case management services.
 - b. The MCP must assure and coordinate the placement of the member into case management — including identification of the member's need for case management services, completion of the comprehensive health needs assessment, and timely development of a care treatment plan. This process must occur within the following timeframes for:
 - i. newly enrolled members – 90 days from the effective date of enrollment; and
 - ii. existing members – 90 days from identifying their need for case management.
 - c. The MCP's comprehensive case management program must include, at a minimum, the following components:
 - i. Identification –

The MCP must have mechanisms in place to identify members potentially eligible for case management services. These mechanisms must include an administrative data review (e.g. diagnosis, cost threshold, and/or service utilization) and may also include telephone interviews; provider/self-referrals; information as reported by the Managed Care Enrollment Center (MCEC) during membership selection; or home visits.
 - ii. Assessment -

The MCP must arrange for or conduct a comprehensive assessment of the member's physical and/or behavioral health condition(s) to confirm the results of a positive identification, and to determine the need for case management services. The goals of the assessment are to identify the member's existing and/or potential health care needs and assess the member's need for case management services.

The assessment must be completed by a physician, physician assistant, RN, LPN, licensed social worker, or a graduate of a two or four year allied health program. If the assessment is completed by another medical professional, there should be oversight and monitoring by either a registered nurse or a physician.

The MCP must have a process to inform members and their PCPs that they have been identified as meeting the criteria for case management, including their enrollment into case management services.

The MCP must develop a strategy to assign members to risk stratification levels, based on the member's comprehensive needs assessment.
 - iii. Care Treatment Plan –

The care treatment plan is defined by ODJFS as the one developed by the MCP for the member.
-

The development of the care treatment plan must be based on the comprehensive health assessment and reflect the member's primary medical diagnosis and health conditions, any comorbidities, and the member's psychological, behavioral health and community support needs. The care treatment plan must also include specific provisions for periodic reviews (i.e., no less than semi-annually) of the member's condition and appropriate updates to the plan. The member and the member's PCP must be actively involved in the development of and revisions to the care treatment plan. The designated PCP is the provider, or specialist, who will manage and coordinate the overall care for the member. Ongoing communication regarding the status of the care treatment plan may be accomplished between the MCP and the PCP's designee (i.e., qualified health professional). Revisions to the clinical portion of the care treatment plan should be completed in consultation with the PCP.

The elements of a comprehensive care treatment plan include:

Goals and actions that address medical, social, behavioral and psychological needs;

Member level interventions, (i.e., referrals and making appointments) that assist members in obtaining services, providers and programs;

Continuous review, revision and contact follow-up, as needed, to ensure the care treatment plan is adequately monitored including the following:

- Documentation that services are provided in accordance with the care treatment plan;
- Re-evaluation to determine if the care treatment plan is adequate to meet the member's current needs;
- Identification of gaps between recommended care and actual care provided;
- A change in needs or status from the re-evaluation that requires revisions to the care treatment plan;
- Active participation by the member or representative in the care treatment plan development;
- Monitoring of specific service delivery including service utilization; and
- Re-evaluation of a member's risk stratification level with adjustment to the level of case management services provided.

iv. Coordination of Care and Communication

There should be an accountable point of contact at the MCP for each member in case management who can help obtain medically necessary care, assist with health-related services and coordinate care needs, including behavioral health. The MCP must arrange or provide for professional case management services that are performed collaboratively by a team of professionals appropriate for the member's condition and health care needs. At a minimum, the MCP's case manager must attempt to coordinate with the member's case manager from other

health systems, including behavioral health. The MCP must have a process to facilitate, maintain, and coordinate both care and communication with the member, PCP, and other service providers and case managers. The MCP must also have a process to coordinate care for a member that is receiving services from state sub-recipient agencies as appropriate [e.g., the Ohio Department of Mental Health (ODMH); the Ohio Department of Mental Retardation and Developmental Disabilities (ODMR/DD); and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS)].

The MCP must have a provision to disseminate information to the member/caregiver concerning the health condition, types of services that may be available, and how to access services.

The MCP must implement mechanisms to notify all Members with Special Health Care Needs of their right to directly access a specialist. Such access may be assured through, for example, a standing referral or an approved number of visits, and documented in the care treatment plan.

v. ODJFS Targeted Case Management Conditions

The MCP **must**, at a minimum, case manage members with the following physical and behavioral health conditions:

- Congestive Heart Failure
- Coronary Artery Disease
- Non-Mild Hypertension
- Diabetes
- Chronic Obstructive Pulmonary Disease
- Asthma
- Severe mental illness
- High risk or high cost substance abuse disorders
- Severe cognitive and/or developmental limitation

The MCP must also case manage any member enrolled in an MCP's CSMM as specified in section G(3)(a)(i).

The MCP should also focus on all members whose health conditions warrant case management services and should not limit these services only to members with these conditions (e.g., cystic fibrosis, cerebral palsy and sickle cell anemia).

Refer to *Appendix M* for the performance measures and standards related to case management.

vi. Case Management Program Staffing

The MCP must identify the staff that will be involved in the operations of the case management program, including but not limited to: case manager supervisors, case managers, and administrative support staff. The MCP must identify the role and functions of each case management staff member as well as the educational

requirements, clinical licensure standards, certification and relevant experience with case management standards and/or activities. The MCP must provide case manager staff/member ratios based on the member risk stratification and different levels of care being provided to members.

vii. Case Management Strategies

The MCP must follow best-practice and/or evidence based clinical guidelines when devising a member's care treatment plan and coordinating the case management needs. If an MCP uses a disease management methodology to identify and/or stratify members in need of case management services, the methods must be validated by scientific research and/or nationally accepted in the health care industry.

The MCP must develop and implement mechanisms to educate and equip providers and case managers with evidence-based clinical guidelines or best practice approaches to assist in providing a high level of quality of care to members.

viii. Information Technology System for Case Management

The MCP's information technology system for its case management program must maximize the opportunity for communication between the plan, PCP, the member, and other service providers and case managers. The MCP must have an integrated database that allows MCP staff that may be contacted by a member in case management to have immediate access to, and review of, the most recent information with the MCP's information systems relevant to the case. The integrated database may include the following: administrative data, call center communications, service authorizations, care treatment plans, patient assessments, case management notes, and PCP notes. The information technology system must also have the capability to share relevant information with the member, the PCP, and other service providers and case managers.

ix. Data Submission

The MCP must submit a monthly electronic report to the Case Management System (CAMS) for all members that are case managed. In order for a member to be submitted as case managed in CAMS, the MCP must: (1) complete the identification process, a comprehensive health needs assessment and development of a care treatment plan for the member; and (2) document the member's written or verbal confirmation of his/her case management status in the case management record. ODJFS, or its designated entity, the external quality review vendor, will validate on an annual basis the accuracy of the information contained in CAMS with the member's case management record. The CAMS files are due the 10th business day of each month.

d. Annual Case Management Program Submission

The MCP must have an ODJFS-approved case management program which includes the items in Section 4. Each MCP must implement an evaluation process

to review, revise and/or update the case management program. The MCP must annually submit its case management program for review and approval by ODJFS. Any subsequent changes to an approved case management program description must be submitted to ODJFS in writing for review and approval prior to implementation.

APPENDIX H
PROVIDER PANEL SPECIFICATIONS
ABD ELIGIBLE POPULATION

1. GENERAL PROVISIONS

MCPs must provide or arrange for the delivery of all medically necessary, Medicaid-covered health services, as well as assure that they meet all applicable provider panel requirements for their entire designated service area. The ODJFS provider panel requirements are specified in the charts included with this appendix and must be met prior to the MCP receiving a provider agreement with ODJFS. The MCP must remain in compliance with these requirements for the duration of the provider agreement.

If an MCP is unable to provide the medically necessary, Medicaid-covered services through their contracted provider panel, the MCP must ensure access to these services on an as needed basis. For example, if an MCP meets the gastroenterologist requirement but a member is unable to obtain a timely appointment from a gastroenterologist on the MCP's provider panel, the MCP will be required to secure an appointment from a panel gastroenterologist or arrange for an out-of-panel referral to a gastroenterologist.

MCPs are **required** to make transportation available to any member requesting transportation when they **must** travel 30 miles or more from their home to receive a medically-necessary Medicaid-covered service. If the MCP offers transportation to their members as an additional benefit and this transportation benefit only covers a limited number of trips, the required transportation listed above may **not** be counted toward this trip limit (as specified in Appendix C).

In developing the provider panel requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Aged, Blind or Disabled (ABD) consumers, as well as the potential availability of the designated provider types. ODJFS has integrated existing utilization patterns into the provider network requirements to avoid disruption of care. Most provider panel requirements are county-specific but in certain circumstances, ODJFS requires providers to be located anywhere in the region. Although all provider types listed in this appendix are required provider types, only those listed on the attached charts must be submitted for ODJFS prior approval.

2. PROVIDER SUBCONTRACTING

Unless otherwise specified in this appendix or OAC rule 5101:3-26-05, all MCPs are required to enter into fully-executed subcontracts with their providers. These subcontracts must include a baseline contractual agreement, as well as the appropriate ODJFS-approved Model Medicaid Addendum. The Model Medicaid Addendum incorporates all applicable Ohio

Administrative Code rule requirements specific to provider subcontracting and therefore cannot be modified except to add personalizing information such as the MCP's name.

ODJFS must prior approve all MCP providers in the ODJFS- required provider type categories before they can begin to provide services to that MCP's members. MCPs may not employ or contract with providers excluded from participation in Federal health care programs under either section 1128 or section 1128A of the Social Security Act. As part of the prior approval process, MCPs must submit documentation verifying that all necessary contract documents have been appropriately completed. ODJFS will verify the approvability of the submission and process this information using the ODJFS Provider Verification System (PVS), or other designated process. The PVS is a centralized database system that maintains information on the status of all MCP-submitted providers.

Only those providers who meet the applicable criteria specified in this document, and as determined by ODJFS, will be approved by ODJFS. MCPs must credential/recredential providers in accordance with the standards specified by the National Committee for Quality Assurance (or receive approval from ODJFS to use an alternate industry standard) and must have completed the credentialing review before submitting any provider to ODJFS for approval. Regardless of whether ODJFS has approved a provider, the MCP must ensure that the provider has met all applicable credentialing criteria before the provider can render services to the MCP's members.

MCPs must notify ODJFS of the addition and deletion of their contracting providers as specified in OAC rule 5101:3-26-05, and must notify ODJFS within one working day in instances where the MCP has identified that they are not in compliance with the provider panel requirements specified in this appendix.

3. PROVIDER PANEL REQUIREMENTS

The provider network criteria that must be met by each MCP are as follows:

a. Primary Care Providers (PCPs)

Primary Care Provider (PCP) means an individual physician (M.D. or D.O.), certain physician group practice/clinic (Primary Care Clinics [PCCs]), or an advanced practice nurse (APN) as defined in ORC 4723.43 or advanced practice nurse group practice within an acceptable specialty, contracting with an MCP to provide services as specified in paragraph (B) of OAC rule 5101: 3-26-03.1. Acceptable specialty types for PCPs include family/general practice, internal medicine, pediatrics, and obstetrics/gynecology (OB/GYN). Acceptable PCCs include FQHCs, RHCs and the acceptable group practices/clinics specified by ODJFS. As part of their subcontract with an MCP, PCPs must stipulate the total Medicaid member capacity that they can ensure for that individual MCP. Each PCP must have the capacity and agree to serve at least 50 Medicaid members at each practice site in order to be approved by ODJFS as a PCP. The

capacity-by-site requirement must be met for all ODJFS-approved PCPs.

ODJFS reviews the capacity totals for each PCP to determine if they appear excessive. ODJFS reserves the right to request clarification from an MCP for any PCP whose total stated capacity for all MCP networks added together exceeds 2000 Medicaid members (i.e., 1 FTE). ODJFS may allow up to an additional 750 member capacity for each nurse practitioner or physician's assistant that is used to provide clinical support for a PCP.

For PCPs contracting with more than one MCP, the MCP must ensure that the capacity figure stated by the PCP in their subcontract reflects only the capacity the PCP intends to provide for that one MCP. ODJFS utilizes each approved PCP's capacity figure to determine if an MCP meets the provider panel requirements and this stated capacity figure does not prohibit a PCP from actually having a caseload that exceeds the capacity figure indicated in their subcontract.

ODJFS expects that MCPs will need to utilize specialty physicians to serve as PCPs for some special needs members. In these situations it will not be necessary for the MCP to submit these specialists to the PVS database, or other system, as PCPs, however, they must be submitted to PVS, or other system, as the appropriate required provider type. Also, in some situations (e.g., continuity of care) a PCP may only want to serve a very small number of members for an MCP. In these situations it will not be necessary for the MCP to submit these PCPs to ODJFS for prior approval. These PCPs will not be included in the ODJFS PVS database, or other system and therefore may not appear as PCPs in the MCP's provider directory. These PCPs will, however, need to execute a subcontract with the MCP which includes the appropriate Model Medicaid Addendum.

The PCP requirement is based on an MCP having sufficient PCP capacity to serve 40% of the eligibles in the region if three MCPs are serving the region and 55% of the eligibles in the region if two MCPs are serving the region. Each MCP must meet the PCP minimum FTE requirement for that region. MCPs must also satisfy a PCP geographic accessibility standard. ODJFS will match the PCP practice sites and the stated PCP capacity with the geographic location of the eligible population in that region (on a county-specific basis) and perform analysis using Geographic Information Systems (GIS) software. The analysis will be used to determine if at least 40% of the eligible population is located within 10 miles of a PCP with available capacity in urban counties and 40% of the eligible population within 30 miles of a PCP with available capacity in rural counties. [Rural areas are defined pursuant to 42 CFR 412.62(f)(1)(iii).]

Until July 1, 2008, MCPs may only use PCPs who are individual physicians (M.D. or D.O.), physician group practices, or PCCs to meet capacity and FTE requirements.

b. Non-PCP Provider Network

In addition to the PCP capacity requirements, each MCP is also required to maintain adequate capacity in the remainder of its provider network within the following categories: hospitals,

cardiovascular, dentists, gastroenterology, nephrology, neurology, oncology, physical medicine, podiatry, psychiatry, urology, vision care providers, obstetricians/gynecologists (OB/GYNs), allergists, general surgeons, otolaryngologists, orthopedists, federally qualified health centers (FQHCs)/rural health centers (RHCs) and qualified family planning providers (QFPPs). CNMs, CNPs, FQHCs/RHCs and QFPPs are federally-required provider types.

All Medicaid-contracting MCPs must provide all medically-necessary Medicaid-covered services to their members and therefore their complete provider network will include many other additional specialists and provider types. MCPs must ensure that all non-PCP network providers follow community standards in the scheduling of routine appointments (i.e., the amount of time members must wait from the time of their request to the first available time when the visit can occur).

Although there are currently no capacity requirements for the non-PCP required provider types, MCPs are required to ensure that adequate access is available to members for all required provider types. Additionally, for certain non-PCP required provider types, MCPs must ensure that these providers maintain a full-time practice at a site(s) located in the specified county/region (i.e., the ODJFS-specified county within the region or anywhere within the region if no particular county is specified). A full-time practice is defined as one where the provider is available to patients at their practice site(s) in the specified county/region for at least 25 hours a week. ODJFS will monitor access to services through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures.

Hospitals — MCPs must contract with the number and type of hospitals specified by ODJFS for each county/region. In developing these hospital requirements, ODJFS considered, on a county-by-county basis, the population size and utilization patterns of the Aged, Blind or Disabled (ABD) consumers and integrated the existing utilization patterns into the hospital network requirements to avoid disruption of care. For this reason, ODJFS may require that MCPs contract with out-of-state hospitals (i.e. Kentucky, West Virginia, etc.).

For each Ohio hospital, ODJFS utilizes the hospital's most current Annual Hospital Registration and Planning Report, as filed with the Ohio Department of Health, in verifying types of services that hospital provides. Although ODJFS has the authority, under certain situations, to obligate a non-contracting hospital to provide non-emergency hospital services to an MCP's members, MCPs must still contract with the specified number and type of hospitals unless ODJFS approves a provider panel exception (see Section 4 of this appendix — Provider Panel Exceptions).

If an MCP-contracted hospital elects not to provide specific Medicaid-covered hospital services because of an objection on moral or religious grounds, the MCP must ensure that these hospital services are available to its members through another MCP-contracted hospital in the specified county/region.

OB/GYNs - MCPs must contract with the specified number of OB/GYNs for each county/region, all of whom must maintain a full-time obstetrical practice at a site(s) located in the specified county/region. Only MCP-contracting OB/GYNs with current hospital delivery privileges at a hospital under contract with the MCP in the region can be submitted to the PVS, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory.

Certified Nurse Midwives (CNMs) and Certified Nurse Practitioners (CNPs) - MCPs must ensure access to CNM and CNP services in the region if such provider types are present within the region. The MCP may contract directly with the CNM or CNP providers, or with a physician or other provider entity who is able to obligate the participation of a CNM or CNP. If an MCP does not contract for CNM or CNP services and such providers are present within the region, the MCP will be required to allow members to receive CNM or CNP services outside of the MCP's provider network.

Only CNMs with hospital delivery privileges at a hospital under contract to the MCP in the region can be submitted to the PVS, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory. The MCP must ensure a member's access to CNM and CNP services if such providers are practicing within the region.

Vision Care Providers — MCPs must contract with the specified number of ophthalmologists/optometrists for each specified county/region, all of whom must maintain a full-time practice at a site(s) located in the specified county/region. All ODJFS-approved vision providers must regularly perform routine eye exams. (MCPs will be expected to contract with an adequate number of ophthalmologists as part of their overall provider panel, but only ophthalmologists who regularly perform routine eye exams can be used to meet the vision care provider panel requirement.) If optical dispensing is not sufficiently available in a region through the MCP's contracting ophthalmologists/optometrists, the MCP must separately contract with an adequate number of optical dispensers located in the region.

Dental Care Providers - MCPs must contract with the specified number of dentists.

Federally Qualified Health Centers/Rural Health Clinics (FQHCs/RHCs) - MCPs are required to ensure member access to any federally qualified health center or rural health clinic (FQHCs/RHCs), regardless of contracting status. Contracting FQHC/RHC providers must be submitted for ODJFS approval via the PVS process, or other designated process. Even if no FQHC/RHC is available within the region, MCPs must have mechanisms in place to ensure coverage for FQHC/RHC services in the event that a member accesses these services outside of the region.

In order to ensure that any FQHC/RHC has the ability to submit a claim to ODJFS for the state's supplemental payment, MCPs must offer FQHCs/RHCs reimbursement pursuant to the following:

- MCPs must provide expedited reimbursement on a service-specific basis in an amount no less than the payment made to other providers for the same or similar service.
- If the MCP has no comparable service-specific rate structure, the MCP must use the regular Medicaid fee-for-service payment schedule for non-FQHC/RHC providers.
- MCPs must make all efforts to pay FQHCs/RHCs as quickly as possible and not just attempt to pay these claims within the prompt pay time frames.

MCPs are required to educate their staff and providers on the need to assure member access to FQHC/RHC services.

Qualified Family Planning Providers (QFPPs) — All MCP members must be permitted to self-refer to family planning services provided by a QFPP. A QFPP is defined as any public or not-for-profit health care provider that complies with Title X guidelines/standards, and receives either Title X funding or family planning funding from the Ohio Department of Health. MCPs must reimburse all medically-necessary Medicaid-covered family planning services provided to eligible members by a QFPP provider (including on-site pharmacy and diagnostic services) on a patient self-referral basis, regardless of the provider's status as a panel or non-panel provider. MCPs will be required to work with QFPPs in the region to develop mutually-agreeable HIPAA compliant policies and procedures to preserve patient/provider confidentiality, and convey pertinent information to the member's PCP and/or MCP.

Behavioral Health Providers— MCPs must assure member access to all Medicaid-covered behavioral health services for members as specified in Appendix G.b.ii. herein. Although ODJFS is aware that certain outpatient substance abuse services may only be available through Medicaid providers certified by the Ohio Department of Drug and Alcohol Addiction Services (ODADAS) in some areas, MCPs must maintain an adequate number of contracted mental health providers in the region to assure access for members who are unable to timely access services or unwilling to access services through community mental health centers. MCPs are advised not to contract with community mental health centers as all services they provide to MCP members are to be billed to ODJFS.

Other Specialty Types (general surgeons, otolaryngologists, orthopedists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists) - MCPs must contract with the specified number of all other ODJFS designated specialty provider types. In order to be counted toward meeting the provider panel requirements, these specialty providers must maintain a full-time practice at a site(s) located within the specified county/region. Only contracting general surgeons, orthopedists, otolaryngologists, cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists with admitting privileges at a hospital

under contract with the MCP in the region can be submitted to the PVS, or other system, count towards MCP minimum panel requirements, and be listed in the MCPs' provider directory.

4. PROVIDER PANEL EXCEPTIONS

ODJFS may specify provider panel criteria for a service area that deviates from that specified in this appendix if:

- the MCP presents sufficient documentation to ODJFS to verify that they have been unable to meet or maintain certain provider panel requirements in a particular service area despite all reasonable efforts on their part to secure such a contract(s), and
- if notified by ODJFS, the provider(s) in question fails to provide a reasonable argument why they would not contract with the MCP, and
- the MCP presents sufficient assurances to ODJFS that their members will have adequate access to the services in question.

If an MCP is unable to contract with or maintain a sufficient number of providers to meet the ODJFS-specified provider panel criteria, the MCP may request an exception to these criteria by submitting a provider panel exception request as specified by ODJFS. ODJFS will review the exception request and determine whether the MCP has sufficiently demonstrated that all reasonable efforts were made to obtain contracts with providers of the type in question and that they will be able to provide access to the services in question.

ODJFS will aggressively monitor access to all services related to the approval of a provider panel exception request through a variety of data sources, including: consumer satisfaction surveys; member appeals/grievances/complaints and state hearing notifications/requests; member just-cause for termination requests; clinical quality studies; encounter data volume; provider complaints, and clinical performance measures. ODJFS approval of a provider panel exception request does not exempt the MCP from assuring access to the services in question. If ODJFS determines that an MCP has not provided sufficient access to these services, the MCP may be subject to sanctions.

5. PROVIDER DIRECTORIES

MCP provider directories must include all MCP-contracted providers [except as specified by ODJFS] as well as certain non-contracted providers. At the time of ODJFS' review, the information listed in the MCP's provider directory for all ODJFS-required provider types specified on the attached charts must exactly match the data currently on file in the ODJFS PVS, or other designated process.

MCP provider directories must utilize a format specified by ODJFS. Directories may be region-specific or include multiple regions, however, the providers within the directory must be divided by region, county, and provider type, in that order.

The directory must also specify:

- provider address(es) and phone number(s);
- an explanation of how to access providers (e.g. referral required vs. self-referral);
- an indication of which providers are available to members on a self-referral basis;
- foreign-language speaking PCPs and specialists and the specific foreign language(s) spoken;
- how members may obtain directory information in alternate formats that takes into consideration the special needs of eligible individuals including but not limited to, visually-limited, LEP, and LRP eligible individuals; and
- any PCP or specialist practice limitations.

Printed Provider Directory

Prior to receiving a provider agreement, all MCPs must develop a printed provider directory that shall be prior-approved by ODJFS for each population. For example, an MCP who serves CFC and ABD in the Central Region would have two provider directories, one for CFC and one for ABD. Once approved, this directory may be regularly updated with provider additions or deletions by the MCP without ODJFS prior-approval, however, copies of the revised directory (or inserts) must be submitted to ODJFS prior to distribution to members.

On a quarterly basis, MCPs **must** create an insert to each printed directory that lists those providers **deleted** from the MCP's provider panel during the previous three months. Although this insert does not need to be prior approved by ODJFS, copies of the insert must be submitted to ODJFS two weeks prior to distribution to members.

Internet Provider Directory

MCPs are required to have an internet-based provider directory available in the same format as their ODJFS-approved printed directory. This internet directory must allow members to electronically search for MCP panel providers based on name, provider type, and geographic proximity, and population (e.g. CFC and/or ABD). If an MCP has one internet-based directory for multiple populations, each provider must include a description of which population they serve.

The internet directory may be updated at any time to include providers who are **not** one of the ODJFS-required provider types listed on the charts included with this appendix. ODJFS-required providers **must** be added to the internet directory within one week of the MCP's notification of ODJFS-approval of the provider via the Provider Verification process. Providers

being deleted from the MCP's panel must be deleted from the internet directory within one week of notification from the provider to the MCP. These deleted providers must be included in the inserts to the MCP's provider directory referenced above.

6. FEDERAL ACCESS STANDARDS

MCPs must demonstrate that they are in compliance with the following federally defined provider panel access standards as required by 42 CFR 438.206:

In establishing and maintaining their provider panel, MCPs must consider the following:

- The anticipated Medicaid membership.
- The expected utilization of services, taking into consideration the characteristics and health care needs of specific Medicaid populations represented in the MCP.
- The number and types (in terms of training, experience, and specialization) of panel providers required to deliver the contracted Medicaid services.
- The geographic location of panel providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members, and whether the location provides physical access for Medicaid members with disabilities.
- MCPs must adequately and timely cover services to an out-of-network provider if the MCP's contracted provider panel is unable to provide the services covered under the MCP's provider agreement. The MCP must cover the out-of-network services for as long as the MCP network is unable to provide the services. MCPs must coordinate with the out-of-network provider with respect to payment and ensure that the provider agrees with the applicable requirements.

Contracting providers must offer hours of operation that are no less than the hours of operation offered to commercial members or comparable to Medicaid fee-for-service, if the provider serves only Medicaid members. MCPs must ensure that services are available 24 hours a day, 7 days a week, when medically necessary. MCPs must establish mechanisms to ensure that panel providers comply with timely access requirements, and must take corrective action if there is failure to comply.

In order to demonstrate adequate provider panel capacity and services, 42 CFR 438.206 and 438.207 stipulates that the MCP must submit documentation to ODJFS, in a format specified by ODJFS, that demonstrates it offers an appropriate range of preventive, primary care and specialty services adequate for the anticipated number of members in the service area, while maintaining a provider panel that is sufficient in number, mix, and geographic distribution to meet the needs of the number of members in the service area.

This documentation of assurance of adequate capacity and services must be submitted to ODJFS no less frequently than at the time the MCP enters into a contract with ODJFS; at any time there is a significant change (as defined by ODJFS) in the MCP's operations that would affect adequate capacity and services (including changes in services, benefits, geographic service or payments); and at any time there is enrollment of a new population in the MCP.

APPENDIX J
FINANCIAL PERFORMANCE
ABD ELIGIBLE POPULATION

Molina

1. SUBMISSION OF FINANCIAL STATEMENTS AND REPORTS

MCPs must submit the following financial reports to ODJFS:

- a. The National Association of Insurance Commissioners (NAIC) quarterly and annual Health Statements (hereafter referred to as the “Financial Statements”), as outlined in Ohio Administrative Code (OAC) rule 5101:3-26-09(B). The Financial Statements must include all required Health Statement filings, schedules and exhibits as stated in the NAIC Annual Health Statement Instructions including, but not limited to, the following sections: Assets, Liabilities, Capital and Surplus Account, Cash Flow, Analysis of Operations by Lines of Business, Five-Year Historical Data, and the Exhibit of Premiums, Enrollment and Utilization. The Financial Statements must be submitted to BMHC even if the Ohio Department of Insurance (ODI) does not require the MCP to submit these statements to ODI. A signed hard copy and an electronic copy of the reports in the NAIC-approved format must both be provided to ODJFS;
 - b. Hard copies of annual financial statements for those entities who have an ownership interest totaling five percent or more in the MCP or an indirect interest of five percent or more, or a combination of direct and indirect interest equal to five percent or more in the MCP;
 - c. Annual audited Financial Statements prepared by a licensed independent external auditor as submitted to the ODI, as outlined in OAC rule 5101:3- 26-09(B);
 - d. Medicaid Managed Care Plan Annual Ohio Department of Job and Family Services (ODJFS) Cost Report and the auditor’s certification of the cost report, as outlined in OAC rule 5101:3-26-09(B);
 - e. Medicaid MCP Annual Restated Cost Report for the prior calendar year. The restated cost report shall be audited upon BMHC request;
 - f. Annual physician incentive plan disclosure statements and disclosure of and changes to the MCP’s physician incentive plans, as outlined in OAC rule 5101:3-26-09(B);
 - g. Reinsurance agreements, as outlined in OAC rule 5101:3-26-09(C);
-

- h. Prompt Pay Reports, in accordance with OAC rule 5101:3-26-09(B). A hard copy and an electronic copy of the reports in the ODJFS-specified format must be provided to ODJFS;
- i. Notification of requests for information and copies of information released pursuant to a tort action (i.e., third party recovery), as outlined in OAC rule 5101:3-26-09.1;
- j. Financial, utilization, and statistical reports, when ODJFS requests such reports, based on a concern regarding the MCP's quality of care, delivery of services, fiscal operations or solvency, in accordance with OAC rule 5101:3-26-06(D);
- k. In accordance with ORC Section 5111.76 and Appendix C, MCP Responsibilities, MCPs must submit ODJFS-specified franchise fee reports in hard copy and electronic formats pursuant to ODJFS specifications.

2. FINANCIAL PERFORMANCE MEASURES AND STANDARDS

This Appendix establishes specific expectations concerning the financial performance of MCPs. In the interest of administrative simplicity and nonduplication of areas of the ODI authority, ODJFS' emphasis is on the assurance of access to and quality of care. ODJFS will focus only on a limited number of indicators and related standards to monitor plan performance. The three indicators and standards for this contract period are identified below, along with the calculation methodologies. The source for each indicator will be the NAIC Quarterly and Annual Financial Statements.

Report Period: Compliance will be determined based on the annual Financial Statement.

- a. **Indicator: Net Worth as measured by Net Worth Per Member**

Definition: Net Worth = Total Admitted Assets minus Total Liabilities divided by Total Members across all lines of business

Standard: For the financial report that covers calendar year 2008, a minimum net worth per member of \$172.00, as determined from the annual Financial Statement submitted to ODI and the ODJFS.

The Net Worth Per Member (NWPM) standard is the Medicaid Managed Care Capitation amount paid to the MCP during the preceding calendar year, excluding the at-risk amount, expressed as a per-member per-month figure, multiplied by the applicable proportion below:

0.75 if the MCP had a total membership of 100,000 or more during that calendar year

0.90 if the MCP had a total membership of less than 100,000 for that calendar year

If the MCP did not receive Medicaid Managed Care Capitation payments during the preceding calendar year, then the NWPM standard for the MCP is the average Medicaid Managed Care capitation amount paid to Medicaid-contracting MCPs during the preceding calendar year, excluding the at-risk amount, multiplied by the applicable proportion above.

b. Indicator: Administrative Expense Ratio

Definition: Administrative Expense Ratio = Administrative Expenses minus Franchise Fees divided by Total Revenue minus Franchise Fees

Standard: Administrative Expense Ratio not to exceed 15%, as determined from the annual Financial Statement submitted to ODI and ODJFS.

c. Indicator: Overall Expense Ratio

Definition: Overall Expense Ratio = The sum of the Administrative Expense Ratio and the Medical Expense Ratio

Administrative Expense Ratio = Administrative Expenses minus Franchise Fees divided by Total Revenue minus Franchise Fees

Medical Expense Ratio = Medical Expenses divided by Total Revenue minus Franchise Fees

Standard: Overall Expense Ratio not to exceed 100% as determined from the annual Financial Statement submitted to ODI and ODJFS.

Penalty for noncompliance: Failure to meet any standard on 2.a., 2.b., or 2.c. above will result in ODJFS requiring the MCP to complete a corrective action plan (CAP) and specifying the date by which compliance must be demonstrated. Failure to meet the standard or otherwise comply with the CAP by the specified date will result in a new membership freeze unless ODJFS determines that the deficiency does not potentially jeopardize access to or quality of care or affect the MCP's ability to meet administrative requirements (e.g., prompt pay requirements). Justifiable reasons for noncompliance may include one-time events (e.g., MCP investment in information system products).

If the financial statement is not submitted to ODI by the due date, the MCP continues to be obligated to submit the report to ODJFS by ODI's originally

specified due date unless the MCP requests and is granted an extension by ODJFS.

Failure to submit complete quarterly and annual Financial Statements on a timely basis will be deemed a failure to meet the standards and will be subject to the noncompliance penalties listed for indicators 2.a., 2.b., and 2.c., including the imposition of a new membership freeze. The new membership freeze will take effect at the first of the month following the month in which the determination was made that the MCP was non-compliant for failing to submit financial reports timely.

In addition, ODJFS will review two liquidity indicators if a plan demonstrates potential problems in meeting related administrative requirements or the standards listed above. The two standards, 2.d and 2.e, reflect ODJFS' expected level of performance. At this time, ODJFS has not established penalties for noncompliance with these standards; however, ODJFS will consider the MCP's performance regarding the liquidity measures, in addition to indicators 2.a., 2.b., and 2.c., in determining whether to impose a new membership freeze, as outlined above, or to not issue or renew a contract with an MCP. The source for each indicator will be the NAIC Quarterly and annual Financial Statements.

Long-term investments that can be liquidated without significant penalty within 24 hours, which a plan would like to include in Cash and Short-Term Investments in the next two measurements, must be disclosed in footnotes on the NAIC Reports. Descriptions and amounts should be disclosed. Please note that "significant penalty" for this purpose is any penalty greater than 20%. Also, enter the amortized cost of the investment, the market value of the investment, and the amount of the penalty.

d. Indicator: Days Cash on Hand

Definition: Days Cash on Hand = Cash and Short-Term Investments divided by (Total Hospital and Medical Expenses plus Total Administrative Expenses) divided by 365.

Standard: Greater than 25 days as determined from the annual Financial Statement submitted to ODI and ODJFS.

e. Indicator: Ratio of Cash to Claims Payable

Definition: Ratio of Cash to Claims Payable = Cash and Short-Term Investments divided by claims Payable (reported and unreported).

Standard: Greater than 0.83 as determined from the annual Financial Statement submitted to ODI and ODJFS.

3. REINSURANCE REQUIREMENTS

Pursuant to the provisions of OAC rule 5101:3-26-09 (C), each MCP must carry reinsurance coverage from a licensed commercial carrier to protect against inpatient-related medical expenses incurred by Medicaid members.

The annual deductible or retention amount for such insurance must be specified in the reinsurance agreement and must not exceed \$75,000.00, except as provided below. Except for transplant services, and as provided below, this reinsurance must cover, at a minimum, 80% of inpatient costs incurred by one member in one year, in excess of \$75,000.00.

For transplant services, the reinsurance must cover, at a minimum, 50% of inpatient transplant related costs incurred by one member in one year, in excess of \$75,000.00.

An MCP may request a higher deductible amount and/or that the reinsurance cover less than 80% of inpatient costs in excess of the deductible amount. If the MCP does not have more than 75,000 members in Ohio, but does have more than 75,000 members between Ohio and other states, ODJFS may consider alternate reinsurance arrangements. However, depending on the corporate structures of the Medicaid MCP, other forms of security may be required in addition to reinsurance. These other security tools may include parental guarantees, letters of credit, or performance bonds. In determining whether or not the request will be approved, the ODJFS may consider any or all of the following:

- a. whether the MCP has sufficient reserves available to pay unexpected claims;
- b. the MCP's history in complying with financial indicators 2.a., 2.b., and 2.c., as specified in this Appendix;
- c. the number of members covered by the MCP;
- d. how long the MCP has been covering Medicaid or other members on a full risk basis;
- e. risk based capital ratio of 2.5 or higher calculated from the last annual ODI financial statement;
- f. graph/chart showing the claims history for reinsurance above the previously approved deductible from the last calendar year.

The MCP has been approved to have a reinsurance policy with a deductible amount of \$400,000 that covers 80% of inpatient costs in excess of the deductible amount for non-transplant services.

Penalty for noncompliance: If it is determined that an MCP failed to have reinsurance coverage, that an MCP's deductible exceeds \$75,000.00 without approval from ODJFS, or that the MCP's reinsurance for non-transplant services covers less than 80% of inpatient costs in excess of the deductible incurred by one member for one year without approval from ODJFS, then the MCP will be required to pay a monetary penalty to ODJFS. The amount of the penalty will be the difference between the estimated amount, as determined by ODJFS, of what the MCP would have paid in premiums for the reinsurance policy if it had been in compliance and what the MCP did actually pay while it was out of compliance plus 5%. For example, if the MCP paid \$3,000,000.00 in premiums during the period of non-compliance and would have paid \$5,000,000.00 if the requirements had been met, then the penalty would be \$2,100,000.00.

If it is determined that an MCP's reinsurance for transplant services covers less than 50% of inpatient costs incurred by one member for one year, the MCP will be required to develop a corrective action plan (CAP).

4. PROMPT PAY REQUIREMENTS

In accordance with 42 CFR 447.46, MCPs must pay 90% of all submitted clean claims within 30 days of the date of receipt and 99% of such claims within 90 days of the date of receipt, unless the MCP and its contracted provider(s) have established an alternative payment schedule that is mutually agreed upon and described in their contract. The prompt pay requirement applies to the processing of both electronic and paper claims for contracting and non-contracting providers by the MCP and delegated claims processing entities.

The date of receipt is the date the MCP receives the claim, as indicated by its date stamp on the claim. The date of payment is the date of the check or date of electronic payment transmission. A claim means a bill from a provider for health care services that is assigned a unique identifier. A claim does not include an encounter form.

A "claim" can include any of the following: (1) a bill for services; (2) a line item of services; or (3) all services for one recipient within a bill. A "clean claim" is a claim that can be processed without obtaining additional information from the provider of a service or from a third party.

Clean claims do not include payments made to a provider of service or a third party where the timing of payment is not directly related to submission of a completed claim by the provider of service or third party (e.g., capitation). A clean claim also does not include a claim from a provider who is under investigation for fraud or abuse, or a claim under review for medical necessity.

Penalty for noncompliance: Noncompliance with prompt pay requirements will result in progressive penalties to be assessed on a quarterly basis, as outlined in Appendix N of the Provider Agreement.

5. PHYSICIAN INCENTIVE PLAN DISCLOSURE REQUIREMENTS

MCPs must comply with the physician incentive plan requirements stipulated in 42 CFR 438.6(h) . If the MCP operates a physician incentive plan, no specific payment can be made directly or indirectly under this physician incentive plan to a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

If the physician incentive plan places a physician or physician group at substantial financial risk [as determined under paragraph (d) of 42 CFR 422.208] for services that the physician or physician group does not furnish itself, the MCP must assure that all physicians and physician groups at substantial financial risk have either aggregate or per-patient stop-loss protection in accordance with paragraph (f) of 42 CFR 422.208, and conduct periodic surveys in accordance with paragraph (h) of 42 CFR 422.208.

In accordance with 42 CFR 417.479 and 42 CFR 422.210, MCPs must maintain copies of the following required documentation and submit to ODJFS annually, no later than 30 days after the close of the state fiscal year and upon any modification of the MCP's physician incentive plan:

- a. A description of the types of physician incentive arrangements the MCP has in place which indicates whether they involve a withhold, bonus, capitation, or other arrangement. If a physician incentive arrangement involves a withhold or bonus, the percent of the withhold or bonus must be specified.
 - b. A description of information/data feedback to a physician/group on their: 1) adherence to evidence-based practice guidelines; and 2) positive and/or negative care variances from standard clinical pathways that may impact outcomes or costs. The feedback information may be used by the MCP for activities such as physician performance improvement projects that include incentive programs or the development of quality improvement initiatives.
 - c. A description of the panel size for each physician incentive plan. If patients are pooled, then the pooling method used to determine if substantial financial risk exists must also be specified.
 - d. If more than 25% of the total potential payment of a physician/group is at risk for referral services, the MCP must maintain a copy of the results of the required patient satisfaction survey and documentation verifying that the physician or physician group has adequate stop-loss protection, including the type of coverage (e.g., per member per year, aggregate), the
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threshold amounts, and any coinsurance required for amounts over the threshold.

Upon request by a member or a potential member and no later than 14 calendar days after the request, the MCP must provide the following information to the member: (1) whether the MCP uses a physician incentive plan that affects the use of referral services; (2) the type of incentive arrangement; (3) whether stop-loss protection is provided; and (4) a summary of the survey results if the MCP was required to conduct a survey. The information provided by the MCP must adequately address the member's request.

6. NOTIFICATION OF REGULATORY ACTION

Any MCP notified by the ODI of proposed or implemented regulatory action must report such notification and the nature of the action to ODJFS no later than one working day after receipt from ODI. The ODJFS may request, and the MCP must provide, any additional information as necessary to assure continued satisfaction of program requirements. MCPs may request that information related to such actions be considered proprietary in accordance with established ODJFS procedures. Failure to comply with this provision will result in an immediate membership freeze.

APPENDIX K
QUALITY ASSESSMENT AND PERFORMANCE IMPROVEMENT PROGRAM
AND
EXTERNAL QUALITY REVIEW
ABD ELIGIBLE POPULATION

1. As required by federal regulation, 42 CFR 438.240, each managed care plan (MCP) must have an ongoing Quality Assessment and Performance Improvement Program (QAPI) that is annually prior-approved by the Ohio Department of Job and Family Services (ODJFS). The program must include the following elements:

a. PERFORMANCE IMPROVEMENT PROJECTS

Each MCP must conduct performance improvement projects (PIPs), including those specified by ODJFS. PIPs must achieve, through periodic measurements and intervention, significant and sustained improvement in clinical and non-clinical areas which are expected to have a favorable effect on health outcomes and satisfaction. MCPs must adhere to ODJFS PIP content and format specifications.

All ODJFS-specified PIPs must be prior-approved by ODJFS. As part of the external quality review organization (EQRO) process, the EQRO will assist MCPs with conducting PIPs by providing technical assistance and will annually validate the PIPs. In addition, the MCP must annually submit to ODJFS the status and results of each PIP.

ODJFS will identify the clinical and/or non-clinical study topics for the SFY 2009 Provider Agreement. Initiation of the PIPs will begin in the second year of participation in the ABD Medicaid managed care program.

b. UNDER- AND OVER-UTILIZATION

Each MCP must have mechanisms in place to detect under- and over-utilization of health care services. The MCP must specify the mechanisms used to monitor utilization in its annual submission of the QAPI program to ODJFS.

It should also be noted that pursuant to the program integrity provisions outlined in Appendix I, MCPs must monitor for the potential under-utilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any under-utilized services are identified, the MCP must immediately investigate and correct the problem(s) which resulted in such under-utilization of services.

The MCP must conduct an ongoing review of service denials and must monitor utilization on an ongoing basis in order to identify services which may be under-utilized.

c. SPECIAL HEALTH CARE NEEDS

Each MCP must have mechanisms in place to assess the quality and appropriateness of care furnished to members with special health care needs. The MCP must specify the mechanisms used in its annual submission of the QAPI program to ODJFS.

d. SUBMISSION OF PERFORMANCE MEASUREMENT DATA

Each MCP must submit clinical performance measurement data as required by ODJFS that enables ODJFS to calculate standard measures. Refer to Appendix M "Performance Evaluation" for a more comprehensive description of the clinical performance measures.

Each MCP must also submit clinical performance measurement data as required by ODJFS that uses standard measures as specified by ODJFS. MCPs will be required to submit Health Employer Data Information Set (HEDIS) audited data for measures that will be identified by ODJFS for the SFY 2009 Provider Agreement.

The measures must have received a "report" designation from the HEDIS certified auditor and must be specific to the Medicaid population. Data must be submitted annually and in an electronic format. Data will be used for MCP clinical performance monitoring and will be incorporated into comparative reports developed by the EQRO.

Initiation of submission of performance data will begin in the second year of participation in the Medicaid managed care program.

e. QAPI PROGRAM SUBMISSION

Each MCP must implement an evaluation process to review, revise, and/or update the QAPI program. The MCP must annually submit its QAPI program for review and approval by ODJFS.

2. EXTERNAL QUALITY REVIEW

In addition to the following requirements, MCPs must participate in external quality review activities as outlined in OAC 5101:3-26-07.

a. EQRO ADMINISTRATIVE REVIEWS

The EQRO will conduct annual focused administrative compliance assessments for each MCP which will include, but not be limited to, the following domains as specified by ODJFS: member rights and services, QAPI program, case management, provider networks, grievance system, coordination and continuity of care, and utilization management. In addition, the EQRO will complete a comprehensive administrative compliance assessment every three (3) years as required by 42 CFR 438.358 and specified by ODJFS.

In accordance with 42 CFR 438.360 and 438.362, MCPs with accreditation from a national accrediting organization approved by the Centers for Medicare and Medicaid Services (CMS) may request a non-duplication exemption from certain specified components of the administrative review. Non-duplication exemptions may not be requested for SFY 2008.

b. EXTERNAL QUALITY REVIEW PERFORMANCE

In accordance with OAC rule 5101:3-26-07, each MCP must participate in an annual external quality review survey. If the EQRO cites a deficiency in performance, the MCP will be required to complete a Corrective Action Plan (e.g., ODJFS technical assistance session) or Quality Improvement Directives depending on the severity of the deficiency. (An example of a deficiency is if an MCP fails to meet certain clinical or administrative standards as supported by national evidence-based guidelines or best practices.) Serious deficiencies may result in immediate termination or non-renewal of the provider agreement. These quality improvement measures recognize the importance of ongoing MCP performance improvement related to clinical care and service delivery.

APPENDIX L
DATA QUALITY
ABD ELIGIBLE POPULATION

A high level of performance on the data quality measures established in this appendix is crucial in order for the Ohio Department of Job and Family Services (ODJFS) to determine the value of the Aged, Blind or Disabled (ABD) Medicaid Managed Health Care program and to evaluate Medicaid consumers' access to and quality of services. Data collected from MCPs are used in key performance assessments such as the external quality review, clinical performance measures, utilization review, care coordination and case management, and in determining incentives. The data will also be used in conjunction with the cost reports in setting the premium payment rates. The following measures, as specified in this appendix, will be calculated per MCP and include all Ohio Medicaid members receiving services from the MCP (i.e., Covered Families and Children (CFC) and ABD membership, if applicable): Incomplete Outpatient Hospital Data, Rejected Encounters, Acceptance Rate, Encounter Data Accuracy, and Generic Provider Number Usage.

Data sets collected from MCPs with data quality standards include: encounter data; case management data; data used in the external quality review; members' PCP data; and appeal and grievance data.

1. ENCOUNTER DATA

For detailed descriptions of the encounter data quality measures below, see *ODJFS Methods for the ABD and CFC Medicaid Managed Care Programs Data Quality Measures*.

1.a. Encounter Data Completeness

Each MCP's encounter data submissions will be assessed for completeness. The MCP is responsible for collecting information from providers and reporting the data to ODJFS in accordance with program requirements established in Appendix C, *MCP Responsibilities*. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with other performance standards.

1.a.i. Encounter Data Volume

Measure: The volume measure for each service category, as listed in Table 2 below, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM) for the ABD program. The measure will be calculated per MCP.

Report Period: The report periods for the SFY 2008 and SFY 2009 contract periods are listed in Table 1. below.

Table 1. Report Periods for the SFY 2008 and 2009 Contract Periods

Report Period	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 1 2007	July 2007	August 2007	
Qtr 1, Qtr 2 2007	October 2007	November 2007	
Qtr 1 thru Qtr 3 2007	January 2008	February 2008	SFY 2008
Qtr 1 thru Qtr 4 2007	April 2008	May 2008	
Qtr 1 thru Qtr 4 2007, Qtr 1 2008	July 2008	August 2008	
Qtr 1 thru Qtr 4 2007, Qtr 1, Qtr 2 2008	October 2008	November 2008	
Qtr 1 thru Qtr 4 2007, Qtr 1 thru Qtr 3 2008	January 2009	February 2009	SFY 2009
Qtr 1 thru Qtr 4 2007, Qtr 1 thru Qtr 4 2008	April 2009	May 2009	
Qtr1 = January to March Qtr2 = April to June Qtr3 = July to September Qtr 4 = October to December			

Data Quality Standard: The utilization rate for all service categories listed in Table 2 must be equal to or greater than the interim standards established in Table 2. below (Interim Standards - Encounter Data Volume).

Statewide Approach: Prior to establishment of statewide minimum performance standards, ODJFS will evaluate MCP performance using the interim standards for Encounter data volume. ODJFS will use the first four quarters of data (i.e., full calendar year quarters) from all MCPs serving ABD program membership to determine statewide minimum encounter volume data quality standards.

Table 2. Interim Standards — Encounter Data Volume

Category	Measure per 1,000/MM	Standard for Dates of Service on or after 1/1/2007	Description
Inpatient Hospital	Discharges	2.7	General/acute care, excluding newborns and mental health and chemical dependency services
Emergency Department		25.3	Includes physician and hospital emergency department encounters
Dental		25.5	Non-institutional and hospital dental visits
Vision	Visits	5.3	Non-institutional and hospital outpatient optometry and ophthalmology visits
Primary and Specialist Care		116.6	Physician/practitioner and hospital outpatient visits
Ancillary Services		66.8	Ancillary visits
Behavioral Health	Service	5.2	Inpatient and outpatient behavioral encounters
Pharmacy	Prescriptions	246.1	Prescribed drugs

Determination of Compliance: Performance is monitored once every quarter for the entire report period. If the standard is not met for every service category in all quarters of the report period, then the MCP will be determined to be noncompliant for the report period.

Penalty for noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for three consecutive quarters, membership will be frozen. Once the MCP is determined to be compliant with the standard and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

1.a.ii. Incomplete Outpatient Hospital Data

ODJFS will be monitoring, on a quarterly basis, the percentage of hospital encounters which contain a revenue code and CPT/HCPCS code. A CPT/HCPCS code must accompany certain revenue center codes. These codes are listed in Appendix B of Ohio Administrative Code rule 5101:3-2-21 (fee-for-service outpatient hospital policies) and in the methods for calculating the completeness measures.

Measure: The percentage of outpatient hospital line items with certain revenue center codes, as explained above, which had an accompanying valid procedure (CPT/HCPCS) code. The measure will be calculated per MCP.

Report Period: The report periods for the SFY 2008 and SFY 2009 contract periods are listed in Table 3. below.

Table 3. Report Periods for the SFY 2008 and 2009 Contract Periods

Quarterly Report Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 3 & Qtr 4 2004, 2005, 2006 Qtr 1 2007	July 2007	August 2007	
Qtr 3 & Qtr 4 2004, 2005, 2006 Qtr 1, Qtr 2 2007	October 2007	November 2007	SFY 2008
Qtr 4 2004, 2005, 2006 Qtr 1 thru Qtr 3 2007	January 2008	February 2008	
Qtr 1 thru Qtr 4: 2005, 2006, 2007	April 2008	May 2008	
Qtr 2 thru Qtr 4 2005, Qtr 1 thru Qtr 4: 2006, 2007 Qtr 1 2008	July 2008	August 2008	
Qtr 3, Qtr 4: 2005, Qtr 1 thru Qtr 4: 2006, 2007 Qtr 1, Qtr 2 2008	October 2008	November 2008	SFY 2009
Qtr 4: 2005, Qtr 1 thru Qtr 4: 2006, 2007 Qtr 1 thru Qtr 3: 2008	January 2009	February 2009	
Qtr 1 thru Qtr 4: 2006, 2007, 2008	April 2009	May 2009	
Qtr1 = January to March	Qtr2 = April to June	Qtr3 = July to September	Qtr4 = October to December

Data Quality Standard: The data quality standard is a minimum rate of 95%.

Determination of Compliance: Performance is monitored once every quarter for all report periods. For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

Penalty for noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction.

Upon all subsequent quarterly measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6) of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.a.iii. Rejected Encounters

Encounters submitted to ODJFS that are incomplete or inaccurate are rejected and reported back to the MCPs on the Exception Report. If an MCP does not resubmit rejected encounters, ODJFS' encounter data set will be incomplete.

Measure 1 only applies to MCPs that have had Medicaid membership for more than one year.

Measure 1: The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

Report Period: For the SFY 2008 contract period, performance will be evaluated using the following report periods July - September 2007; October - December 2007; January - March 2008; April - June 2008. For the SFY 2009 contract period, performance will be evaluated using the following report periods July - September 2008; October - December 2008; January - March 2009; April - June 2009.

Data Quality Standard for measure 1: Data Quality Standard 1 is a maximum encounter data rejection rate of 10% for each file in the ODJFS-specified medium per format. The measure will be calculated per MCP.

Files in the ODJFS-specified medium per format that are totally rejected will not be considered in the determination of noncompliance.

Determination of Compliance: Performance is monitored once every quarter. Compliance determination with the standard applies only to the quarter under consideration and does not include performance in previous quarters.

Penalty for noncompliance with the Data Quality Standard for measure 1: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of one percent of the current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance.

Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

Measure 2 only applies to MCPs that have had Medicaid membership for one year or less.

Measure 2: The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP.

Report Period: The report period for Measure 2 is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

Data Quality Standard for measure 2: The data quality standard is a maximum encounter data rejection rate for each file in the ODJFS-specified medium per format as follows:

Third through sixth month with membership:	50%
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Seventh through twelfth month with membership:	25%
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Files in the ODJFS-specified medium per format that are totally rejected will not be considered in the determination of noncompliance.

Determination of Compliance: Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous quarters.

Penalty for Noncompliance with the Data Quality Standard for measure 2: If the MCP is determined to be noncompliant for either standard, ODJFS will impose a monetary sanction of one

percent of the MCP's current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. The monetary sanction will be applied only once per file type per compliance determination period and will not exceed a total of two percent of the MCP's current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. Special consideration will be made for MCPs with less than 1,000 members.

1.a.iv. Acceptance Rate

This measure only applies to MCPs that have had Medicaid membership for one year or less.

Measure: The rate of encounters that are submitted to ODJFS and accepted (i.e. accepted encounters per 1,000 member months). The measure will be calculated per MCP.

Report Period: The report period for this measure is monthly. Results are calculated and performance is monitored monthly. The first reporting month begins with the third month of enrollment.

Data Quality Standard: The data quality standard is a monthly minimum accepted rate of encounters for each file in the ODJFS-specified medium per format as follows:

Third through sixth month with membership:

50 encounters per 1,000 MM for NCPDP
65 encounters per 1,000 MM for NSF
20 encounters per 1,000 MM for UB-92

Seventh through twelfth month of membership:

250 encounters per 1,000 MM for NCPDP
350 encounters per 1,000 MM for NSF
100 encounters per 1,000 MM for UB-92

Determination of Compliance: Performance is monitored once every month. Compliance determination with the standard applies only to the month under consideration and does not include performance in previous months.

Penalty for Noncompliance: If the MCP is determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one percent of the MCP's current month's premium payment. The monetary sanction will be applied for each file type in the ODJFS-specified medium per format that is determined to be out of compliance. The monetary sanction will be applied only once per file type per compliance determination period and will not exceed a total of two percent of

the MCP's current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. Special consideration will be made for MCPs with less than 1,000 members.

1.a.v. Informational Encounter Data Completeness Measure

The 'Incomplete Data for Last Menstrual Period' measure is informational only for the ABD population. Although there is no minimum performance standard for this measure, results will be reported and used as one component in monitoring the quality of data submitted to ODJFS by the MCPs.

1.b. Encounter Data Accuracy

As with data completeness, MCPs are responsible for assuring the collection and submission of accurate data to ODJFS. Failure to do so jeopardizes MCPs' performance, credibility and, if not corrected, will be assumed to indicate a failure in actual performance.

1.b.i. Encounter Data Accuracy Study

Measure: This accuracy study will compare the accuracy and completeness of payment data stored in MCPs' claims systems during the study period to payment data submitted to and accepted by ODJFS. The measure will be calculated per MCP.

Payment information found in MCPs' claims systems for paid claims that does not match payment information found on a corresponding encounter will be counted as omissions.

Report Period: In order to provide timely feedback on the omission rate of encounters, the report period will be the most recent from when the measure is initiated. This measure is conducted annually.

Data Quality Standard for Measure: TBD for SFY 2008 and SFY 2009.

Penalty for Noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction.

Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.b.ii. Generic Provider Number Usage

Measure: This measure is the percentage of non-pharmacy encounters with the generic provider number. Providers submitting claims which do not have an MMIS provider number must be submitted to ODJFS with the generic provider number 9111115. The measure will be calculated per MCP.

All other encounters are required to have the MMIS provider number of the servicing provider. The report period for this measure is quarterly.

Report Period: For the SFY 2008 and SFY 2009 contract period, performance will be evaluated using the report periods listed in 1.a.iii., Table 3.

Data Quality Standard: A maximum generic provider number usage rate of 10%.

Determination of Compliance: Performance is monitored once every quarter for all report periods. For quarterly reports that are issued on or after July 1, 2007, an MCP will be determined to be noncompliant for the quarter if the standard is not met in any report period and the initial instance of noncompliance in a report period is determined on or after July 1, 2007. An initial instance of noncompliance means that the result for the applicable report period was in compliance as determined in the prior quarterly report, or the instance of noncompliance is the first determination for an MCP's first quarter of measurement.

Penalty for noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 6.) of three percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.c. Timely Submission of Encounter Data

1.c.i. Timeliness

ODJFS recommends submitting encounters no later than thirty-five days after the end of the month in which they were paid. ODJFS does not monitor standards specifically for timeliness, but the minimum claims volume (Section 1.a.i.) and the rejected encounter (Section 1.a.iv.) standards are based on encounters being submitted within this time frame.

1.c.ii. Submission of Encounter Data Files in the ODJFS-specified medium per format

Information concerning the proper submission of encounter data may be obtained from the *ODJFS Encounter Data File Submission Specifications* document. The MCP must submit a letter of certification, using the form required by ODJFS, with each encounter data file in the ODJFS-specified medium per format.

The letter of certification must be signed by the MCP's Chief Executive Officer (CEO), Chief Financial Officer (CFO), or an individual who has delegated authority to sign for, and who reports directly to, the MCP's CEO or CFO.

2. CASE MANAGEMENT DATA

ODJFS designed a case management system (CAMS) in order to monitor MCP compliance with program requirements specified in Appendix G, *Coverage and Services*. Each MCP's case management data submissions will be assessed for completeness and accuracy. The MCP is responsible for submitting a case management file every month. Failure to do so jeopardizes the MCP's ability to demonstrate compliance with case management requirements. For detailed descriptions of the case management measures below, see *ODJFS Methods for the ABD and CFC Medicaid Managed Care Programs Data Quality Measures*.

2.a. Case Management System Data Accuracy

2.a.i. Open Case Management Spans for Disenrolled Members (*this measure will be discontinued as of January 2008*)

Measure: The percentage of the MCP's case management records in CAMS for the ABD program that have open case management date spans for members who have disenrolled from the MCP.

Report Period: For the third and fourth quarters of SFY 2007, January - March 2007, and April - June 2007 report periods. For the SFY 2008 contract period, July - September 2007, and October - December 2007 report periods.

Data Quality Standard: A rate of open case management spans for disenrolled members of no more than 1.0%.

Statewide Approach: MCPs will be evaluated using a statewide result specific for the ABD program, including all regions in which an MCP has ABD membership. An MCP will not be evaluated until the MCP has at least 3,000 ABD members statewide. As the ABD Medicaid managed care program expands statewide and regions become active in different months, statewide results will

include every region in which an MCP has membership [Example: MCP AAA has: 6,000 members in the South West region beginning in January 2007; 7,000 members in the West Central region beginning in February 2007; and 8,000 members in the South East region beginning in March 2007. MCP AAA's statewide results for the April-June 2007 report period will include data for the South West, West Central, and South East regions.]

Penalty for noncompliance: If an MCP is noncompliant with the standard, then the ODJFS will issue a Sanction Advisory informing the MCP that a monetary sanction will be imposed if the MCP is noncompliant for any future report periods. Upon all subsequent semi-annual measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction of one-half of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

2.b. Timely Submission of Case Management Files

Data Quality Submission Requirement: The MCP must submit Case Management files on a monthly basis according to the specifications established in *ODJFS' Case Management File and Submission Specifications*.

Penalty for noncompliance: See Appendix N, *Compliance Assessment System*, for the penalty for noncompliance with this requirement.

3. EXTERNAL QUALITY REVIEW DATA

In accordance with federal law and regulations, ODJFS is required to conduct an independent quality review of contracting managed care plans. The OAC rule 5101:3-26-07(C) requires MCPs to submit data and information as requested by ODJFS or its designee for the annual external quality review.

Two information sources are integral to these studies: encounter data and medical records. Because encounter data is used to draw samples for these studies, quality must be sufficient to ensure valid sampling.

An adequate number of medical records must then be retrieved from providers and submitted to ODJFS or its designee in order to generalize results to all applicable members. To aid MCPs in achieving the required medical record submittal rate, ODJFS will give at least an eight week period to retrieve and submit medical records.

3.a. Independent External Quality Review

Measure: The percentage of requested records for a study conducted by the External Quality Review Organization (EQRO) that are submitted by the managed care plan.

Report Period: The report period is one year. Results are calculated and performance is monitored annually. Performance is measured with each review.

Data Quality Standard: A minimum record submittal rate of 85% for each clinical measure.

Penalty for noncompliance for Data Quality Standard: For each study that is completed during this contract period, if an MCP is noncompliant with the standard, ODJFS will impose a non-refundable \$10,000 monetary sanction.

4. MEMBERS' PCP DATA

The designated PCP is the provider who will manage and coordinate the overall care for ABD members including those who have case management needs. The MCP must submit a Members' Designated PCP file every month. Specialists may and should be identified as the PCP as appropriate for the member's condition per the specialty types specified for the ABD population in *ODJFS Member's PCP Data File and Submission Specifications*; however, no ABD member may have more than one PCP identified for a given month.

4.a. Timely submission of Member's PCP Data

Data Quality Submission Requirement: The MCP must submit a Members' Designated PCP Data files on a monthly basis according to the specifications established in *ODJFS Member's PCP Data File and Submission Specifications*.

Penalty for noncompliance: See Appendix N, Compliance Assessment System, for the penalty for noncompliance with this requirement.

4.b. Designated PCP for newly enrolled members (applicable for report periods prior to January 2008)

Measure: The percentage of MCP's newly enrolled members who were designated a PCP by their effective date of enrollment.

Report Periods: For the third and fourth quarters of SFY 2007 contract period, performance will be evaluated quarterly using the January — March 2007 and April — June 2007 report periods. For the SFY 2008 contract period, performance will be evaluated quarterly using the July-September 2007, and October — December 2007 report periods.

Data Quality Standard: A minimum rate of 65% of new members with PCP designation by

their effective date of enrollment for quarter 3 and quarter 4 of SFY 2007. A minimum rate of 75% of new members with PCP designation by their effective date of enrollment for quarter 1 and quarter 2 of SFY 2008.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has ABD membership. An MCP will not be evaluated until the MCP has at least 3,000 ABD members statewide.

Penalty for noncompliance: If an MCP is noncompliant with the standard, ODJFS will impose a monetary sanction of one-half of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. As stipulated in OAC rule 5101:3-26-08.2, each new member must have a designated primary care provider (PCP) prior to their effective date of coverage. Therefore, MCPs are subject to additional corrective action measures under Appendix N, Compliance Assessment System, for failure to meet this requirement.

4.b.i. Designated PCP for newly enrolled members (*applicable for report periods after December 2007*)

Measure: The percentage of MCP's newly enrolled members who were designated a PCP by their effective date of enrollment.

Report Periods: For the SFY 2009 contract period, performance will be evaluated annually using CY 2008.

Data Quality Standards: For SFY 2009, a minimum rate of 85% of new members with PCP designation by their effective date of enrollment.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has ABD membership. An MCP will not be evaluated until the MCP has at least 3,000 ABD members statewide.

Penalty for noncompliance: If an MCP is noncompliant with the standard, ODJFS will impose a monetary sanction of one-half of one percent of the current month's premium payment. Once the MCP is performing at standard levels and violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. As stipulated in OAC rule 5101:3-26-08.2, each new member must have a designated primary care provider (PCP) prior to their effective date of coverage. Therefore, MCPs are subject to additional corrective action measures under Appendix N, Compliance Assessment System, for failure to meet this requirement.

5. APPEALS AND GRIEVANCES DATA

Pursuant to OAC rule 5101:3-26-08.4, MCPs are required to submit information at least monthly to ODJFS regarding appeal and grievance activity. ODJFS requires these submissions to be in an electronic data file format pursuant to the *Appeal File and Submission Specifications* and *Grievance File and Submission Specifications*.

The appeal data file and the grievance data file must include all appeal and grievance activity, respectively, for the previous month, and must be submitted by the ODJFS-specified due date. These data files must be submitted in the ODJFS-specified format and with the ODJFS-specified filename in order to be successfully processed.

Penalty for noncompliance: MCPs who fail to submit their monthly electronic data files to the ODJFS by the specified due date or who fail to resubmit, by no later than the end of that month, a file which meets the data quality requirements will be subject to penalty as stipulated under the Compliance Assessment System (Appendix N).

6. NOTES

6.a. Penalties, Including Monetary Sanctions, for Noncompliance

Penalties for noncompliance with standards outlined in this appendix, including monetary sanctions, will be imposed as the results are finalized. With the exception of Sections 1.a.i., 1.a.iii., 1.a.iv., 1.a.v., and 1.b.ii no monetary sanctions described in this appendix will be imposed if the MCP is in its first contract year of Medicaid program participation. Notwithstanding the penalties specified in this Appendix, ODJFS reserves the right to apply the most appropriate penalty to the area of deficiency identified when an MCP is determined to be noncompliant with a standard. Monetary penalties for noncompliance with any individual measure, as determined in this appendix, shall not exceed \$300,000 during each evaluation.

Refundable monetary sanctions will be based on the premium payment in the month of the cited deficiency and due within 30 days of notification by ODJFS to the MCP of the amount.

Any monies collected through the imposition of such a sanction will be returned to the MCP (minus any applicable collection fees owed to the Attorney General's Office, if the MCP has been delinquent in submitting payment) after the MCP has demonstrated full compliance with the particular program requirement and the violations/deficiencies are resolved to the satisfaction of ODJFS. If an MCP does not comply within two years of the date of notification of noncompliance, then the monies will not be refunded.

6.b. Combined Remedies

If ODJFS determines that one systemic problem is responsible for multiple deficiencies, ODJFS may impose a combined remedy which will address all areas of deficient performance. The total fines assessed in any one month will not exceed 15% of the MCP's monthly premium payment for the Ohio Medicaid program.

6.c. Membership Freezes

MCPs found to have a pattern of repeated or ongoing noncompliance may be subject to a membership freeze.

6.d. Reconsideration

Requests for reconsideration of monetary sanctions and enrollment freezes may be submitted as provided in Appendix N, *Compliance Assessment System*.

6.e. Contract Termination, Nonrenewals, or Denials

Upon termination either by the MCP or ODJFS, nonrenewal, or denial of an MCP provider agreement, all previously collected refundable monetary sanctions will be retained by ODJFS.

APPENDIX M
PERFORMANCE EVALUATION
ABD ELIGIBLE POPULATION

This appendix establishes minimum performance standards for managed care plans (MCPs) in key program areas, under the Agreement. Standards are subject to change based on the revision or update of applicable national standards, methods, benchmarks, or other factors as deemed relevant. Performance will be evaluated in the categories of Quality of Care, Access, Consumer Satisfaction, and Administrative Capacity. Each performance measure has an accompanying minimum performance standard. MCPs with performance levels below the minimum performance standards will be required to take corrective action. All performance measures, as specified in this appendix, will be calculated per MCP and include only members in the ABD Medicaid managed care program. Selected measures in this appendix will be used to determine incentives as specified in *Appendix O, Pay for Performance (P4P)*.

1. QUALITY OF CARE

1.a. Independent External Quality Review

In accordance with federal law and regulations, state Medicaid agencies must annually provide for an external quality review of the quality outcomes and timeliness of, and access to, services provided by Medicaid-contracting MCPs [(42 CFR 438.204(d))]. The external review assists the state in assuring MCP compliance with program requirements and facilitates the collection of accurate and reliable information concerning MCP performance.

Measure: The independent external quality review covers a review of clinical and non-clinical performance as outlined in Appendix K.

Report Period: Performance will be evaluated using the reviews conducted during SFY 2008.

Action Required for Deficiencies: For all reviews conducted during the contract period, if the EQRO cites a deficiency in performance the MCP will be required to complete a Corrective Action Plan or Quality Improvement Directive, depending on the severity of the deficiency. Serious deficiencies may result in immediate termination or non-renewal of the Agreement.

1.b. Members with Special Health Care Needs (MSHCN)

Given the substantial proportion of members with chronic conditions and co-morbidities in the ABD population, one of the quality of care initiatives of the ABD Medicaid managed care program focuses on case management. In order to ensure state compliance with the provisions of 42 CFR 438.208, the Bureau of Managed Health Care established Members with Special Health Care Needs (MSHCN) basic program requirements as set forth in Appendix G, *Coverage and Services* of the

Agreement, and corresponding minimum performance standards as described below. The purpose of these measures is to provide appropriate and targeted case management services to MSHCN who have specific diagnoses and/or who require high-cost or extensive services. Given the expedited schedule for implementing the ABD Medicaid managed care program, coupled with the challenges facing a new Medicaid program in the State of Ohio, the minimum performance standards for the case management requirements for MSHCN are phased in throughout SFY 2007 and SFY 2008. The minimum standards for these performance measures will be fully phased in by no later than SFY 2009. For detailed methodologies of each measure, see *ODJFS Methods for the ABD Medicaid Managed Care Program's Case Management Performance Measures*.

1.b.i Case Management of Members

Measure: The average monthly case management rate for members who have at least three months of consecutive enrollment in one MCP.

Report Period: For the SFY 2007 contract period, April — June 2007 report period. For the SFY 2008 contract period, July — September 2007, October — December 2007, January — March 2008, and April — June 2008 report periods. For the SFY 2009 contract period, July — September 2008, October — December 2008, January — March 2009, and April — June 2009 report periods.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership. An MCP will not be evaluated until the MCP has at least 3,000 members statewide who have had at least three months of continuous enrollment during each month of the entire report period. As the ABD Medicaid managed care program expands statewide and regions become active in different months, statewide results will include every region in which an MCP has membership [Example: MCP AAA has: 6,000 members in the South West region beginning in January 2007; 7,000 members in the West Central region beginning in February 2007; and 8,000 members in the South East region beginning in March 2007. MCP AAA's statewide results for the April-June 2007 report period will include case management rates for all members who meet minimum continuous enrollment criteria for this measure in: the South West region for April 2007's monthly rate calculation; the South West and West Central regions for May 2007's monthly rate calculation; and the South West, West Central, and South East regions for June 2007's monthly rate calculation.]

Statewide Target: For the first and second quarters of SFY 2008, a case management rate of 30%. For the third and fourth quarters of SFY 2008, a case management rate of 35%. For the first and second quarters of SFY 2009, a case management rate of 40%. For the third and fourth quarters of SFY 2009, a case management rate of 45%.

Statewide Minimum Performance Standard: The level of improvement must result in at least a 20% decrease in the difference between the target and the previous report period's results.

Penalty for Noncompliance: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be

noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 5) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for a subsequent quarter, new member selection freezes or a reduction of assignments will occur as outlined in Appendix N of the Provider Agreement. Once the MCP is performing at standard levels and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

1.b.ii. Case Management of Members with an ODJFS-Mandated Condition

Measure 1: The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of asthma who have had at least three consecutive months of enrollment in one MCP that are case managed.

Measure 2: The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of chronic obstructive pulmonary disease who have had at least three consecutive months of enrollment in one MCP that are case managed.

Measure 3: The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of congestive heart failure who have had at least three consecutive months of enrollment in one MCP that are case managed.

Measure 4: The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS mandated case management condition of behavioral health who have had at least three consecutive months of enrollment in one MCP that are case managed.

Measure 5: The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of diabetes who have had at least three consecutive months of enrollment in one MCP that are case managed.

Measure 6: The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of non-mild hypertension who have had at least three consecutive months of enrollment in one MCP that are case managed.

Measure 7: The percent of members with a positive identification through an ODJFS administrative review of data for the ODJFS-mandated case management condition of coronary arterial disease who have had at least three consecutive months of enrollment in one MCP that are case managed.

Report Periods for Measures 1- 7: For the SFY 2007 contract period April — June 2007 report periods. For the SFY 2008 contract period, July — September 2007, October — December 2007, January — March 2008, and April — June 2008 report periods. For the SFY 2009 contract period, July — September 2008, October — December 2008, January — March 2009, and April — June 2009 report periods.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership. An MCP will not be evaluated until the MCP has at least 3,000 members statewide who have had at least three months of continuous enrollment during each month of the entire report period. As the ABD Medicaid managed care programs expands statewide and regions become active in different months, statewide results will include every region in which an MCP has membership [Example: MCP AAA has: 6,000 members in the South West region beginning in January 2007; 7,000 members in the West Central region beginning in February 2007; and 8,000 members in the South East region beginning in March 2007. MCP AAA's statewide results for the April-June 2007 report period will include case management rates for all members in the South West, West Central, and South East regions who are identified through the administrative data review as having a mandated condition and are continuously enrolled for at least three consecutive months in one MCP.]

Statewide Target for Measures 1, 2, 3, 5, 6, and 7: For the first and second quarters of SFY 2008, a case management rate of 60%. For the third and fourth quarters of SFY 2008, a case management rate of 65%. For SFY 2009, a case management rate of 75%.

Statewide Minimum Performance Standard: The level of improvement must result in at least a 20% decrease in the difference between the target and the previous report period's results.

Statewide Target for Measure 4: For the first and second quarters of SFY 2008, a case management rate of 30%. For the third and fourth quarters of SFY 2008, a case management rate of 35%. For SFY 2009, the case management rate is TBD.

Statewide Minimum Performance Standard: The level of improvement must result in at least a 20% decrease in the difference between the target and the previous report period's results.

Penalty for Noncompliance for Measures 1-7: The first time an MCP is noncompliant with a standard for this measure, ODJFS will issue a Sanction Advisory informing the MCP that any future noncompliance instances with the standard for this measure will result in ODJFS imposing a monetary sanction. Upon all subsequent measurements of performance, if an MCP is again determined to be noncompliant with the standard, ODJFS will impose a monetary sanction (see Section 5) of two percent of the current month's premium payment. Monetary sanctions will not be levied for consecutive quarters that an MCP is determined to be noncompliant. If an MCP is noncompliant for a subsequent quarter, new member selection freezes or a reduction of assignments will occur as outlined in Appendix N of the Provider Agreement. Once the MCP is performing at standard levels and the violations/deficiencies are resolved to the satisfaction of ODJFS, the penalties will be lifted, if applicable, and monetary sanctions will be returned.

1.c. Clinical Performance Measures

MCP performance will be assessed based on the analysis of submitted encounter data for each year. For certain measures, standards are established; the identification of these standards is not intended to limit the assessment of other indicators for performance improvement activities. Performance on multiple measures will be assessed and reported to the MCPs and others, including Medicaid consumers.

The clinical performance measures described below closely follow the National Committee for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS). NCQA may annually change its method for calculating a measure. These changes can make it difficult to evaluate whether improvement occurred from a prior year. For this reason, ODJFS will use the same methods to calculate the baseline results and the results for the period in which the MCP is being held accountable. For example, the same methods are used to calculate calendar year 2008 results (the baseline period) and calendar year 2009 results. The methods will be updated and a new baseline will be created during 2009 for calendar year 2010 results. These results will then serve as the baseline to evaluate whether improvement occurred from calendar year 2009 to calendar year 2010. Clinical performance measure results will be calculated after a sufficient amount of time has passed after the end of the report period in order to allow for claims runout. For a comprehensive description of the clinical performance measures below, see *ODJFS Methods for Clinical Performance Measures, ABD Medicaid Managed Care Program*. Performance standards are subject to change, based on the revision or update of NCQA methods or other national standards, methods or benchmarks.

MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership. ODJFS will use the first calendar year of an MCP's ABD managed care program membership as the baseline year (i.e., CY2007). The baseline year will be used to determine performance standards and targets; baseline data will come from a combination of FFS claims data and MCP encounter data. For those performance measures that require two calendar years of baseline data, the additional calendar year (i.e., the calendar year prior to the first calendar year of ABD managed care program membership, i.e., CY2006) data will come from FFS claims data.

An MCP's second calendar year of ABD managed care program membership (i.e., CY2008) will be the initial report period of evaluation for performance measures that require one calendar year of baseline data (i.e., CY2007), and for performance measures that require two calendar years of baseline data (i.e., CY2006 and CY2007).

Report Period: For the SFY 2008 contract period, performance will be evaluated using the January — December 2007 report period and may be adjusted based on the number of months of ABD managed care membership. For the SFY 2009 contract period, performance will be evaluated using the January — December 2008 report period.

1.c.i. Congestive Heart Failure (CHF) — Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the principal diagnosis was CHF, per thousand member months, for members who had a diagnosis of CHF in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results. (For example, if last year's results were TBD%, then the difference between the target and last year's results is

TBD%. In this example, the standard is an improvement in performance of TBD% of this difference or TBD%. In this example, results of TBD% or better would be compliant with the standard.)

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.ii. Congestive Heart Failure (CHF) — Emergency Department (ED) Utilization Rate

Measure: The number of emergency department visits in the reporting year where the primary diagnosis was CHF, per thousand member months, for members who had a diagnosis of CHF in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.iii. Congestive Heart Failure (CHF) — Cardiac Related Hospital Readmission

Measure: The rate of cardiac related readmissions during the reporting period for members who had a diagnosis of CHF in the year prior to the reporting period. A readmission is defined as a cardiac related admission that occurs within 30 days of a prior cardiac related admission.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.iv. Coronary Artery Disease (CAD) — Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the primary diagnosis was CAD, per thousand member months, for members who had a diagnosis of CAD in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.v. Coronary Artery Disease (CAD) – Emergency Department (ED) Utilization Rate

Measure: The number of emergency department visits in the reporting year where the principal diagnosis was CAD, per thousand member months, for members who had a diagnosis of CAD in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.vi. Coronary Artery Disease (CAD) – Cardiac Related Hospital Readmission

Measure: The rate of cardiac related readmissions in the reporting year for members who had a diagnosis of CAD in the year prior to the reporting year. A readmission is defined as a cardiac related admission that occurs within 30 days of a prior cardiac related admission.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If



the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.vii. Coronary Artery Disease (CAD) – Beta Blocker Treatment after Heart Attack

The evaluation report period for this measure is CY 2008 only.

Measure: The percentage of members 35 years of age and older as of December 31st of the reporting year who were hospitalized from January 1 – December 24th of the reporting year with a diagnosis of acute myocardial infarction (AMI) and who received an ambulatory prescription for beta blockers within seven days of discharge.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.viii. Persistence of Beta Blocker Treatment after Heart Attack

The initial report period of evaluation for this measure is CY 2009. This measure will replace the Coronary Artery Disease (CAD) – Beta Blocker Treatment after Heart Attack measure (1.c.vii.) in the P4P for SFY 2010.

Measure: The percentage of members 35 years of age and older as of December 31st of the reporting year who were hospitalized and discharged alive from July 1 of the year prior to the reporting year to June 30 of the measurement year with a diagnosis of acute myocardial information (AMI) and who received persistent beta-blocker treatment for six months after discharge.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.ix. Coronary Artery Disease (CAD) – Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C Screening Performed

Measure: The percentage of members who had a diagnosis of CAD in the year prior to the reporting year, who were enrolled for at least 11 months in the reporting year, and who received a lipid profile during the reporting year.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.x. Hypertension – Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the primary diagnosis was non-mild hypertension, per thousand member months, for members who had a diagnosis of non-mild hypertension in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xi. Hypertension – Emergency Department (ED) Utilization Rate

Measure: The number of emergency department visits in the reporting year where the principal diagnosis was non-mild hypertension, per thousand member months, for members who had a diagnosis of non-mild hypertension in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xii. Diabetes – Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the principal diagnosis was diabetes, per thousand member months, for members identified as diabetic in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xiii. Diabetes – Emergency Department (ED) Utilization Rate

Measure: The number of emergency department visits in the reporting year where the primary diagnosis was diabetes, per thousand member months, for members identified as diabetic in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xiv. Diabetes – Eye Exam

Measure: The percentage of diabetic members who were enrolled for at least 11 months during the reporting year, who received one or more retinal or dilated eye exams from an ophthalmologist or optometrist during the reporting year.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% increase in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xv. Chronic Obstructive Pulmonary Disease (COPD) – Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the primary diagnosis was COPD, per thousand member months, for members who had a diagnosis of COPD in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xvi. Chronic Obstructive Pulmonary Disease (COPD) – Emergency Department (ED) Utilization Rate

Measure: The number of emergency department visits in the reporting year where the principal diagnosis was COPD, per thousand member months, for members who had a diagnosis of COPD in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xvii. Asthma – Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the primary diagnosis was asthma, per thousand member months, for members with persistent asthma.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xviii. Asthma – Emergency Department (ED) Utilization Rate

Measure: The number of emergency department visits in the reporting year where the principal diagnosis was asthma, per thousand member months, for members with persistent asthma.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xix. Asthma – Use of Appropriate Medications for People with Asthma

Measure: The percentage of members with persistent asthma who received prescribed medications acceptable as primary therapy for long-term control of asthma.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xx. Mental Health, Severely Mentally Disabled (SMD) – Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the primary diagnosis was SMD, per thousand member months, for members who had a primary diagnosis of SMD in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xxi. Mental Health, Severely Mentally Disabled (SMD) – Emergency Department Utilization Rate

Measure: The number of emergency department visits in the reporting year where the primary diagnosis was SMD, per thousand member months, for members who had a primary diagnosis of SMD in the year prior to the reporting year.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality

Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xxii. Follow-up After Hospitalization for Mental Illness

Measure: The percentage of discharges for members enrolled from the date of discharge through 30 days after discharge, who were hospitalized for treatment of selected mental health disorders and

who had a follow-up visit (i.e., were seen on an outpatient basis or were in intermediate treatment with a mental health provider) within:

- 1) 30 Days of discharge, and
- 2) 7 Days of discharge.

Target: TBD.

Minimum Performance Standard For Each Measure: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance (Follow-up visits within 30 days of discharge): If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

Action Required for Noncompliance (Follow-up visits within 7 days of discharge): If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xxiii. Mental Health, Severely Mentally Disabled (SMD) – SMD Related Hospital Readmission

Measure: The number of SMD related readmissions for members who had a diagnosis of SMD in the year prior to the reporting year. A readmission is defined as a SMD related admission that occurs within 30 days of a prior SMD related admission.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xxiv. Substance Abuse – Inpatient Hospital Discharge Rate

Measure: The number of acute inpatient hospital discharges in the reporting year where the primary diagnosis was alcohol and other drug abuse or dependence (AOD), per thousand member months, for members who had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: AOD-related acute inpatient admission or two AOD related Emergency Department visits.

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xxv. Substance Abuse – Emergency Department Utilization Rate

Measure: The number of emergency department visits in the reporting year where the principal diagnosis was AOD, per thousand member months, for members who had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: AOD-related acute inpatient admission or two AOD related Emergency Department visits .

Target: TBD

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous report period's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xxvi. Substance Abuse – Inpatient Hospital Readmission Rate

Measure: The number of AOD related readmissions in the reporting year for members who had, in the year prior to the reporting year, a diagnosis of AOD and one of the following: AOD-related acute inpatient admission or two AOD related Emergency Department visits. A readmission is defined as an AOD-related admission that occurs within 30 days of a prior AOD-related admission.

Target: TBD.

Minimum Performance Standard: The level of improvement must result in at least a TBD% decrease in the difference between the target and the previous year's results.

Action Required for Noncompliance: If the standard is not met and the results are below TBD%, the MCP is required to complete a Corrective Action Plan to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, ODJFS will issue a Quality Improvement Directive which will notify the MCP of noncompliance and may outline the steps that the MCP must take to improve the results.

1.c.xxvii. Informational Clinical Performance Measures

The clinical performance measures listed in Table 1 are informational only. Although there are no performance targets or minimum performance standards for these measures, results will be reported and used as one component in assessing the quality of care provided by MCPs to the ABD managed care population.

Table 1. Informational Clinical Performance Measures

Condition	Informational Performance Measure
CHF	Discharge rate with age group breakouts
CAD	Discharge rate with age group breakouts
Hypertension	Discharge rate with age group breakouts
Diabetes	Discharge rate with age group breakouts Comprehensive Diabetes Care (CDC)/HbA1c testing CDC/kidney disease monitored CDC/LDL-C screening performed
COPD	Discharge rate with age group breakouts Use of Spirometry Testing in the Assessment and Diagnosis of COPD
Asthma	Discharge rate with age group breakouts
Mental Health (SMD)	Discharge rate with age group breakouts Antidepressant Medication Management
Substance Abuse	Discharge rate with age group breakouts Initiation and Engagement of Alcohol and Other Drug Dependence Treatment

2. ACCESS

Performance in the Access category will be determined by the following measures: Primary Care Provider (PCP) Turnover, Adults' Access to Preventive/Ambulatory Health Services, and Adults' Access to Designated PCP. For a comprehensive description of the access performance measures below, see *ODJFS Methods for the ABD Medicaid Managed Care Program Access Performance Measures*.

2.a. PCP Turnover

A high PCP turnover rate may affect continuity of care and may signal poor management of providers. However, some turnover may be expected when MCPs end contracts with providers who are not adhering to the MCP's standard of care. Therefore, this measure is used in conjunction with the adult access and designated PCP measures to assess performance in the access category.

Measure: The percentage of primary care providers affiliated with the MCP as of the beginning of the measurement year who were not affiliated with the MCP as of the end of the year.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership. ODJFS will use the first calendar year of ABD managed care program membership as the baseline year (i.e., CY2007). The baseline year will be used to determine a minimum statewide performance standard. An MCP's second calendar year of ABD managed care program membership (i.e., CY2008) will be the initial report period of evaluation, and penalties will be applied for noncompliance.

Report Period: For the SFY 2008 contract period, a baseline level of performance will be established using the CY 2007 report period (and may be adjusted based on the number of months of ABD managed care membership). For the SFY 2009 contract period, performance will be evaluated using the CY 2008 report period. The first reporting period in which MCPs will be held accountable to the performance standards will be the SFY 2009 contract period.

Minimum Performance Standard: A maximum PCP Turnover rate of TBD.

Action Required for Noncompliance: MCPs are required to perform a causal analysis of the high PCP turnover rate and assess the impact on timely access to health services, including continuity of care. If access has been reduced or coordination of care affected, then the MCP must develop and implement a corrective action plan to address the findings.

2.b. Adults' Access to Designated PCP

The MCP must encourage and assist ABD members without a designated primary care provider (PCP) to establish such a relationship, so that a designated PCP can coordinate and manage member's health care needs. This measure is used to assess MCPs' performance in the access category.

Measure: The percentage of members who had a visit through the members' designated PCPs.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership. ODJFS will use the first calendar year of ABD managed care program membership as the baseline year (i.e., CY2007). The baseline year will be used to determine a minimum statewide performance standard. An MCP's second calendar year of ABD managed care program membership (i.e., CY2008) will be the initial report period of evaluation, and penalties will be applied for noncompliance.

Report Period: For the SFY 2008 contract period, performance will be evaluated using the January — December 2007 report period (and may be adjusted based on the number of months of

ABD managed care membership). For the SFY 2009 contract period, performance will be evaluated using the January — December 2008 report period. The first reporting period in which MCPs will be held accountable to the performance standards will be the SFY 2009 contract period.

Minimum Performance Standards: TBD

Penalty for Noncompliance: If an MCP is noncompliant with the Minimum Performance Standard, then the MCP must develop and implement a corrective action plan.

2.c. Adults' Access to Preventive/Ambulatory Health Services

This measure indicates whether adult members are accessing health services.

Measure: The percentage of members who had an ambulatory or preventive-care visit.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership. ODJFS will use the first calendar year of ABD managed care program membership as the baseline year (i.e., CY2007). The baseline year will be used to determine a minimum statewide performance standard. An MCP's second calendar year of ABD managed care program membership (i.e., CY2008) will be the initial report period of evaluation, and penalties will be applied for noncompliance.

Report Period: For the SFY 2008 contract period, performance will be evaluated using the January — December 2007 report period (and may be adjusted based on the number of months of ABD managed care membership). For the SFY 2009 contract period, performance will be evaluated using the January — December 2008 report period. The first reporting period in which MCPs will be held accountable to the performance standards will be the SFY 2009 contract period.

Minimum Performance Standards: TBD

Penalty for Noncompliance: If an MCP is noncompliant with the Minimum Performance Standard, then the MCP must develop and implement a corrective action plan.

3. CONSUMER SATISFACTION

MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership.

In accordance with federal requirements and in the interest of assessing enrollee satisfaction with MCP performance, ODJFS annually conducts independent consumer satisfaction surveys. Results are used to assist in identifying and correcting MCP performance overall and in the areas of access, quality of care, and member services. Results from the SFY 2009 evaluation will be used to set a standard. For the SFY 2009 contract period, this measure is a reporting only measure. SFY 2010

will be the first contract period in which MCPs will be held accountable to the performance standards for this measure.

Measure: TBD. The results of this measure are reported annually.

Report Period: For the SFY 2009 contract period, the measure is under review and the report period has not been determined.

Minimum Performance Standard: TBD.

Penalty for noncompliance: If an MCP is determined noncompliant with the Minimum Performance Standard, then the MCP must develop a corrective action plan and provider agreement renewals may be affected.

4. ADMINISTRATIVE CAPACITY

The ability of an MCP to meet administrative requirements has been found to be both an indicator of current plan performance and a predictor of future performance. Deficiencies in administrative capacity make the accurate assessment of performance in other categories difficult, with findings uncertain. Performance in this category will be determined by the Compliance Assessment System, and the emergency department diversion program. For a comprehensive description of the Administrative Capacity performance measures below, see *ODJFS Methods for the ABD Medicaid Managed Care Program Administrative Capacity Performance Measure*, which are incorporated in this Appendix.

4.a. Compliance Assessment System

Measure: The number of points accumulated during a rolling 12-month period through the *Compliance Assessment System*.

Report Period: For the SFY 2008 and SFY 2009 contract periods, performance will be evaluated using a rolling 12-month report period.

Performance Standard: A maximum of 15 points

Penalty for Noncompliance: Penalties for points are established in Appendix N, *Compliance Assessment System*.

4.b. Emergency Department Diversion

Managed care plans must provide access to services in a way that assures access to primary and urgent care in the most effective settings and minimizes inappropriate utilization of emergency department (ED) services. MCPs are required to identify high utilizers of targeted ED services and implement action plans designed to minimize inappropriate, preventable and/or primary care sensitive ED utilization.

Measure: The percentage of members who had *TBD targeted* ED visits during the twelve month reporting period.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions in which an MCP has membership. ODJFS will use the first calendar year of ABD managed care membership as the baseline year (i.e., CY2007). The baseline year will be used to determine a minimum statewide performance standard and a target. The number of members with an ED visit used to calculate the measure for the baseline year will be adjusted based on the number of months of ABD managed care membership in the baseline year. An MCP's second calendar year of ABD managed care program membership (i.e., CY2008) will be the initial report period of evaluation, and penalties will be applied for noncompliance.

Report Period: For the SFY 2008 contract period, a baseline level of performance will be established using the CY2007 report period (and may be adjusted based on the number of months of ABD managed care membership). For the SFY 2009 contract period, results will be calculated for the reporting period of CY2008 and compared to the CY2007 baseline results to determine if the minimum performance standard is met.

Target: TBD

Minimum Performance Standard: TBD

Penalty for Noncompliance: If the standard is not met and the results are above TBD%, then the MCP must develop a corrective action plan, for which ODJFS may direct the MCP to develop the components of their targeted EDD program as specified by ODJFS. If the standard is not met and the results are at or below TBD%, then the MCP must develop a Quality Improvement Directive.

5. Notes

Given that unforeseen circumstances (e.g., revision or update of applicable national standards, methods or benchmarks, or issues related to program implementation) may impact performance

assessment as specified in Sections 1 through 4, ODJFS reserves the right to apply the most appropriate penalty to the area of deficiency identified with any individual measure, notwithstanding the penalties specified in this Appendix.

5.a. Monetary Sanctions

Penalties for noncompliance with individual standards in this appendix will be imposed as the results are finalized. Penalties for noncompliance with individual standards for each period of compliance is determined in this appendix and will not exceed \$250,000.

Refundable monetary sanctions will be based on the capitation payment for the month of the cited deficiency and will be due within 30 days of notification by ODJFS to the MCP of the amount. Any monies collected through the imposition of such a sanction would be returned to the MCP (minus any applicable collection fees owed to the Attorney General's Office, if the MCP has been

delinquent in submitting payment) after they have demonstrated improved performance in accordance with this appendix. If an MCP does not comply within two years of the date of notification of noncompliance, then the monies will not be refunded.

5.b. Combined Remedies

If ODJFS determines that one systemic problem is responsible for multiple deficiencies, ODJFS may impose a combined remedy which will address all areas of deficient performance. The total fines assessed in any one month will not exceed 15% of the MCP's monthly capitation payment.

5.c. Enrollment Freezes

MCPs found to have a pattern of repeated or ongoing noncompliance may be subject to an enrollment freeze.

5.d. Reconsideration

Requests for reconsideration of monetary sanctions and enrollment freezes may be submitted as provided in Appendix N, *Compliance Assessment System*.

5.e. Contract Termination, Nonrenewals or Denials

Upon termination, nonrenewal or denial of an MCP contract, all monetary sanctions collected under this appendix will be retained by ODJFS. The at-risk amount paid to the MCP under the current provider agreement will be returned to ODJFS in accordance with Appendix P, *Terminations*, of the provider agreement.

APPENDIX N
COMPLIANCE ASSESSMENT SYSTEM
ABD ELIGIBLE POPULATION

I. General Provisions of the Compliance Assessment System

- A. The Compliance Assessment System (CAS) is designed to improve the quality of each managed care plan's (MCP's) performance through actions taken by the Ohio Department of Job and Family Services (ODJFS) to address identified failures to meet program requirements. This appendix applies to the MCP specified in the baseline of this MCP Provider Agreement (hereinafter referred to as the Agreement).
- B. The CAS assesses progressive remedies with specified values (e.g., points, fines, etc.) assigned for certain documented failures to satisfy the deliverables required by Ohio Administrative Code (OAC) rule or the Agreement. Remedies are progressive based upon the severity of the violation, or a repeated pattern of violations. The CAS allows the accumulated point total to reflect patterns of less serious violations as well as less frequent, more serious violations.
- C. The CAS focuses on clearly identifiable deliverables and sanctions/remedial actions are only assessed in documented and verified instances of noncompliance. The CAS does not include categories which require subjective assessments or which are not within the MCPs control.
- D. The CAS does not replace ODJFS' ability to require corrective action plans (CAPs) and program improvements, or to impose any of the sanctions specified in OAC rule 5101:3-26-10, including the proposed termination, amendment, or nonrenewal of the MCP's Provider Agreement.
- E. As stipulated in OAC rule 5101:3-26-10(F), regardless of whether ODJFS imposes a sanction, MCPs are required to initiate corrective action for any MCP program violations or deficiencies as soon as they are identified by the MCP or ODJFS.
- F. In addition to the remedies imposed in Appendix N, remedies related to areas of financial performance, data quality, and performance management may also be imposed pursuant to Appendices J, L, and M respectively, of the Agreement.
- G. If ODJFS determines that an MCP has violated any of the requirements of sections 1903(m) or 1932 of the Social Security Act which are not specifically identified within the CAS, ODJFS may, pursuant to the provisions of OAC rule 5101:3-26-10(A), notify the MCP's members that they may terminate from the MCP without cause and/or
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suspend any further new member selections.

H. For purposes of the CAS, the date that ODJFS first becomes aware of an MCP's program violation is considered the date on which the violation occurred. Therefore, program violations that technically reflect noncompliance from the previous compliance term will be subject to remedial action under CAS at the time that ODJFS first becomes aware of this noncompliance.

I. In cases where an MCP contracted healthcare provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, inappropriate member billing, etc.), ODJFS will not assess points if: (1) the MCP can document that they provided sufficient notification/education to providers of applicable program requirements and prohibited activities; and (2) the MCP takes immediate and appropriate action to correct the problem and to ensure that it does not happen again to the satisfaction of ODJFS. Repeated incidents will be reviewed to determine if the MCP has a systemic problem in this area, and if so, sanctions/remedial actions may be assessed, as determined by ODJFS.

J. All notices of noncompliance will be issued in writing via email and facsimile to the identified MCP contact.

II. Types of Sanctions/Remedial Actions

ODJFS may impose the following types of sanctions/remedial actions, including, but not limited to, the items listed below. The following are examples of program violations and their related penalties. This list is not all inclusive. As with any instance of noncompliance, ODJFS retains the right to use their sole discretion to determine the most appropriate penalty based on the severity of the offense, pattern of repeated noncompliance, and number of consumers affected. Additionally, if an MCP has received any previous written correspondence regarding their duties and obligations under OAC rule or the Agreement, such notice may be taken into consideration when determining penalties and/or remedial actions.

A. Corrective Action Plans (CAPs) – A CAP is a structured activity/process implemented by the MCP to improve identified operational deficiencies.

MCPs may be required to develop CAPs for any instance of noncompliance, and CAPs are not limited to actions taken in this Appendix. All CAPs requiring ongoing activity on the part of an MCP to ensure their compliance with a program requirement remain in effect for twenty-four months.

In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a CAP, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" CAP.

In situations where a penalty is assessed for a violation an MCP has previously been assessed a CAP (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

B. Quality Improvement Directives (QIDs) – A QID is a general instruction that directs the MCP to implement a quality improvement initiative to improve identified administrative or clinical deficiencies. All QIDs remain in effect for twelve months from the date of implementation.

MCPs may be required to develop QIDs for any instance of noncompliance.

In situations where ODJFS has already determined the specific action which must be implemented by the MCP or if the MCP has failed to submit a QID, ODJFS may require the MCP to comply with an ODJFS-developed or “directed” QID.

In situations where a penalty is assessed for a violation an MCP has previously been assessed a QID (or any penalty or any other related written correspondence), the MCP may be assessed escalating penalties.

C. Points — Points will accumulate over a rolling 12-month schedule. Each month, points that are more than 12-months old will expire. Points will be tracked and monitored separately for each Agreement the MCP concomitantly holds with the BMHC, beginning with the commencement of this Agreement (i.e., the MCP will have zero points at the onset of this Agreement).

No points will be assigned for any violation where an MCP is able to document that the precipitating circumstances were completely beyond their control and could not have been foreseen (e.g., a construction crew severs a phone line, a lightning strike blows a computer system, etc.).

C.1. 5 Points — Failures to meet program requirements, including but not limited to, actions which could impair the member’s ability to obtain correct **information** regarding services or which could impair a consumer’s or member’s rights, as determined by ODJFS, will result in the assessment of 5 points.

Examples include, but are not limited to, the following:

- Violations which result in a member’s MCP selection or termination based on inaccurate provider panel information from the MCP.
 - Failure to provide member materials to new members in a timely manner.
 - Failure to comply with appeal, grievance, or state hearing requirements, including the failure to notify a member of their right to a state hearing when the MCP proposes to deny, reduce, suspend or
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terminate a Medicaid-covered service.

- Failure to staff 24-hour call-in system with appropriate trained medical personnel.
- Failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Provision of false, inaccurate or materially misleading information to health care providers, the MCP's members, or any eligible individuals.
- Use of unapproved marketing or member materials.
- Failure to appropriately notify ODJFS or members of provider panel terminations.
- Failure to update website provider directories as required.

C.2. 10 Points — Failures to meet program requirements, including but not limited to, actions which could affect the ability of the MCP to deliver or the **consumer to access** covered services, as determined by ODJFS. Examples include, but are not limited to, the following:

- Discrimination among members on the basis of their health status or need for health care services (this includes any practice that would reasonably be expected to encourage termination or discourage selection by individuals whose medical condition indicates probable need for substantial future medical services).
- Failure to assist a member in accessing needed services in a timely manner after request from the member.
- Failure to provide medically-necessary Medicaid covered services to members.
- Failure to process prior authorization requests within the prescribed time frames.

D. Fines – Refundable or nonrefundable fines may be assessed as a penalty separate to or in combination with other sanctions/remedial actions.

D.1. Unless otherwise stated, all fines are nonrefundable.

D.2. Pursuant to procedures as established by ODJFS, refundable and nonrefundable monetary sanctions/assurances must be remitted to ODJFS within thirty (30) days of receipt of the invoice by the MCP. In addition, per Ohio Revised Code Section 131.02, payments not received within forty-five (45) days will be certified to the Attorney General's (AG's) office. MCP payments certified to the AG's office will be assessed the appropriate collection fee by the AG's office.

D.3. Monetary sanctions/assurances imposed by ODJFS will be based on the most recent premium payments.

D.4. Any monies collected through the imposition of a refundable fine will be returned to the MCP (minus any applicable collection fees owed to the Attorney General's Office if the MCP has been delinquent in submitting payment) after they have demonstrated full compliance, as determined by ODJFS, with the particular program requirement. If an MCP does not comply within one (1) year of the date of notification of noncompliance involving issues of case management and two (2) years of the date of notification of noncompliance in issues involving encounter data, then the monies will not be refunded.

D.5. MCPs are required to submit a written request for refund to ODJFS at the time they believe is appropriate before a refund of monies will be considered.

E. Combined Remedies — Notwithstanding any other action ODJFS may take under this Appendix, ODJFS may impose a combined remedy which will address all areas of noncompliance if ODJFS determines, in its sole discretion, that (1) one systemic problem is responsible for multiple areas of noncompliance and/or (2) that there are a number of repeated instances of noncompliance with the same program requirement.

F. Progressive Remedies — Progressive remedies will be based on the number of points accumulated at the time of the most recent incident. Unless specifically otherwise indicated in this appendix, all fines are nonrefundable. The designated fine amount will be assessed when the number of accumulated points falls within the ranges specified below:

0 -15 Points	Corrective Action Plan (CAP)
16-25 Points	CAP + \$5,000 fine
26-50 Points	CAP + \$10,000 fine
51-70 Points	CAP + \$20,000 fine
71-100 Points	CAP + \$30,000 fine
100+ Points	Proposed Contract Termination

G. New Member Selection Freezes — Notwithstanding any other penalty or point assessment that ODJFS may impose on the MCP under this Appendix, ODJFS may prohibit an MCP from receiving new membership through consumer initiated selection or the assignment process if: (1) the MCP has accumulated a total of 51 or more points during a rolling 12-month period; (2) or the MCP fails to fully implement a CAP within the designated time frame; or (3) circumstances exist which potentially jeopardize the MCP's members' access to care. [Examples of circumstances that ODJFS may consider

as jeopardizing member access to care include:

- the MCP has been found by ODJFS to be noncompliant with the prompt payment or the non-contracting provider payment requirements;
- the MCP has been found by ODJFS to be noncompliant with the provider panel requirements specified in Appendix H of the Agreement;
- the MCP's refusal to comply with a program requirement after ODJFS has directed the MCP to comply with the specific program requirement; or
- the MCP has received notice of proposed or implemented adverse action by the Ohio Department of Insurance.]

Payments provided for under the Agreement will be denied for new enrollees, when and for so long as, payments for those enrollees are denied by CMS in accordance with the requirements in 42 CFR 438.730.

H. Reduction of Assignments – ODJFS has sole discretion over how member auto-assignments are made. ODJFS may reduce the number of assignments an MCP receives to assure program stability within a region or if ODJFS determines that the MCP lacks sufficient capacity to meet the needs of the increased volume in membership. Examples of circumstances which ODJFS may determine demonstrate a lack of sufficient capacity include, but are not limited to an MCP's failure to: maintain an adequate provider network; repeatedly provide new member materials by the member's effective date; meet the minimum call center requirements; meet the minimum performance standards for identifying and assessing children with special health care needs and members needing case management services; and/or provide complete and accurate appeal/grievance, member's PCP and CAMS data files.

I. Termination, Amendment, or Nonrenewal of MCP Provider Agreement - ODJFS can at any time move to terminate, amend or deny renewal of a provider agreement. Upon such termination, nonrenewal, or denial of an MCP provider agreement, all previously collected monetary sanctions will be retained by ODJFS.

J. Specific Pre-Determined Penalties

I.1. Adequate network-minimum provider panel requirements - Compliance with provider panel requirements will be assessed quarterly. Any deficiencies in the MCP's provider network as specified in Appendix H of the Agreement or by ODJFS, will result in the assessment of a \$1,000 nonrefundable fine for each category (practitioners, PCP capacity, hospitals), for each county, and for each population (e.g., ABD, CFC). For example if the MCP did not meet the following minimum panel requirements, the MCP would be assessed (1) a \$3,000

nonrefundable fine for the failure to meet CFC panel requirements; and, (2) a \$1,000 nonrefundable fine for the failure to meet ABD panel requirements).

- practitioner requirements in Franklin county for the CFC population
- practitioner requirements in Franklin county for the ABD population
- hospital requirements in Franklin county for the CFC population
- PCP capacity requirements in Fairfield county for the CFC population

In addition to the pre-determined penalties, ODJFS may assess additional penalties pursuant to this Appendix (e.g. CAPs, points, fines) if member specific access issues are identified resulting from provider panel noncompliance.

J.2. Geographic Information System - Compliance with the Geographic Information System (GIS) requirements will be assessed semi-annually. Any failure to meet GIS requirements as specified in Appendix H of the Agreement will result a \$1,000 nonrefundable fine for each county and for each population (e.g., ABD, CFC, etc.). For example if the MCP did not meet GIS requirements in the following counties, the MCP would be assessed (1) a nonrefundable \$2,000 fine for the failure to meet GIS requirements for the CFC population and (2) a \$1,000 nonrefundable fine for the failure to meet GIS requirements for the ABD population.

- GIS requirements in Franklin county for the CFC population
- GIS requirements in Fairfield county for the CFC population
- GIS requirements in Franklin county for the ABD population

J.3. Late Submissions - All required submissions/data and documentation requests must be received by their specified deadline and must represent the MCP in an honest and forthright manner. Failure to provide ODJFS with a required submission or any data/documentation requested by ODJFS will result in the assessment of a nonrefundable fine of \$100 per day, unless the MCP requests and is granted an extension by ODJFS. Assessments for late submissions will be done monthly. Examples of such program violations include, but are not limited to:

- Late required submissions
 - o Annual delegation assessments
 - o Call center report
 - o Franchise fee documentation
 - o Reinsurance information (e.g., prior approval of changes)
 - o State hearing notifications
 - Late required data submissions
 - o Appeals and grievances, case management, or PCP data
 - Late required information requests
 - o Automatic call distribution reports
 - o Information/resolution regarding consumer or provider
-

complaint

- o Just cause or other coordination care request from ODJFS
- o Provider panel documentation
- o Failure to provide ODJFS with a required submission after ODJFS has notified the MCP that the prescribed deadline for that submission has passed

If an MCP determines that they will be unable to meet a program deadline or data/documentation submission deadline, the MCP must submit a written request to its Contract Administrator for an extension of the deadline, as soon as possible, but no later than 3 PM EST on the date of the deadline in question. Extension requests should only be submitted in situations where unforeseeable circumstances have occurred which make it impossible for the MCP to meet an ODJFS-stipulated deadline and all such requests will be evaluated upon this standard. Only written approval as may be granted by ODJFS of a deadline extension will preclude the assessment of compliance action for untimely submissions.

J.4. Noncompliance with Claims Adjudication Requirements — If ODJFS finds that an MCP is unable to (1) electronically accept and adjudicate claims to final status and/or (2) notify providers of the status of their submitted claims, as stipulated in Appendix C of the Agreement, ODJFS will assess the MCP with a monetary sanction of \$20,000 per day for the period of noncompliance.

If ODJFS has identified specific instances where an MCP has failed to take the necessary steps to comply with the requirements specified in Appendix C of the Agreement for (1) failing to notify non-contracting providers of procedures for claims submissions when requested and/or (2) failing to notify contracting and non-contracting providers of the status of their submitted claims, the MCP will be assessed 5 points per incident of noncompliance.

J.5. Noncompliance with Prompt Payment: - Noncompliance with the prompt pay requirements as specified in Appendix J of the Agreement will result in progressive penalties. The first violation during a rolling 12-month period will result in the submission of quarterly prompt pay and monthly status reports to ODJFS until the next quarterly report is due. The second violation during a rolling 12-month period will result in the submission of monthly status reports and a refundable fine equal to 5% of the MCP's monthly premium payment or \$300,000, whichever is less. The refundable fine will be applied in lieu of a nonrefundable fine and the money will be refunded by ODJFS only after the MCP complies with the required standards for two (2) consecutive quarters. Subsequent violations will result in an enrollment freeze.

If an MCP is found to have not been in compliance with the prompt pay requirements for any time period for which a report and signed attestation have been submitted representing the MCP as being in compliance, the MCP will be subject to an enrollment freeze of not less than three (3) months duration.

J.6. Noncompliance with Franchise Fee Assessment Requirements - In accordance with ORC Section 5111.176, and in addition to the imposition of any other penalty, occurrence or points under this Appendix, an MCP that does not pay the franchise permit fee in full by the due date is subject to any or all of the following:

- A monetary penalty in the amount of \$500 for each day any part of the fee remains unpaid, except the penalty will not exceed an amount equal to 5 % of the total fee that was due for the calendar quarter for which the penalty was imposed;
- Withholdings from future ODJFS capitation payments. If an MCP fails to pay the full amount of its franchise fee when due, or the full amount of the imposed penalty, ODJFS may withhold an amount equal to the remaining amount due from any future ODJFS capitation payments. ODJFS will return all withheld capitation payments when the franchise fee amount has been paid in full;
- Proposed termination or non-renewal of the MCP's Medicaid provider agreement may occur if the MCP:
 - a. Fails to pay its franchise permit fee or fails to pay the fee promptly;
 - b. Fails to pay a penalty imposed under this Appendix or fails to pay the penalty promptly;
 - c. Fails to cooperate with an audit conducted in accordance with ORC Section 5111.176.

J.7. Noncompliance with Clinical Laboratory Improvement Amendments - Noncompliance with CLIA requirements as specified by ODJFS will result in the assessment of a nonrefundable \$1,000 fine for each violation.

J.8. Noncompliance with Abortion and Sterilization Payment - Noncompliance with abortion and sterilization requirements as specified by ODJFS will result in the assessment of a nonrefundable \$2,000 fine for each documented violation. Additionally, MCPs must take all appropriate action to correct each ODJFS-documented violation.

J.9. Refusal to Comply with Program Requirements - If ODJFS has instructed an MCP that they must comply with a specific program requirement and the MCP

refuses, such refusal constitutes documentation that the MCP is no longer operating in the best interests of the MCP's members or the state of Ohio and ODJFS will move to terminate or nonrenew the MCP's provider agreement.

III. Request for Reconsiderations

MCPs may request a reconsideration of remedial action taken under the CAS for penalties that include points, fines, reductions in assignments and/or selection freezes. Requests for reconsideration must be submitted on the ODJFS required form as follows:

- A. MCPs notified of ODJFS' imposition of remedial action taken under the CAS will have ten (10) working days from the date of receipt of the facsimile to request reconsideration, although ODJFS will impose enrollment freezes based on an access to care concern concurrent with initiating notification to the MCP. Any information that the MCP would like reviewed as part of the reconsideration request must be submitted at the time of submission of the reconsideration request, unless ODJFS extends the time frame in writing.
 - B. All requests for reconsideration must be submitted by either facsimile transmission or overnight mail to the Chief, Bureau of Managed Health Care, and received by ODJFS by the tenth business day after receipt of the faxed notification of the imposition of the remedial action by ODJFS.
 - C. The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests for reconsideration must explain in detail why the specified remedial action should not be imposed. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP. The Bureau Chief will review all correspondence and materials related to the violation in question in making the final reconsideration decision.
 - D. Final decisions or requests for additional information will be made by ODJFS within ten (10) business days of receipt of the request for reconsideration.
 - E. If additional information is requested by ODJFS, a final reconsideration decision will be made within three (3) business days of the due date for the submission. Should ODJFS require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.
 - F. If a reconsideration request is decided, in whole or in part, in favor of the MCP, both the penalty and the points associated with the incident, will be rescinded or reduced, in the sole discretion of ODJFS. The MCP may still be required to submit a CAP if ODJFS, in its sole discretion, believes that a CAP is still warranted under the circumstances.
-

APPENDIX O
PAY-FOR-PERFORMANCE (P4P)
ABD ELIGIBLE POPULATION

This Appendix establishes a Pay-for-performance (P4P) incentive system for managed care plans (MCPs) to improve performance in specific areas important to the Medicaid MCP members. P4P includes the at-risk amount included with the monthly premium payments (see Appendix F, *Rate Chart*), and possible additional monetary rewards up to \$250,000.

To qualify for consideration of any P4P, MCPs must meet minimum performance standards established in Appendix M, *Performance Evaluation* on selected measures, and achieve P4P standards established for selected Clinical Performance Measures, as set forth herein below. For qualifying MCPs, higher performance standards for three measures must be reached to be awarded a portion of the at-risk amount and any additional P4P (see Sections 1). An excellent and superior standard is set in this Appendix for each of the three measures. Qualifying MCPs will be awarded a portion of the at-risk amount for each excellent standard met. If an MCP meets all three excellent and superior standards, they may be awarded additional P4P (see Section 2).

ODJFS will use the first calendar year of an MCP's ABD managed care program membership as the baseline year (i.e., CY2007). The baseline year will be used to determine performance standards and targets; baseline data may come from a combination of FFS claims data and MCP encounter data. As many of the performance measures used in the determination of P4P require two calendar years of baseline data, the additional calendar year (i.e., the calendar year prior to the first calendar year of ABD managed care program membership, [i.e., CY2006]) data will come from FFS claims.

An MCP's second calendar year of ABD managed care program membership (i.e., CY2008) will be the initial report period of evaluation for performance measures that require one calendar year of baseline data (i.e., CY2007), and for performance measures that require two calendar years of baseline data (i.e., CY2006 and CY2007). CY2008 will be the initial report period upon which compliance with the performance standards will be determined. SFY 2009 will become the first year an MCP's performance level for P4P can be determined.

1. SFY 2009 P4P

1.a. Qualifying Performance Levels

To qualify for consideration of the SFY 2009 P4P, an MCP's performance level must:

- 1) Meet the minimum performance standards set in Appendix M, *Performance Evaluation*, for the measures listed below; and
 - 2) Meet the P4P standards established for the Clinical Performance Measures below.
-

Appendix O

Aged, Blind or Disabled (ABD) population

Page 2

- A detailed description of the methodologies for each measure can be found on the BMHC page of the ODJFS website.

Measures for which the minimum performance standard for SFY 2009 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of incentives are as follows:

1. PCP Turnover (Appendix M, Section 2.a.)

Report Period: CY 2008

2. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2008

For each clinical performance measure listed below, the MCP must meet the P4P standard to be considered for SFY 2009 P4P. The MCP meets the P4P standard if one of two criteria is met. The P4P standard is a performance level of either:

- 1) The minimum performance standard established in Appendix M, *Performance Evaluation*, for five of eight clinical performance measures listed below; or
- 2) The Medicaid benchmarks for five of eight clinical performance measures listed below. The Medicaid benchmarks are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

Clinical Performance Measure	Medicaid Benchmark
CHF: Inpatient Hospital Discharge Rate	TBD
1. CAD: Beta-Blocker Treatment after Heart Attack (AMI -related admission)	TBD
2. CAD: Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C screening performed	TBD
3. Hypertension: Inpatient Hospital Discharge Rate	TBD
4. Diabetes: Comprehensive Diabetes Care (CDC)/Eye exam	TBD
5. COPD: Inpatient Hospital Discharge Rate	TBD
6. Asthma: Use of Appropriate Medications for People with Asthma	TBD
7. Mental Health: Follow-up After Hospitalization for Mental Illness	TBD

1.b. Excellent and Superior Performance Levels

For qualifying MCPs as determined by Section 1.a., herein, performance will be evaluated on the measures below to determine the status of the at-risk amount or any additional P4P that may be

awarded. Excellent and Superior standards are set for the three measures described below. The standards are subject to change based on the revision or update of applicable national standards, methods or benchmarks.

A brief description of these measures is provided in Appendix M, *Performance Evaluation*. A detailed description of the methodologies for each measure can be found on the BMHC page of the ODJFS website.

1. Case Management of Members (Appendix M, Section 1.b.i)

Report Period: April – June 2009

Excellent Standard: TBD

Superior Standard: TBD

2. Comprehensive Diabetes Care (CDC)/Eye exam (Appendix M, Section 1.c.xiv.)

Report Period: CY 2008

Excellent Standard: TBD

Superior Standard: TBD

3. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2008

Excellent Standard: TBD

Superior Standard: TBD

1.c. Determining SFY 2009 P4P

MCPs reaching the minimum performance standards described in Section 1.a. herein, will be considered for P4P including retention of the at-risk amount and any additional P4P. For each Excellent standard established in Section 1.b. herein, that an MCP meets, one-third of the at-risk amount may be retained. For MCPs meeting all of the Excellent and Superior standards established in Section 1.b. herein, additional P4P may be awarded. For MCPs receiving additional P4P, the amount in the P4P fund (see section 2.) will be divided equally, up to the maximum additional amount, among all MCPs' ABD and/or CFC programs receiving additional P4P. The maximum additional amount to be awarded per plan, per program, per contract year is \$250,000. An MCP may receive up to \$500,000 should both of the MCP's ABD and CFC programs achieve the Superior Performance Levels.

2. NOTES

2.a. Initiation of the P4P System

For MCPs in their first twenty-four (24) months of Ohio Medicaid ABD Managed Care Program participation, the status of the at-risk amount will not be determined because compliance with many of the standards in the ABD program cannot be determined in an MCP's first two contract years (see Appendix F., *Rate Chart*). In addition, MCPs in their first two (2) contract years in the ABD program are not eligible for the additional P4P amount awarded for superior performance.

Starting with the twenty-fifth (25th) month of participation in the ABD program, the MCP's at-risk amount will be included in the P4P system. The determination of the status of this at-risk amount will occur after two (2) calendar years of ABD membership. Because of this requirement, the number of months of at-risk dollars to be included in an MCP's first at-risk status determination may vary depending on when an MCP starts with the ABD program relative to the calendar year.

2.b. Determination of at-risk amounts and additional P4P payments

For MCPs that have participated in the Ohio Medicaid ABD Managed Care Program long enough to calculate performance levels for all of the performance measures included in the P4P system, determination of the status of an MCP's at-risk amount will occur within six (6) months of the end of the contract period. Determination of additional P4P payments will be made at the same time the status of an MCP's at-risk amount is determined.

2.c. Statewide P4P system

All MCPs will be included in a statewide P4P system for the ABD program. The at-risk amount will be determined using a statewide result for all regions in which an MCP serves ABD membership.

2.d. Contract Termination, Nonrenewals, or Denials

Upon termination, nonrenewal or denial of an MCP contract, the at-risk amount paid to the MCP under the current provider agreement will be returned to ODJFS in accordance with Appendix P., *Terminations/Nonrenewals/Amendments*, of the provider agreement.

Additionally, in accordance with Article XI of the provider agreement, the return of the at-risk amount paid to the MCP under the current provider agreement will be a condition necessary for ODJFS' approval of a provider agreement assignment.

2.e. Report Periods

The report period used in determining the MCP's performance levels varies for each measure depending on the frequency of the report and the data source. Unless otherwise noted, the most

Appendix O

Aged, Blind or Disabled (ABD) population

Page 5

recent report or study finalized prior to the end of the contract period will be used in determining the MCP's overall performance level for that contract period.

[SEAL] **STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR BEST AND FINAL OFFER (BAFO)
FOR REQUEST FOR PROPOSAL (RFP)**

BAFO REQUEST NO.: 002

RFP NO.: B3Z06118

TITLE: Medicaid Managed Care – Central, Eastern, & Western Regions

ISSUE DATE: 03/28/06

REQ NO.: NR 886 25756004320

BUYER: Julie Kleffner

PHONE NO.: (573) 751-7656

E-MAIL: Julie.Kleffner@oa.mo.gov

RETURN BAFO RESPONSE NO LATER THAN 03/30/06 AT 5:00 PM CENTRAL TIME

MAILING INSTRUCTIONS:

Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Sealed BAFOs should be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN BAFO RESPONSE TO:	(U.S. Mail)	(Courier Service)
	DPMM	or DPMM
	PO BOX 809	301 WEST HIGH STREET, RM 630
	JEFFERSON CITY MO 65102-0809	JEFFERSON CITY MO 65101

CONTRACT PERIOD: July 1, 2006 through June 30, 2007
(with two additional one-year renewal periods at the State's sole option)

DELIVER SUPPLIES/SERVICES FOB (Free on Board) DESTINATION TO THE FOLLOWING ADDRESS:

*Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500*

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by any previously issued RFP amendments and by this and any previously issued BAFO requests. The offeror agrees that the language of the original RFP as modified by any previously issued RFP amendments and by this and any previously issued BAFO requests shall govern in the event of a conflict with his/his proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED**DOING BUSINESS AS (DBA) NAME**

Community CarePlus

LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID NO.

Alliance for Community Health

MAILING ADDRESS

10123 Corporate Square Drive

IRS FORM 1099 MAILING ADDRESS

10123 Corporate Square Drive

CITY, STATE, ZIP CODE

St. Louis, MO 63132

CITY, STATE, ZIP CODE

St. Louis, MO 63132

CONTACT PERSON

Jerry Linder or Marcia Albridge

jlinder@ccphealth.commalbridge@ccphealth.com**PHONE NUMBER**

314-432-9300

FAX NUMBER

314-994-9398

TAXPAYER ID NUMBER (TIN) TAXPAYER ID (TIN) TYPE (CHECK ONE) VENDOR NUMBER (IF KNOWN)

43-1743902

☒ X ☐ FEIN☐ SSN

817919905

VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)

(NOTE: LLC IS NOT A VALID TAX FILING TYPE.)

☒ **X** Corporation ☐ Individual ☐ State/Local Government ☐ Partnership ☐ Sole Proprietor ☐ Other _____

AUTHORIZED SIGNATURE

DATE

3/29/06

PRINTED NAME

TITLE

Jerry Linder

CEO

Medicaid Managed Care – Central, Eastern, & Western Regions
Department of Social Services, Division of Medical Services

Contract Period: July 1, 2006 through June 30, 2007

(with two additional one-year renewal periods at the State's sole option)

Offerors are hereby notified that paragraph 2.1.2 a. is hereby revised.

[SEAL]

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR BEST AND FINAL OFFER (BAFO)
FOR REQUEST FOR PROPOSAL (RFP)

BAFO REQUEST NO.: 001

RFP NO.: B3Z06118

TITLE: Medicaid Managed Care — Central, Eastern, & Western Regions

ISSUE DATE: March 10, 2006

REQ NO.: NR 886 25756004320

BUYER: Julie Kleffner

PHONE NO.: (573) 751-7656

E-MAIL: Julie.Kleffner@oa.mo.gov

RETURN BAFO RESPONSE NO LATER THAN March 15, 2006 AT 5:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Sealed BAFOs should be in DPMM office (301 W High Street, Room 630) by the return date and time.

(U.S. Mail)

RETURN BAFO RESPONSE TO: DPMM

PO BOX 809

JEFFERSON CITY MO 65102-0809

(Courier Service)

or DPMM

301 WEST HIGH STREET, RM 630

JEFFERSON CITY MO 65101

CONTRACT PERIOD: July 1, 2006 through June 30, 2007

(with two additional one-year renewal periods at the State's sole option)

DELIVER SUPPLIES/SERVICES FOB (Free on Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Services

Division of Medical Services

P.O. Box 6500

Jefferson City, MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by any previously issued RFP amendments and by this and any previously issued BAFO requests. The offeror agrees that the language of the original RFP as modified by any previously issued RFP amendments and by this and any previously issued BAFO requests shall govern in the event of a conflict with his/his proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME

LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID NO.

MAILING ADDRESS

IRS FORM 1099 MAILING ADDRESS

CITY, STATE, ZIP CODE

CITY, STATE, ZIP CODE

CONTACT PERSON

EMAIL ADDRESS

PHONE NUMBER

FAX NUMBER

TAXPAYER ID NUMBER (TIN)

TAXPAYER ID (TIN) TYPE (CHECK ONE) VENDOR NUMBER (IF KNOWN)

___ FEIN ___ SSN

VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)

___ Corporation ___ Individual ___ State/Local Government ___ Partnership ___ Sole Proprietor ___ Other ___

(NOTE: LLC IS NOT A VALID TAX FILING TYPE.)

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

TITLE

Medicaid Managed Care — Central, Eastern, & Western Regions
Department of Social Services, Division of Medical Services

Contract Period: July 1, 2006 through June 30, 2007

(with two additional one-year renewal periods at the State's sole option)

Offerors are hereby notified the following paragraphs have been revised:

2.14.4
2.14.4 b. 4)
2.31.1
2.31.3

[SEAL]

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)

AMENDMENT NO.: 002
RFP NO.: B3Z06118
TITLE: Medicaid Managed Care — Central, Eastern, & Western Regions
ISSUE DATE: 02/07/06

REQ NO.: NR 886 25756004320
BUYER: Julie Kleffner
PHONE NO.: (573) 751-7656
E-MAIL: Julie.Kleffner@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: 02/15/06 AT 2:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Delivered Sealed Proposals must be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN PROPOSAL AND AMENDMENT(S) TO:

(U.S. Mail)
DPMM
PO BOX 809
JEFFERSON CITY MO 65102-0809

(Courier Service)
or DPMM
301 WEST HIGH STREET, ROOM 630
JEFFERSON CITY MO 65101

CONTRACT PERIOD: July 1, 2006 through June 30, 2007
(with two additional one-year renewal periods at the State's sole option)

DELIVER SUPPLIES/SERVICES FOB (Free on Board) DESTINATION TO THE FOLLOWING ADDRESS:

*Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500*

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by this and any previously issued RFP amendments. The offeror should, as a matter of clarity and assurance, also sign and return all previously issued RFP amendment(s) and the original RFP document. The offeror agrees that the language of the original RFP as modified by this and any previously issued RFP amendments shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

LEGAL NAME OF ENTITY/INDIVIDUAL

MAILING ADDRESS

CITY, STATE, ZIP CODE

CONTACT PERSON

EMAIL ADDRESS

PHONE NUMBER

FAX NUMBER

TAXPAYER ID NUMBER (TIN) TAXPAYER ID (TIN) TYPE (CHECK ONE) VENDOR NUMBER (IF KNOWN)
____ FEIN ____ SSN

VENDOR TYPE (CHECK ONE)
____ Corporation ____ Individual ____ State/Local Government ____ Partnership ____ Sole Proprietor ____ Other ____

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

TITLE

Medicaid Managed Care — Central, Eastern, and Western Regions
Department of Social Services, Division of Medical Services

CONTRACT PERIOD: July 1, 2006 through June 30, 2007
(with two additional one-year renewal periods at the State's sole option)

Prospective offerors are hereby advised of the following:

1. The return by date and time shall be February 15, 2006 at 2:00 PM Central Time in lieu of February 10, 2006 at 2:00 PM Central Time.
2. The following have been revised:

1.3.1 b.

2.12.5 d.

2.14.4

Attachment 6 revised to amend Exhibit 1

Attachment 10 revised to clarify the Annual Audit instructions

[SEAL]

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)

AMENDMENT NO.: 001

RFP NO.: B3Z06118

TITLE: Medicaid Managed Care – Central, Eastern, & Western Regions

ISSUE DATE: 01/31/06

REQ NO.: NR 886 25756004320

BUYER: Julie Kleffner

PHONE NO.: (573) 751-7656

E-MAIL: Julie.Kleffner@oa.mo.gov

Amendment #002 changed the proposal receipt date from February 10, 2006 to February 15, 2006

RETURN PROPOSAL NO LATER THAN: 02/10/06 AT 2:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Delivered sealed proposals must be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN PROPOSAL AND AMENDMENT(S) TO:

(U.S. Mail)

DPMM

PO BOX 809

JEFFERSON CITY MO 65102-0809

or

(Courier Service)

DPMM

301 WEST HIGH STREET, ROOM 630

JEFFERSON CITY MO 65101

CONTRACT PERIOD: July 1, 2006 through June 30, 2007

(with two additional one-year renewal periods at the State's sole option)

DELIVER SUPPLIES/SERVICES FOB (Free on Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Services

Division of Medical Services

P.O. Box 6500

Jefferson City, MO 65102-6500

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all terms and conditions, requirements, and specifications of the original RFP as modified by this and any previously issued RFP amendments. The offeror should, as a matter of clarity and assurance, also sign and return all previously issued RFP amendment(s) and the original RFP document. The offeror agrees that the language of the original RFP as modified by this and any previously issued RFP amendments shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

LEGAL NAME OF ENTITY/INDIVIDUAL

MAILING ADDRESS

CITY, STATE, ZIP CODE

CONTACT PERSON

EMAIL ADDRESS

PHONE NUMBER

FAX NUMBER

TAXPAYER ID NUMBER (TIN)

TAXPAYER ID (TIN) TYPE (CHECK ONE)

VENDOR NUMBER (IF KNOWN)

___ FEIN ___ SSN

VENDOR TYPE (CHECK ONE)

___ Corporation ___ Individual ___ State/Local Government ___ Partnership ___ Sole Proprietor ___ Other ___

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

TITLE

Medicaid Managed Care – Central, Eastern, and Western Regions
Department of Social Services, Division of Medical Services

CONTRACT PERIOD: July 1, 2006 through June 30, 2007
(with two additional one-year renewal periods at the State's sole option)

Prospective offerors are hereby advised of the following:

1. The following have been revised, inserted, deleted or renumbered:

1.3.1 c.
1.3.1 i.
1.3.1 l.
1.3.1 n.
1.3.1 o.
1.7.2 q.
2.5.5 b.
2.5.5 c.
2.6.2 t. 5)
2.6.2 v.
2.12.10
2.25.5
4.1.1

Attachment 3 – All references to Attachment 3 shall be deemed to mean revised Attachment 3
Attachment 6 – All references to Attachment 6 shall be deemed to mean revised Attachment 6

The State of Missouri anticipates that another amendment will be forthcoming at a later date.

[SEAL]

STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
REQUEST FOR PROPOSAL (RFP)

RFP NO.: B3Z06118
TITLE: Medicaid Managed Care – Central, Eastern, & Western Regions
ISSUE DATE: 01/10/06

REQ NO.: NR 886 25756004320
BUYER: Julie Kleffner
PHONE NO.: (573) 751-7656
E-MAIL: Julie.Kleffner@oa.mo.gov

RETURN PROPOSAL NO LATER THAN: 02/10/06 AT 2:00 PM CENTRAL TIME

MAILING INSTRUCTIONS: Print or type **RFP Number** and **Return Due Date** on the lower left hand corner of the envelope or package. Delivered sealed proposals must be in DPMM office (301 W High Street, Room 630) by the return date and time.

RETURN PROPOSAL TO:	(U.S. Mail) DPMM PO BOX 809 JEFFERSON CITY MO 65102-0809	or	(Courier Service) DPMM 301 WEST HIGH STREET, RM 630 JEFFERSON CITY MO 65101
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CONTRACT PERIOD: July 1, 2006 through June 30, 2007
(with two additional one-year renewal periods at the State's sole option)

DELIVER SUPPLIES/SERVICES FOB (Free on Board) DESTINATION TO THE FOLLOWING ADDRESS:

*Department of Social Services
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500*

The offeror hereby declares understanding, agreement and certification of compliance to provide the items and/or services, at the prices quoted, in accordance with all requirements and specifications contained herein and the Terms and Conditions Request for Proposal (Revised 01/03/06). The offeror further agrees that the language of this RFP shall govern in the event of a conflict with his/her proposal. The offeror further agrees that upon receipt of an authorized purchase order from the Division of Purchasing and Materials Management or when a Notice of Award is signed and issued by an authorized official of the State of Missouri, a binding contract shall exist between the offeror and the State of Missouri.

SIGNATURE REQUIRED

LEGAL NAME OF ENTITY/INDIVIDUAL

MAILING ADDRESS

CITY, STATE, ZIP CODE

CONTACT PERSON

EMAIL ADDRESS

PHONE NUMBER

FAX NUMBER

TAXPAYER ID NUMBER (TIN)

TAXPAYER ID (TIN) TYPE (CHECK ONE)
___ FEIN ___ SSN

VENDOR NUMBER (IF KNOWN)

VENDOR TYPE (CHECK ONE)

___ Corporation ___ Individual ___ State/Local Government ___ Partnership ___ Sole Proprietor ___ Other ___

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

TITLE

1. INTRODUCTION AND GENERAL INFORMATION

1.1 Introduction:

1.1.1 This document constitutes a request for competitive, sealed proposals from the health plan provider community for becoming providers in the Missouri managed care program, hereinafter referred to as “MC+ managed care” in the following regions of the State of Missouri:

- a. Central Region: Audrain, Boone, Callaway, Camden, Chariton, Cole, Cooper, Gasconade, Howard, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Randolph, and Saline counties.
- b. Eastern Region: Franklin, Jefferson, Lincoln, St. Charles, St. Francois, Ste. Genevieve, St. Louis, Warren, and Washington counties and St. Louis City.
- c. Western Region: Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, and St. Clair counties.

1.1.2 Organization — This document, referred to as a Request for Proposal (RFP), is divided into the following parts:

- 1) Introduction and General Information
- 2) Performance Requirements
- 3) General Contractual Requirements
- 4) Proposal Submission Information
- 5) Pricing Pages: The Pricing Pages are a separate link that must be downloaded from the Division of Purchasing and Materials Management’s Internet web site at: <https://www.moolb.mo.gov>. It shall be the sole responsibility of the offeror to obtain the Pricing Pages. If the pricing page(s) are not downloaded and included with the response, the response could be determined to be non-responsive and eliminated from consideration for award.
- 6) Exhibits A – B
- 7) Terms and Conditions
- 8) Attachments 1 – 14: The offeror is advised that attachments exist to this document which provide additional information and instruction. These attachments are separate links that must be downloaded from the Division of Purchasing and Materials Management’s Internet web site at: <https://www.moolb.mo.gov>. It shall be the sole responsibility of the offeror to obtain each of the attachments. The offeror shall not be relieved of any responsibility for performance under the contract due to the failure of the offeror to obtain a copy of the attachments.

1.2 Pre-Proposal Conference and MC+ Managed Care Quality Assessment and Improvement Advisory Groups Meeting:

- 1.2.1 A pre-proposal conference regarding this Request for Proposal will be held on January 24, 2006, at 10:00 a.m. in the Interpretive Center of the James C. Kirkpatrick State Information Center, 600 West Main Street, Jefferson City, Missouri.
 - 1.2.2 The MC+ Managed Care Quality Assessment and Improvement Advisory Groups quarterly meeting is scheduled for January 25, 2006 at 10:30 a.m. in room 202 of the Howerton Court Building, 615 Howerton Court, Jefferson City, Missouri. During the meeting, portions of the RFP will be discussed; specifically section 2.28.2 Adjustments for Performance Based on HEDIS Performance Ratings and the Quality Strategy, Attachment 6.
 - 1.2.3 All potential offerors are encouraged to attend this conference and the MC+ Managed Care Quality Assessment and Improvement Advisory Groups quarterly meeting in order to ask questions and provide comments on the RFP. Attendance is not required in order to submit a response; however, offerors are encouraged to attend since information relating to this RFP will be discussed in detail. The offeror should bring a copy of the RFP to the pre-proposal conference since it will be used as the agenda for the pre-
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proposal conference. The offeror should also bring a copy of the RFP to the MC+ Managed Care Quality Assessment and Improvement Advisory Groups quarterly meeting.

- 1.2.4 Offerors may submit questions regarding the RFP prior to the Pre-Proposal Conference to allow time for the State of Missouri to prepare answers. However, the offeror should restate each question for verbal response during the Pre-Proposal Conference and/or MC+ Managed Care Quality Assessment and Improvement Advisory Groups quarterly meeting. Only those questions/answers which necessitate changes to the RFP will be included in an amendment, if any.
- 1.2.5 Offerors are strongly encouraged to advise the Division of Purchasing and Materials Management within five (5) working days of the scheduled pre-proposal conference and/or MC+ Managed Care Quality Assessment and Improvement Advisory Groups quarterly meeting of any special accommodations needed for disabled personnel who will be attending the conference and/or meeting so that these accommodations can be made.

1.3 Available Documentation and Offeror's Contact:

- 1.3.1 The offeror may request a copy of any of the following documents by contacting Julie Kleffner at the Division of Purchasing and Materials Management. Requests for copies may be sent to Ms. Kleffner via fax at 573-526-9817, or emailed to Julie.Kleffner@oa.mo.gov, or mailed to the Division of Purchasing and Materials Management, P.O. Box 809, Jefferson City, MO 65102.
 - a. Overview — Division of Medical Services. Available via the Internet at the Division of Medical Services' website: www.dss.state.mo.us/dms (Look under Missouri Medicaid Description and Missouri Medicaid History).

Paragraph 1.3.1 b. revised by Amendment #002

- b. Quality Improvement System for Managed Care (QISMC)

Paragraph 1.3.1 c. revised by Amendment #001

- c. Health Plan Record Layout Manual – available electronically at website www.emomed.com (Look under Provider, Electronic Billing Layout, System Manuals, Health Plan Layout Manual)
- d. Medicaid Fee-for-Service Pricing File available electronically at the Division of Medical Service' website: <http://www.dss.mo.gov/dms/providers/pages/cptagree.htm>
- e. Division of Medical Services MC+ Managed Care Policy Statements
- f. Missouri's 1115 Waiver Amendment
- g. EPSDT Screening Codes and Reporting Methodology
- h. Historical Enrollment Data

Paragraph 1.3.1 i(MRDD Waiver Services) deleted by Amendment #001 and all other paragraphs renumbered accordingly

- i. Description of Member Satisfaction Survey Data Reporting
- j. Hospital Per Diem Rates
- k. Federal regulations regarding home health agencies are available via the Internet at <http://www.gpoaccess.gov/cfr/retrieve.html> (42 CFR 484, Subpart A, B, C and 42 CFR 441.15).

Paragraph 1.3.1 l. revised by Amendment #001

- l. Guidelines for Addressing Fraud and Abuse in managed Care", is available via the internet at http://new.cms.hhs.gov/FraudAbuseforProfs/02_MedicaidGuidance.asp
 - m. Jackson County Consent Decree and Operational Guide
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Paragraphs 1.3.1 n. and o. inserted by Amendment #001

- n. Mercer presentation from the January 24, 2006 Pre-proposal Conference
- o. Criteria for Post-Payment Review of Specialty Pediatric Hospital Discharges.

1.3.2 All possible efforts have been made to ensure that the information provided in these relevant documents is complete and current. However, the offeror shall not assume that such information is indeed complete or current.

1.4 Questions:

1.4.1 All questions regarding this Request for Proposal and/or the competitive procurement process must be directed to Julie Kleffner at the Division of Purchasing and Materials Management. Questions may be faxed to Julie Kleffner at 573-526-9817, or emailed to Julie.Kleffner@oa.mo.gov, or mailed to the Division of Purchasing and Materials Management, P.O. Box 809, Jefferson City, MO 65102. All questions should be submitted three weeks prior to the proposal receipt date specified on Page 1.

1.5 Description of Missouri MC+ Managed Care Program:

- 1.5.1 Effective July 1, 2006, the State of Missouri will continue a health care delivery program in Audrain, Boone, Callaway, Camden, Cass, Chariton, Clay, Cole, Cooper, Franklin, Gasconade, Henry, Howard, Jackson, Jefferson, Johnson, Lafayette, Lincoln, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Platte, Randolph, Ray, Saline, St. Charles, St. Clair, St. Francois, Ste. Genevieve, St. Louis, Warren, and Washington counties and St. Louis City to serve MC+ managed care eligibles meeting specified eligibility criteria. The goal is to improve the accessibility and quality of health care services for Missouri's MC+ managed care and State aid eligible populations, while controlling the program's rate of cost increase.
- a. The Missouri Department of Social Services, Division of Medical Services intends to achieve this goal by enrolling MC+ managed care eligibles in comprehensive, qualified health plans that contract with the State of Missouri to provide a specified scope of benefits to each enrolled member in return for a capitated payment made on a per member, per month basis.
- 1.5.2 The health care delivery program was designed through a collaborative process that included feedback from providers, consumers, health plans, communities, the State of Missouri government agencies, and the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration).
- 1.5.3 The Missouri Department of Social Services, Division of Medical Services has identified eight (8) guiding principles for Missouri's Medicaid Program as follows:
- 1) All recipients must have a medical home.
 - 2) Attention to wellness of the individual (i.e. education).
 - 3) Chronic care management.
 - 4) Care management – (resources focused towards people receiving the services they need, not necessarily because the service is available).
 - 5) Appropriate setting at the right cost.
 - 6) Emphasis on the individual person.
 - 7) Evidenced based guidelines for improved quality care and use of resources.
 - 8) Encourage responsibility and investment on the part of the recipient to ensure wellness.
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1.6 Program Management and Oversight:

- 1.6.1 In the State of Missouri, the Department of Social Services, Division of Medical Services is officially designated with administration of the medical assistance and federal Medicaid (Title XIX and Title XXI) programs. In addition to Division of Medical Services' oversight, CMS also monitors MC+ managed care activities through its Regional Office in Kansas City, Missouri and its Center for Medicaid and State Operations, Division of Integrated Health Systems in Baltimore, Maryland.

1.7 Missouri MC+ Managed Care Program Eligibility Groups:

- 1.7.1 For purposes of this Request for Proposal, the MC+ managed care population consists of different eligibility groups which have been combined for the purpose of rate setting. The qualifications for the program are based on a combination of factors, including family composition, income level, insurance status, or pregnancy status depending on the eligibility group in question. The eligibility groups and their current estimated sizes are described below and summarized in Attachment 1.
- a. **Eligibility of Parents/Caretakers, Children, Pregnant Women, and Refugees:** Individuals covered under MC+ managed care within this group are as follows:
 - 1) Parents/Caretakers and Children eligible under Medical Assistance for Families, and Transitional Medical Assistance.
 - 2) Children eligible under MC+ for Poverty Level Children.
 - 3) Women eligible under Medical Assistance for Pregnant Women and 60 days post-partum.
 - 4) Individuals eligible under Recipients of Refugee Medical Assistance.
 - 5) Individuals eligible under the above groups and are MRDD Waiver participants.
 - 6) Those that are eligible are defined by their MC+ Medical Eligibility (ME) Codes as Specified in Attachment 1.
 - b. **Eligibility of Other MC+ Children In the Care and Custody of the State and Receiving Adoption Subsidy Assistance:** All children in the care and custody of the Department of Social Services; all children placed in a not-for-profit residential group home by a juvenile court; all children receiving adoption subsidy assistance; and all children receiving non-medical assistance (i.e., living expenses) that are in the legal custody of the Department of Social Services shall remain the responsibility of the Department of Social Services. Those that are eligible are defined by their MC+ Medical Eligibility code as specified in Attachment 1.
 - c. **1115 Demonstration Waiver:** Missouri submitted an amendment to its pending 1115 demonstration waiver on August 26, 1997. The amendment is to Missouri's 1115 demonstration waiver that was submitted on June 30, 1994. The 1115 demonstration waiver as amended was approved April 28, 1998. The waiver amendment continues Missouri's commitment to improving medical care to low income children and supports families moving from welfare into jobs.
 - 1) **Uninsured Children Below 200 Percent Under Title XIX, Coordinated with Title XXI Funding:** Uninsured children with net family income up to 200 percent of the federal poverty level (300 percent gross income) are covered under an MC+ expansion. The MC+ expansion will occur under a Title XIX 1115 waiver. Children will include individuals birth through age 18. No new eligibles will be excluded because of pre-existing illness or condition. "Uninsured Children" are persons up to nineteen years of age who have not had access to employer-subsidized health care insurance or other health care coverage for six (6) months prior to
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application, are residents of the State of Missouri, and have parents or guardians who meet the following requirements:

- Furnish to the Department of Social Services the uninsured child's social security number or numbers, if the uninsured child has more than one such number;
- Cooperate with the Department of Social Services in identifying and providing information to assist the Division of Medical Services in pursuing any third-party health insurance carrier who may be liable to pay for health care;
- Cooperate with the Department of Social Services, Family Support Division in establishing paternity and in obtaining support payments, including medical support;
- Demonstrate, upon request, their child's participation in wellness programs including immunizations and a periodic physical examination. (This shall not apply to any child whose parent or legal guardian objects in writing to such wellness programs including immunizations and an annual physical examination because of religious beliefs or medical contraindications);
- Demonstrate annually that their total net worth does not exceed two hundred fifty thousand dollars in total value; and
- There will be protections against dropping or foregoing private coverage, including a six (6) month waiting period and insurance availability screens through the Division of Medical Services' Health Insurance Premium Payment (HIPP) program.
 - Any child identified as having special health care needs defined as a condition which left untreated would result in the death or serious physical injury of a child, that does not have access to affordable employer-subsidized health care insurance will be exempt from the requirement to be without health care coverage for six months in order to be eligible for services.
 - A child shall not be subject to the 30-day waiting period as long as the child meets all other qualifications for eligibility.

d. MC+ managed care eligibles in the above specified eligibility groups may voluntarily disenroll from the MC+ Managed Care Program or choose not to enroll in the MC+ Managed Care Program if they:

- 1) Are eligible for Supplemental Security Income (SSI) under Title XVI of the Social Security Act;
- 2) Are described in Section 501(a)(1)(D) of the Social Security Act;
- 3) Are described in Section 1902(e)(3) of the Social Security Act;
- 4) Are receiving foster care or adoption assistance under part E of Title IV of the Social Security Act;
- 5) Are in foster care or otherwise in out-of-home placement; or
- 6) Meet the SSI disability definition as determined by the Department of Social Services.

1.7.2 Not Covered Under the MC+ Managed Care Program: The following individuals are not covered under the MC+ Managed Care Program and receive their services through the Medicaid/MC+ fee-for-service program:

- a. Permanently and Totally Disabled individuals eligible under ME Codes 04 (Permanently and Totally Disabled), 13 (Medical Assistance-PTD), 16 (Nursing Care-PTD), and 11 (Medical Assistance (MA) Spenddown and Non-Spenddown, Old Age Assistance (OAA)).
- b. Individuals eligible under ME Code 14 (Nursing Care-OAA) residing in a nursing home and receiving cash to apply toward their nursing home costs or a vendor payment directly to a nursing home for their care through the Medicaid program.
- c. Individuals eligible under ME Codes 23 and 41 (MA ICF-MR Poverty) residing in a State Mental Institution or an Intermediate Care Facility for the Mentally Retarded (ICF/MR).
- d. Individuals eligible under ME Codes 28, 49, and 67 (Children placed in foster homes or residential care by the Department of Mental Health).
- e. Pregnant women eligible under ME Code 58 and 59, the Presumptive Eligibility Program for ambulatory prenatal care only.
- f. Individuals eligible under ME Codes 2, 3, 12, and 15 (Aid to the Blind and Blind Pension).
- g. AIDS Waiver participants (individuals twenty-one (21) years of age and over).
- h. Any individual eligible and receiving either or both Medicare Part A and Part B benefits.
- i. Individuals eligible under ME Codes 33 and 34 (MO Children with Developmental Disabilities Waiver).
- j. Individuals eligible under ME Code 55 (Qualified Medicare Beneficiary – QMB).
- k. Children eligible under ME Code 65, placed in residential care by their parents, if eligible for MC+/Medicaid on the date of placement.
- l. Uninsured women losing their MC+ eligibility 60 days after the birth of their child would be eligible under ME Code 80 for women's health services for one year plus 60 days, regardless of income level. This population will obtain their services through the MC+ fee-for-service program.
- m. Individuals with ME code 81 (Temporary Assignment Category).
- n. Women eligible under ME codes 83 and 84 (Breast and Cervical Cancer Treatment).
- o. Individuals eligible under ME code 87 (Presumptive Eligibility for Children).
- p. Individuals eligible under ME code 88 (Voluntary Placement).

Paragraph 1.7.2 q. inserted by Amendment #001

- q. Individuals eligible under ME code 82 (MoRx)
- 1.7.3 Where economically cost effective, the Division of Medical Services will use the Division of Medical Services' HIPP program to obtain available coverage through available commercial insurance. Those services included in the comprehensive benefit packages described herein, but not included in the commercial insurance service package, may be obtained through MC+ managed care or fee-for-service as appropriate.
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1.8 Information:

- 1.8.1 Although an attempt has been made to provide accurate and up-to-date information, the State of Missouri does not warrant or represent that the background information provided herein reflects all relationships or existing conditions related to this Request for Proposal.
- 1.8.2 The State of Missouri has previously contracted for these services through C302226001 through C302226004 for the Eastern and Central Regions and through C303182001 through C303182004 for the Western Region. These contracts expire on June 30, 2006. A copy of the contracts can be viewed and printed from the Division of Purchasing and Materials Management's **Public Record Search and Retrieval System** located on the Internet at: <http://www.oa.mo.gov/purch>. In addition, all proposal and evaluation documentation leading to the award of the expiring contracts may also be viewed and printed from the Division of Purchasing and Materials Management's **Public Record Search and Retrieval System**. Please reference the Bid number B3Z02226 and B3Z03182 or any of the contract numbers when searching for these documents.
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2. CONTRACTUAL REQUIREMENTS

2.1.1 The contractor (hereinafter referred to as the “health plan”) shall provide a managed care medical service delivery system for the Department of Social Services, Division of Medical Services (hereinafter referred to as the “state agency”), located in the State of Missouri pursuant to the requirements contained herein.

2.1.2 Prior to performing services in each of the counties, the health plan shall:

Paragraph 2.1.2 a. revised by BAFO #002

- a. Have and maintain a certificate of authority from the Department of Insurance to establish and operate a health maintenance organization in all the counties specified herein by no later than April 14, 2006 so the state agency can proceed with open enrollment with only health plans that are appropriately licensed. In the event the health plan is awarded a contract and fails to achieve appropriate licensure by April 14, 2006, the contract shall be cancelled in its entirety;
 - b. Understand that federal approval is required prior to commitment of the federal financing share of funds under the contract;
 - c. Participate in readiness reviews. If the health plan is new to the MC+ managed care program, the state agency shall conduct on-site readiness reviews of the health plan in order to document the status of the health plan with respect to meeting the program requirements outlined herein. If the health plan has an established relationship with the state agency, the state agency shall conduct off-site reviews of the health plan in order to document the status of the health plan with respect to meeting any new program requirements; and
 - d. Submit to the state agency all policies and procedures that require prior approval listed in Attachment 12. The health plan must submit all modifications, additions, or deletions to such policies and procedures to the state agency at least thirty (30) days prior to implementation. The health plan must operate in accordance with such policies and procedures. The health plan must incorporate and implement any revisions identified by the state agency to the health plan’s policies and procedures within the time frame specified by the state agency. All other policies and procedures required herein shall be submitted to the state agency on request.
- 2.1.3 The health plan awarded a contract for the Eastern region shall provide services to individuals determined eligible by the state agency for the Missouri MC+ Managed Care Program in all of the following ten areas in the State of Missouri:
- a. Franklin County
 - b. Jefferson County
 - c. Lincoln County
 - d. St. Charles County
 - e. St. Francois County
 - f. Ste. Genevieve County
 - g. St. Louis County
 - h. Warren County
 - i. Washington County
 - j. St. Louis City
- 2.1.4 The health plan awarded a contract for the Central region shall provide services to individuals determined eligible by the state agency for the Missouri MC+ Managed Care Program in all of the following eighteen areas in the State of Missouri:
- a. Audrain County
 - b. Boone County
 - c. Callaway County
 - d. Camden County
-

- e. Chariton County
- f. Cole County
- g. Cooper County
- h. Gasconade County
- i. Howard County
- j. Miller County
- k. Moniteau County
- l. Monroe County
- m. Montgomery County
- n. Morgan County
- o. Osage County
- p. Pettis County
- q. Randolph County
- r. Saline County

2.1.5 The health plan awarded a contract for the Western region shall provide services to individuals determined eligible by the state agency for the Missouri MC+ Managed Care Program in all of the following nine areas in the State of Missouri:

- a. Cass County
- b. Clay County
- c. Henry County
- d. Jackson County
- e. Johnson County
- f. Lafayette County
- g. Platte County
- h. Ray County
- i. St. Clair County

2.2 Health Plan Administration:

2.2.1 The health plan shall have in place sufficient administrative staff and organizational structure to comply with all requirements described herein. The health plan must be staffed by qualified persons in numbers appropriate to the health plan's size of enrollment. At a minimum, the health plan must provide the following staff to perform the responsibilities listed. Unless otherwise specified, the health plan may combine or split the listed responsibilities among the health plan's staff as long as the health plan demonstrates that the responsibilities are being met. Similarly, the health plan may contract with a third party (subcontractor) to perform one or more of these responsibilities.

- a. A full time Medicaid Plan Administrator with clear authority over the general administration and implementation of the requirements set forth herein.
 - b. Clerical and support staff to ensure appropriate functioning of the health plan's operation.
 - c. A Medical Director who shall be a Missouri-licensed physician. The Medical Director shall be actively involved in all major clinical and quality program components of the health plan. The Medical Director shall devote sufficient time to the health plan to ensure timely medical decisions, including after hours consultation as needed. The Medical Director shall be responsible for the sufficiency and supervision of the health plan provider network. The Medical Director shall ensure compliance with State and local reporting laws on communicable diseases, child abuse, neglect, etc.
 - d. A Dental Consultant who shall be a Missouri-licensed dentist. The Dental Consultant shall devote sufficient time to the health plan to ensure timely dental decisions and claim review.
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- e. A full-time Chief Financial Officer to oversee the budget and accounting systems implemented by the health plan.
 - f. A Quality Assessment and Improvement and Utilization Management Coordinator who shall be a Missouri-licensed registered nurse, nurse practitioner, or physician.
 - g. A Special Programs Coordinator who shall be a Missouri-licensed social worker, registered nurse including advanced practice nurse, physician, or physician's assistant; or have a Master's degree in health services, public health, or health care administration. In addition, the Special Programs Coordinator should be familiar with the variety of services available through the Missouri human services agencies that interface with health care. The duties of the Special Programs Coordinator shall include care coordination with all stakeholders and providers involved in the care of members. These stakeholders and providers may include, but not be limited to, the state agency, the Department of Health and Senior Services, local public health agencies, the Department of Mental Health, the Department of Elementary and Secondary Education, the Family Support Division, Children's Division, hospitals, the judicial system, schools, and Community Mental Health Centers. The Special Programs Coordinator shall provide timely and comprehensive facilitation of the identification of medically necessary services and implementation of such when included in a member's Individualized Education Program/Individual Family Service Plan. The Special Programs Coordinator is the point of contact for members, their representatives, providers, the state agencies, and local public health agencies.
 - h. A Mental Health Coordinator shall be a qualified mental health professional as specified herein and possess, at a minimum, a master's degree.
 - i. Prior authorization staff shall be available to authorize services twenty-four (24) hours per day, seven (7) days per week. This staff shall be directly supervised by a Missouri-licensed registered nurse, physician, or physician's assistant. Prior approval functions for mental health services shall be performed by a qualified mental health professional.
 - j. Inpatient certification review staff shall conduct inpatient initial, concurrent, and retrospective reviews. The review staff shall consist of registered nurses, physicians, physician's assistants, or licensed practical nurses experienced in inpatient reviews and under the direct supervision of a registered nurse, physician, or physician's assistant.
 - k. Member services staff shall coordinate communications with members and act as member advocates. The health plan shall provide sufficient member services staff to enable members to receive prompt resolution to their problems or inquiries.
 - l. Provider services staff shall coordinate communications between the health plan and providers. The health plan shall provide sufficient provider services staff to enable providers to receive prompt resolution to their problems or inquiries.
 - m. A Complaint, Grievance, and Appeal Coordinator shall manage and adjudicate member and provider complaints, grievances, and appeals in a timely manner.
 - n. Claims Administrator/Management Information System (MIS) Director.
 - o. Compliance Officer.
- 2.2.2 The health plan shall inform the state agency in writing within seven (7) calendar days of staffing changes in the following key positions. The health plan shall fill vacancies in any of these key positions with permanent qualified replacements within ninety (90) calendar days of the departure of the former staff member.
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- a. Medicaid Plan Administrator
 - b. Medical Director
 - c. Quality Assessment and Improvement and Utilization Management Coordinator
 - d. Special Programs Coordinator
 - e. Mental Health Coordinator
 - f. Chief Financial Officer
- 2.2.3 The health plan shall ensure that all staff have appropriate training, education, experience, liability coverage, and orientation to fulfill the requirements of the positions and have met all appropriate licensure requirements.
- 2.2.4 The health plan may not knowingly employ as a director, officer, partner, or person with beneficial ownership of more than 5 percent of the health plan's equity, a person who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued pursuant to Executive Order No. 12549 or under guidelines implementing such order; or is an affiliate (as defined in such Act) of such a person. In addition, the health plan may not have an employment, consulting, or other agreement with such a person described above for the provision of items and services that are significant and material to the health plan's obligations required herein.
- 2.2.5 The health plan shall require each physician providing services to members to have a unique identifier in accordance with the system established under section 1173(b) of the Health Insurance Portability and Accountability Act of 1996.
- 2.2.6 **Non-Discrimination in Hiring and Provision of Services:** The health plan shall ensure that all federal and state laws, as amended, and policies of non-discrimination in hiring and the provision of services are strictly enforced. The health plan shall comply with Title VI of the Civil Rights Act of 1964, as amended; the Rehabilitation Act of 1973, as amended; Title IX of the Education Amendments of 1972, as amended; the Age Discrimination Act of 1975, as amended; and the American Disabilities Act of 1990, as amended.
- a. The health plan shall incorporate in its policies, administration, and delivery of services the values of:
 - 1) Honoring member's beliefs;
 - 2) Being sensitive to cultural diversity; and
 - 3) Fostering in staff and providers attitudes and interpersonal communication styles which respect the member's cultural backgrounds.
 - b. The health plan shall have specific policy statements on minority inclusion and non-discrimination and procedures to communicate the policy statements and procedures to subcontractors.
 - c. The health plan shall not discriminate in regard to the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. If a health plan declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. The health plan's provider selection policies and procedures cannot discriminate against particular providers that serve high risk populations or specialize in conditions that require costly treatment. This section may not be construed to:
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- 1) Require the health plan to contract with providers beyond the number necessary to meet the needs of its members;
- 2) Preclude the health plan from using different reimbursement amounts for different specialties or for different practitioners in the same specialty; or
- 3) Preclude the health plan from establishing measures that are designed to maintain quality of services, control costs, and are consistent with its responsibilities to members.

2.3 Health Plan Provider Networks:

- 2.3.1 The health plan shall establish and maintain health plan provider networks in geographically accessible locations, in accordance with the travel distance standards specified herein, comprised of hospitals, physicians, advanced practice nurses, mental health providers, substance abuse providers, pharmacies, dentists, emergent and non-emergent transportation services, etc., with sufficient capacity to make available all services in accordance with the service accessibility standards specified herein. In order to maintain geographically accessible locations, the health plan should look to providers in contiguous and other counties for full development of the network.
- 2.3.2 **Primary Care Provider Responsibilities:** The health plan shall have written policies and procedures for linking every member to a primary care provider. The primary care provider must serve as the member's initial and most important contact. As such, primary care provider responsibilities must include at a minimum:
- a. Maintaining continuity of each member's health care.
 - b. Making referrals for specialty care and other medically necessary services to both in-network and out-of-network providers.
 - c. Maintaining a comprehensive current medical record for the member, including documentation of all services provided to the member by the primary care provider, as well as any specialty or referral services, diagnostic reports, physical and mental health screens, etc.
 - d. Although primary care providers are responsible for the above activities, the health plan must monitor the primary care providers' actions for compliance with health plan and MC+ Managed Care Program policies.
 - e. Primary care providers may have formalized relationships with other primary care providers to see their members for after hours care, during certain days, for certain services, or other reasons to extend their practice. However, the primary care provider shall be ultimately responsible for the above listed activities.
- 2.3.3 **Eligible Specialties:** The health plan shall limit its primary care providers to licensed residents specializing in family and general practice, pediatrics, obstetrics and gynecology (OB/GYN), and internal medicine; registered nurses who are advanced practice nurses with specialties in family practice, pediatric practice, and OB/GYN practice; and licensed physicians in the following specialties: family and general practitioners, pediatricians, OB/GYN, and internists.
- a. To the maximum extent possible, the health plan should include all of these specialties in its health plan provider network.
- 2.3.4 **Primary Care Provider Teams and Primary Care Clinics:** The responsibilities of a primary care provider team and a primary care clinic shall be the same as the responsibilities listed herein for primary care providers.
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- a. If the health plan provider network includes institutions with teaching programs, primary care provider teams, comprised of residents and a supervising faculty physician, may serve as a primary care provider. In addition, the health plan should establish primary care provider teams that include advanced practice nurses or physician assistants as recognized by the Board of Healing Arts who, at the member's discretion, may serve as the point of first contact for the member. In both instances, the health plan shall organize its primary care provider teams so as to ensure continuity of care to members and identify a "lead physician" within the team for each member. The "lead physician" must be an attending physician and not a resident.
 - b. The health plan may also elect to make available clinics to serve as primary care providers. The primary care clinic must provide the range of services required of all primary care providers. A centralized medical record shall be maintained on each member enrolled with the primary care clinic.
- 2.3.5 The health plan shall offer its members freedom of choice in selecting a primary care provider. The number of members assigned to a primary care provider shall be decreased by the health plan if necessary to maintain the appointment availability standards. To the degree possible, these shifts should occur prospectively (before care has been initiated) and the health plan should take steps to minimize the need for such shifts.
- 2.3.6 The health plan shall include a mix of mental health and substance abuse providers with experience in treating children, adolescents, and adults in the health plan provider network to ensure a broad range of treatment options are available.
- a. To the maximum extent possible, the health plan should include Community Mental Health Centers (CMHC) in the health plan provider network. A listing of CMHC is provided in Attachment 5.
 - b. The mental health provider network may include licensed psychiatrists, licensed psychologists, licensed psychiatric advance practice nurses, provisional licensed professional counselors, licensed professional counselors, provisional licensed clinical social workers, licensed clinical social workers, licensed clinical nurse specialists, licensed home health, licensed psychiatric nurse, and state certified mental health or substance abuse program. To be considered adequate, the mental health provider network must, at a minimum, include Qualified Mental Health Professionals (QMHP), Qualified Substance Abuse Professionals (QSAP), licensed psychiatrists, licensed psychologists, licensed psychiatric nurses, licensed professional counselors, licensed clinical social workers, and licensed clinical nurse specialists.
 - 1) A QMHP shall be one of the following and provide services within their defined scope of practice:
 - A physician, licensed under Missouri state law to practice medicine or osteopathy who has either specialized training in mental health services or one (1) year of experience, under supervision, in treating problems related to mental illness;
 - A psychiatrist, a physician licensed under Missouri state law, who has successfully completed a training program in psychiatry approved by the American Medical Association, the American Osteopathic Association, or other training program identified as equivalent by the state agency;
 - A psychologist licensed under Missouri state law to practice psychology with specialized training in mental health services;
 - A professional counselor licensed under Missouri state law to practice counseling who has specialized training in mental health services;
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- A licensed clinical social worker or a clinical social worker with a Master's Degree in social work from an accredited program who has specialized training in mental health services;
- A psychiatric nurse, a registered professional nurse, licensed under Missouri state law who has at least two (2) years of experience in a psychiatric setting or a Master's Degree in psychiatric nursing; or
- An individual possessing a Master's Degree or Doctorate Degree in counseling and guidance, rehabilitation counseling, vocational counseling, psychology, pastoral counseling, family therapy, social work, or a related field, who has successfully completed a practicum or has one (1) year of experience under the supervision of a mental health professional.

2) A QSAP shall be one of the following and provide services within their defined scope of practice:

- A counselor, psychologist, clinical social worker, or physician licensed in Missouri who has at least one (1) year of full-time experience in the treatment or rehabilitation of substance abuse;
- A graduate of an accredited college or university with a Master's Degree in social work, counseling, psychology, psychiatric nursing, or closely related field who has at least two (2) years of full-time experience in the treatment or rehabilitation of substance abuse;
- A graduate of an accredited college or university with a Bachelor's Degree in social work, counseling, psychology, or closely related field who has at least three (3) years of full-time experience in the treatment or rehabilitation of substance abuse; or
- An alcohol, drug, or substance abuse counselor certified by the Missouri Substance Abuse Counselors Certification Board, Inc.

2.3.7 Mental Health and Substance Abuse In-Network Self Referrals: The health plan shall have written policies and procedures that permit members to seek in-network mental health services and substance abuse services without a referral or authorization from the primary care provider. The policies and procedures shall permit members to contact an in-network mental health and substance abuse provider directly and shall provide for the authorization of at least four (4) visits annually without prior authorization requirements. Health plan mental health and substance abuse providers shall complete a health status screen, at the initial point of contact and as part of the re-assessment process for members in treatment. Members with physical health conditions as indicated by the screen shall be referred to their primary care provider for evaluation and treatment of the physical health condition.

2.3.8 Physician Specialists: Because of the large number of physician specialties that exist, the health plan is not required to maintain specific member-to-specialist provider ratios. However, the health plan must provide adequate access to physician specialists for primary care provider referrals and employ or contract with physician specialists in sufficient numbers to ensure specialty services can be made available in a timely manner. The health plan shall have protocols for coordinating care between primary care providers and specialists which include the expected response time for consults between primary care providers and specialists.

2.3.9 Any Willing Pharmacy Provider: Any pharmacy, licensed without restriction under chapter 338, Revised Statutes of the State of Missouri (RSMo), as amended, and participating as an approved provider in the Missouri Medicaid program, which is qualified under the terms of the health plan and willing to accept the health plan's operating terms including, but not limited to, its schedule of fees, covered expenses, and quality standards, shall be allowed to participate in the health plan. Nothing shall prevent a

health plan from instituting reasonable credentialing criteria, requiring fee discounts, or establishing any other reasonable measure designed to maintain quality or control costs.

- 2.3.10 **Federally Qualified Health Centers and Rural Health Clinics:** The health plan shall include Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) in the health plan provider network, unless the health plan can demonstrate that it has both adequate capacity and an appropriate range of services to provide care for the expected enrollment in the region without contracting with FQHCs or RHCs. (A description of FQHC/RHC services is included in Attachment 2. A listing of FQHCs and RHCs are provided in Attachment 5.) If the health plan is competing against an FQHC or RHC owned health plan, the health plan shall not be required to comply with the previous requirement, although the health plan still must provide the FQHC/RHC services that are within the covered benefits of the MC+ managed care program. The health plan shall have protocols for coordinating care between the primary care provider and the FQHC and RHC provider and indicate the expected response time for consults between the FQHC and RHC and the primary care provider.
- 2.3.11 **Family Planning and Sexually Transmitted Disease (STD) Treatment Providers:** The health plan should include Title X and sexually transmitted disease treatment providers in the health plan provider network to serve members covered under the comprehensive and extended family planning, women's reproductive health, and sexually transmitted diseases benefit packages. The health plan shall allow for full freedom of choice for the provisions of these services. A listing of Family Planning and STD treatment providers is provided in Attachment 5.
- 2.3.12 **Local Public Health Agencies:** The health plan should include local public health agencies in the health plan provider network for the public health services described herein or for other services. (A listing of local public health agencies is provided in Attachment 5.) However, in order to ensure care coordination of members seeking services at a local public health agency, the health plan should establish an agreement with local public health agencies describing, at a minimum, care coordination, medical record management, and billing procedures. Requirements for reimbursement for certain services are specified in the Performance Requirements segment regarding public health programs and mandated health plan reimbursements. Attachment 4 lists a number of conditions for which the health plan shall report to or cooperate with local public health agencies. In addition, the health plan may wish to contract with local public health agencies, as defined above, to provide other health plan covered services.
- a. All statutorily mandated disease or condition reporting requirements remain, regardless of the site of the service. The health plan shall provide a list of their contracted laboratories to the Missouri Department of Health and Senior Services by July 1 each year.
- 2.3.13 **Network Changes:** The health plan shall notify the state agency within five (5) business days of first awareness/notification of change to the composition of the health plan provider network or the health care service subcontractors' provider network that materially affect the health plan's ability to make available all covered services in a timely manner. The health plan shall have procedures to address changes in the health plan provider network that negatively affect the ability of members to access services, including access to a culturally diverse provider network. Material changes in network composition that negatively affect member access to services may be grounds for contract cancellation or State determined sanctions.
- 2.3.14 **Mainstreaming:** The state agency considers mainstreaming of MC+ managed care members into the broader health delivery system to be important. The health plan therefore must ensure that all of the in-network providers accept members for treatment. The health plan also must accept responsibility for ensuring that in-network providers do not intentionally segregate members in any way from other persons receiving services.
- a. To ensure mainstreaming of members, the health plan shall take affirmative action so that members are provided covered services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, program membership, or
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physical or mental disability, except where medically indicated. Examples of prohibited practices include, but are not limited to, the following:

- 1) Denying or not providing to a member any covered service 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, other public or private patients, or the public at large.
 - 3) Subjecting a member to segregation or separate treatment in any manner related to the receipt of any covered service.
- b. If the health plan knowingly executes a subcontract with a provider with the intent of allowing or permitting the subcontractor to implement barriers to care (i.e., the terms of the subcontract are more restrictive than the contract), the State shall consider the health plan to have breached the provisions and requirements of the contract. In addition, if the health plan becomes aware of any of its existing subcontractors' failure to comply with this section and does not take action to correct this within thirty (30) calendar days, the State shall consider the health plan to have breached the provisions and requirements of the contract.

2.3.15 The health plan shall comply with any applicable federal requirements with respect to home health agencies, as amended.

2.3.16 **School Based Dental Services:** The state agency has reimbursed dental providers for the provision of preventive dental services provided to children in a school setting. These preventive services have included dental exams, prophylaxis, and sealants. The state agency is committed to the continuation of such programs for members enrolled with a health plan. The health plan shall contract and reimburse any licensed dental providers who provide such services in a school setting. The dental providers must be qualified under the terms of the health plan and willing to accept the health plan's operating terms, including but not limited to, its fee schedule, covered expenses, and quality standards, to be allowed to participate in the health plan provider network. Nothing shall prevent a health plan from instituting reasonable credentialing criteria for school-based dental services or establishing other reasonable measures designed to maintain quality of care or control costs.

2.3.17 **Tertiary Care:** Tertiary care is defined as health services provided by highly-specialized providers, such as medical sub-specialists. These services frequently require complex technological and support facilities. The health plan shall provide tertiary care services including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the region. If the health plan does not have a full range of tertiary care services, the health plan must have a process for providing such services including transfer protocols and arrangements with out-of-network providers.

2.3.18 **Specialty Pediatric Hospitals:** The health plan shall include specialty pediatric hospitals as defined in 13 CSR 70-15.010 (2) (P), as amended, in the health plan provider network.

2.4 Payments to Providers:

The state agency believes that one of the advantages of a managed care system is that it permits the health plan and providers to enter into creative payment arrangements intended to encourage and reward effective utilization management and quality of care. The state agency therefore shall give the health plan and providers as much freedom as possible to negotiate mutually acceptable payment rates and payment time frames. All subcontracts shall contain the time frames for paying in-network providers for covered services. However, regardless of the specific arrangements the health plan makes with providers, the health plan shall make timely payments to both in-network and out-of-network providers, subject to the conditions described below. All disputes between the health plan and in-network and out-of-network

providers shall be solely between such providers and the health plan. In the case of any disputes regarding payment for covered services between the health plan and providers, the member shall not be charged for any of the disputed costs. This agreement shall only be overcome by written evidence of an agreement between the provider and the member indicating that the member accepts the status and liabilities of a private pay patient. The health plan shall make it clear to members that all covered services are available to the member at no cost subject to any applicable co-pays. The private pay agreement shall only be for services not included in the comprehensive benefit package.

2.4.1 Retroactive Eligibility Period: Except for newborns, the health plan shall not be responsible for any payments owed to providers for services rendered prior to a member's enrollment even if they fell within the established period of retroactive eligibility.

2.4.2 Claims Processing Requirements: The claim processing requirements are set forth by RSMo 376.383 and RSMo 376.384, as amended.

2.4.3 Clean Claims: Clean claim means a claim that can be processed without obtaining additional information from the provider of the service or from a third party.

2.4.4 Inappropriate Payment Denials: If the health plan has a pattern of inappropriately denying or delaying payments for services, the health plan may be subject to suspension of new enrollments, withholding in full or in part of capitation payments, contract cancellation, or refusal to contract in a future time period. This applies not only to cases where the state agency has ordered payment after appeal but to cases where no appeal has been made (i.e., the state agency is knowledgeable about the documented abuse from other sources).

2.4.5 Copayment Requirements and Member Participation in Pharmacy Professional Dispensing Fee:

- a. Copayment requirements do not apply to MC+ Managed Care members.
- b. Member Participation in Pharmacy Professional Dispensing Fee
 - 1) Unlike traditional copayment requirements, the current Missouri Medicaid Recipient Pharmacy fee requirement is considered a portion of the professional dispensing fee and is not deducted from the reimbursement to providers. Therefore, the member portion of the pharmacy dispensing fee is required to be collected, according to current Medicaid policy, for pharmacy services provided by the health plan. The provider must charge and collect dispensing fees as specified in accordance with section 208.152 RSMo, as amended. Providers shall not deny or reduce services to members solely on the basis of the member's inability to pay the fee when charged. A member's inability to pay a required amount as due and charged when a service is delivered, shall in no way extinguish the member's liability to pay the amount due. Fee responsibility and amounts collectible shall be as follows:

Ingredient Cost for Each Item of Service	Member Participation in Pharmacy Professional Dispensing Fee
\$10.00 or Less:	\$0.50
\$10.01 to \$25.00:	\$1.00
\$25.01 or More:	\$2.00

- 2) Under current pharmacy dispensing fee policy, all Missouri eligible recipients are subject to the fee requirement when provided covered pharmacy services, with the exception of the following:
 - Beneficiaries under age 19.

- Services related to Early Periodic Screening, Diagnosis and Treatment (EPSDT): Those drugs which are prescribed and identified as relating to an EPSDT program screening or referral services must be confirmed as such to the dispensing provider through one of the following methods:
 - The prescribing provider identifies on the prescription that it relates to an EPSDT examination and treatment; or
 - The prescribing provider verbally states that the prescription relates to an EPSDT examination and treatment in cases of telephone prescribing. This verbal assertion must be included in the dispensing provider's reduction into writing of the prescription.
 - Institutionalized members residing in a skilled nursing facility, psychiatric hospital, residential care facility, or adult boarding home.
 - Foster Care children.
 - All Medicare/Medicaid crossover claims as primary coverage as afforded by the Medicare program.
 - Those services specifically identified as related to Family Planning services.
 - Emergency services.
 - Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy.
- 3) Participation in the health plan provider network shall be limited to providers who accept, as payment in full, the amounts paid by the health plan plus any fee amount required of the member and collected by the provider.

2.4.6 Pharmacy Dispensing Fee: The health plan shall pay a pharmacy dispensing fee of \$4.09 to each qualifying pharmacy for the first 1,000 prescriptions filled in any calendar quarter. The reimbursement of a pharmacy dispensing fee shall be available only to corporations, partnerships, or individual proprietorships with less than 25 employees who operate pharmacies or pharmacy franchises and to public health entities owned and operated by a state, county, or local government agency and where the entity is a hospital which qualifies as a first-tier 10% add-on disproportionate share hospital in accordance with 13 CSR 70-15.010. The health plan shall identify its pharmacies that qualify. The health plan shall supply the state agency with a list of those pharmacies identified to qualify for a pharmacy dispensing fee reimbursement upon request.

2.4.7 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs): If the health plan includes subcontracted FQHCs or RHCs in the health plan provider network, the FQHC or RHC is entitled to reimbursement of reasonable costs from the state agency and any differential payment paid by the state agency.

- a. The health plan shall reimburse the FQHC/RHC at the same reimbursement level as other providers for the same services. The state agency shall perform reconciliation between the health plan reimbursement and the FQHC/RHC's reasonable costs for the covered services provided under the contract. The FQHC/RHC must fully comply with the state agency's payment and billing systems, and provide the state agency with all cost reporting information required by the state agency to verify reasonable costs and apply applicable reasonable cost reimbursement principles. The health plan shall submit a list of its contracted FQHCs and RHCs to the state agency annually at the start of each contract period.
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- b. If the health plan contracts with FQHCs or RHCs, the health plan shall fulfill the following:
- 1) Billing for Services Provided by an FQHC or RHC: The FQHC/RHC must bill using a valid FQHC/RHC's Medicaid Provider Number. The health plan shall include this Medicaid Provider Number on FQHC/RHC claims as follows:
 - **FQHC Medical and Dental Claims:** The health plan shall submit the FQHC's Missouri Medicaid Provider Number on the NSF layout, record 'FAO', within field number 23. This field is referenced as the Rendering Provider Number.
 - **FQHC Home Health Claims:** The health plan shall submit the FQHC's Missouri Medicaid Provider Number on the UB92 layout, record '80', within field number 11. This field is referenced as the Other Provider.
 - **FQHC Pharmacy Claims:** The health plan shall submit the FQHC's Missouri Medicaid Provider Number on the NCPDP 3C layout, field number 411. This field is referenced as the Prescriber ID.
 - **RHC Claims:** The health plan shall submit the RHC's Missouri Medicaid Provider Number on the UB92 layout, record 80', within field number 11. This field is referenced as the Other Provider.
 - 2) The FQHC/RHC must bill its usual and customary amount for all payor classes. The health plan shall include the billed amount when the health plan submits the encounter claims to the state agency.
 - 3) Reporting Requirements for Services Provided by an FQHC or RHC
 - The health plan shall submit Schedule M-1 included with Attachment 7 documenting the accepted charges, denied charges, and payments for each contracted RHC/FQHC. The health plan shall submit Schedule M-1 thirty (30) calendar days after the month end for services provided by the contracted FQHC/RHC. Attachment 7 also provides the instructions for completing Schedule M-1.
 - The health plan shall submit Schedule M-2 included with Attachment 7 documenting the accepted charges, denied charges, and payments for each contracted RHC/FQHC for the FQHC's/RHC's entire fiscal year. The health plan shall submit Schedule M-2 within 14 business days of request by the state agency for MC+ managed care services provided by contracted FQHC/RHC during the reporting period requested. Attachment 7 also provides the instructions for completing Schedule M-2.
 - Health plan records applicable to a FQHC/RHC are subject to audit by the state agency or its contracted agent.

2.4.8 Payment for Emergency Services and Post-stabilization Care Services:

- a. The health plan shall cover and pay for emergency services regardless of whether the provider that furnishes the services has a contract with the health plan.
 - 1) The state agency encourages the health plan and providers to reach agreement on payment for services.
 - 2) The health plan shall pay out-of-network providers for emergency services at the current Missouri Medicaid program rates in effect at the time of service unless the health plan and provider have negotiated a mutually acceptable rate.
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- b. The health plan may not deny payment for treatment obtained under either of the following circumstances:
 - 1) A member 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 emergency medical condition specified herein.
 - 2) A representative of the health plan instructs the member to seek emergency services.
 - c. The health plan shall not limit what constitutes an emergency medical condition as defined herein on the basis of lists of diagnoses or symptoms.
 - d. The health plan shall not refuse to cover emergency services based on the emergency room provider, hospital, or fiscal agent not notifying the member's primary care provider or the health plan of the member's screening and treatment within ten (10) calendar days of presentation for emergency services.
 - e. A member who has an emergency medical condition may not be held liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient.
 - f. The attending emergency physician, or the provider actually treating the member, is responsible for determining when the member is sufficiently stabilized for transfer or discharge, and that determination is binding on the health plan.
 - g. The health plan must be financially responsible for post-stabilization care services obtained within or outside the health plan that are pre-approved by a health plan provider or other health plan representative.
 - h. The health plan must be financially responsible for post-stabilization care services obtained within or outside the health plan that are not pre-approved by a health plan provider or other health plan organization representative, but administered to maintain the enrollee's stabilized condition within thirty (30) minutes of a request to the health plan for pre-approval of further post-stabilization care services.
 - i. The health plan must be financially responsible for post-stabilization care services obtained within or outside the health plan that are not pre-approved by a health plan provider or other health plan representative, but administered to maintain, improve, or resolve the enrollee's stabilized condition if:
 - 1) The health plan does not respond to a request for pre-approval within thirty (30) minutes;
 - 2) The health plan cannot be contacted; or
 - 3) The health plan representative and the treating physician cannot reach an agreement concerning the member's care and a health plan physician is not available for consultation. In this situation, the health plan must give the treating physician the opportunity to consult with a health plan physician and the treating physician may continue with care of the patient until a health plan physician is reached or one of the criteria in subparagraph l below is met.
 - j. The health plan must limit charges to members for post-stabilization care services to an amount no greater than what the health plan would charge the member if he or she had obtained the services through the health plan.
 - k. The health plan shall negotiate mutually acceptable payment rates with out-of-network providers for post-stabilization services for which the health plan has financial responsibility.
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1. The health plan's financial responsibility for post-stabilization care services it has not pre-approved ends when:
 - 1) A health plan physician with privileges at the treating hospital assumes responsibility for the member's care;
 - 2) A health plan physician assumes responsibility for the member's care through transfer;
 - 3) A health plan representative and the treating physician reach an agreement concerning the enrollee's care; or
 - 4) The member is transferred.
 - 2.4.9 The health plan shall maintain the fee schedule for dental services located in Attachment 14 at no lower than the Medicaid fee-for-service fee schedule in effect at the time of service.
 - 2.4.10 **Specialty Pediatric Hospitals.** The health plan shall reimburse specialty pediatric hospitals as defined in 13 CSR 70-15.010 (2) (P) at no lower than the Medicaid fee-for-service fee schedule in effect at the time of service unless otherwise negotiated with the provider.
 - 2.4.11 A health plan shall pay for services furnished outside their service area to the same extent that it would pay for services furnished within their service area if the services are furnished to a member and any of the following conditions are met:
 - a. Medical services are needed because of a medical emergency;
 - b. Medical services are needed and the member's health would be endangered if he were required to travel to member's residence;
 - c. The health plan determines, on the basis of medical advice, that the needed medical services, or necessary supplementary resources, are more readily available outside the service area. These services are subject to the health plan's prior authorization and concurrent review process.
 - 2.5 **Eligibility Determinations:**

The Missouri Department of Social Services, the Family Support Division performs eligibility determinations. Trained staff are stationed full-time at field offices located throughout the State and on a periodic basis at health care provider sites that serve large numbers of MC+ members.

 - 2.5.1 **Health Plan Lock-In:** All members will have a twelve (12) month lock-in to provide a solid continuum of care. Once a member chooses a health plan or is assigned to a health plan, the member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. This applies to the member's initial enrollment and to any subsequent enrollment periods where the member changed health plans. All transfers between health plans that members request during the first ninety (90) calendar days following initial enrollment shall be granted without review by the state agency. Both the 90-day and the 12-month enrollment period begin on the same day. Children in COA 4 shall be allowed automatic and unlimited changes in health plan choice as often as circumstances necessitate.
 - 2.5.2 **Open Enrollment:** The state agency may conduct an open enrollment for the contract period. The state agency may at its sole option adjust enrollment during the transition between contract periods.
 - a. Annual Open Enrollment: The state agency shall give members an annual open enrollment period prior to their 12-month enrollment anniversary date with the health plan. The state agency shall provide an open enrollment notice to members at least sixty (60) calendar days before each annual enrollment opportunity.
 - 2.5.3 **Enrollment Counseling:** The state agency shall make available helpline operators to all program MC+ managed care eligibles to provide assistance in selecting and enrolling into a health plan through the operation of a toll-free telephone line. Helpline operators also shall be available by telephone to assist
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MC+ managed care eligibles who would like to change health plans (e.g., during open enrollment). MC+ managed care eligibles shall be offered the assistance of a helpline operator when needed. The helpline operator responsibilities shall include the following:

- a. Educating the family about managed care in general, including the requirement to enroll in a health plan, the way services typically are accessed under managed care, the role of the primary care provider, the health plan member's right to choose a primary care provider subject to the capacity of the provider, the responsibilities of the health plan member, and the member's rights to file grievances and appeals and to request a State Fair Hearing.
- b. Educating the family about benefits available through the health plan, both in-network and out-of-network.
- c. Informing the family of available health plans and outlining criteria that might be important when making a choice (e.g., presence or absence of the family's existing provider in the health plan provider network).
- d. Identifying any sources of Third Party Liability that were not identified by the FSD eligibility technician.
- e. Administering a health plan screen when possible, as designated by the state agency, that collects baseline health status data to be used as part of the health plan program evaluation. Any baseline health status data shall be made available to the health plan. (See Attachment 8 for the most current version.)
- f. Explaining options for obtaining services outside the health plan network.
- g. Providing a listing of the health plan primary care providers generated from the provider demographic electronic file submitted by the health plan to the state agency.

2.5.4 Voluntary Selection of Health Plan: Missouri MC+ managed care eligibles shall be given fifteen (15) calendar days from the time of their eligibility for managed care to select a health plan. All members of a family shall be encouraged to select the same health plan. If a family does not select a health plan within the fifteen (15) day window, the state agency shall automatically assign the family to a health plan.

2.5.5 Automatic Assignment Into Health Plans:

- a. The state agency shall employ an algorithm to assign to the health plan, on a prorated basis, any MC+ managed care eligibles who do not make a voluntary selection of a health plan during open enrollment. The algorithm shall be based on the following:
 - 1) If the MC+ managed care eligible's case head is enrolled with a health plan, the MC+ managed care eligible shall be assigned to that health plan. If not, the next step in the algorithm shall be followed.
 - 2) If the MC+ managed care eligible is included in a case where another member is enrolled with a health plan, the MC+ managed care eligible shall be assigned to that health plan. If not, the MC+ managed care eligible shall be assigned randomly.

Paragraph 2.5.5 b. revised by Amendment #001

- b. **Eastern/Western Regions:** The random auto assignment shall be based on the total evaluation determined by the State of Missouri (see Proposal Submission Information section).

Paragraph 2.5.5 c. inserted by Amendment #001

- c. **Central Region:** The random auto assignment shall be based on the inclusion of health plan signed contracts with acute care safety net hospitals, as defined in 13 CSR 70-15.010 of the Code of State
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Regulations, as amended. (A listing of safety net hospitals is provided in Attachment 5.) The acute care safety net hospital must be located in the Central region counties.

- 1) The health plan including such acute care safety net hospitals in its network shall equally divide seventy percent (70%) of the random auto assignments, while the remaining health plans shall equally share the remaining thirty percent (30%) of the algorithm assignments.
- 2) In the event all health plans have such acute care safety net hospitals in their networks, all contracted health plans shall equally share one hundred percent (100%) of the random auto assignments.

2.5.6 Automatic Re-Assignment Following Resumption of Eligibility: Members who are disenrolled from a health plan due to loss of eligibility, shall automatically be re-enrolled, or assigned, into the same health plan and to the same primary care provider should they regain eligibility within sixty (60) calendar days. The member will have ninety (90) calendar days from the effective date of coverage with the health plan in which to change health plans for any reason. If more than sixty (60) calendar days have elapsed, the member shall be permitted to select a health plan and primary care provider through the enrollment process.

2.6 Member Enrollment and Disenrollment:

2.6.1 MC+ Managed Care Marketing Guidelines: The health plan may educate and conduct marketing campaigns for MC+ managed care members, subject to the restrictions and definitions outlined herein. Education activities are efforts directed to current members to provide knowledge or skills. Marketing campaigns are efforts directed to an audience of members and potential health plan members to retain or increase health plan membership. The health plan and subcontractors shall not influence member enrollment.

a. Marketing Guidelines: The health plan shall:

- 1) Submit its proposed marketing plan, all marketing materials, and member education materials to the state agency for written approval prior to use. The state agency shall only consider the marketing plan and materials submitted by the health plan, (not subcontractors). The health plan should submit all materials in mock camera-ready form. When submitting marketing and education materials for approval, the health plan shall indicate how and when the material will be used, the time frames for the use, and the media to be used for distribution if approved. All written materials must be at a 6th grade reading level or less. The state agency shall approve, disapprove, or require modifications of education and marketing materials. The state agency shall review and respond as soon as possible, but within thirty (30) calendar days of receipt by the state agency. Marketing and education materials are deemed approved if a response from the state agency is not returned within thirty (30) calendar days following receipt of the materials by the state agency. The health plan shall engage in only those marketing activities which are prior approved in writing.
 - 2) The health plan's marketing material shall include a listing of their in-network providers identified by specialty and location, as appropriate for the document submitted for approval.
 - 3) The health plan's marketing and education materials shall include the member's rights and responsibilities to assistance in obtaining all covered services.
 - 4) Correct problems and errors with the marketing plan and/or materials as identified by the state agency. The health plan shall submit to the state agency a written corrected marketing plan or revised material within ten (10) business days following receipt date of the written notice from the state agency.
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- 5) Not display or distribute any marketing materials in any manner at Family Support Division (FSD) offices, or health plan provider sites, unless the health plan has received prior written permission to do so from the state agency. Only approved member handbooks and provider network listing may be distributed to local FSD offices. The health plan shall supply current materials and remove their out-dated materials in public areas at the FSD offices.
 - 6) Review all education and marketing materials at least once a year. The health plan shall provide the state agency with copies of materials and documentation verifying the health plan reviewed their education and marketing material.
 - 7) Submit to the state agency, for prior written approval, all materials used by in-network providers to advise members of the health plans with which they have contracts. The health plan shall provide the following listing of what constitutes approved material to in-network providers.
 - A list of all health plans with which they have contracts;
 - A letter to previous fee-for-service recipients who may be eligible for MC+ managed care, informing them of all health plan(s) with which the provider has contracted;
 - A display of all contracted health plan logos in an equal fashion;
 - A listing of all contracted health plan phone numbers;
 - Access to all contracted health plan directories and member handbooks as a member resource but not for distribution; and
 - Displaying enrollment helpline phone number.

The in-network provider shall provide equal representation of all contracted health plans and shall not favor one health plan over another in displayed information.
 - 8) Show the date the state agency approved the material in the lower right-hand corner of all materials.
 - 9) Use mandatory education, marketing, and member notice language provided by the state agency. The state agency shall provide such language as it deems necessary. Any publicity given to the MC+ Managed Care Program or the MC+ managed care benefits, including but not limited to: notices, pamphlets, press releases, research, reports, signs, and public notices prepared by or for the health plan shall be released only with prior written approval by the state agency.
 - 10) Not use the state agency's or the Department of Social Services' name, logo, or other identifying marks on any of the materials produced or issued without the prior written approval of the state agency.
 - 11) Not use any report, graph, chart, picture, or other document produced and included in whole or in part under the MC+ managed care contract which is subject to copyright or the subject of any application for copyright by or on behalf of the health plan.
 - 12) Develop MC+ managed care marketing plans and materials that are accurate and shall not mislead, confuse, defraud, or deceive MC+ managed care eligibles, or otherwise violate Federal or State consumer protection laws or regulations. MC+ managed care benefits must be listed according to the current MC+ managed care contracts. The health plan may not verbally or in writing identify or portray covered benefits as enhanced, additional, or free.
 - 13) Not practice door-to-door, face-to-face, telephonic, or other "cold call" marketing. The offerings of cash, prizes, other items for material gain, or other insurance products as an award for enrollment are prohibited. However, the health plan may offer additional health benefits to their members. If the health plan offers additional health benefits, the health plan must notify
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the state agency of these benefits no later than ten (10) calendar days prior to their offering and must notify the state agency no less than thirty (30) calendar days prior to discontinuing such benefits.

- Cold Call Marketing means any unsolicited personal contact by the health plan with a potential member for the purpose of marketing as defined in this paragraph.
- 14) Provide notice to the state agency or have prior written approval from the state agency in certain situations to sponsor or participate in community activities, programs, or events.
- Community activities are defined for the purpose of this document as: An activity where people come together to learn about or question health care benefits, responsibilities, and procedures. These community activities require no notice to the state agency, except when held at provider sites. At community activities, the health plan shall only use materials approved by the state agency and must adhere to the ban on engaging in enrollment activities required herein.
 - Community activities at provider sites require a seven (7) calendar day notice to the state agency prior to sponsoring or participating in an activity. Provider sites may include, but are not limited to pharmacies in discount or grocery stores if the pharmacies are in an MC+ managed care network, local public health agency, provider clinics, hospitals etc.
 - The health plan may offer the availability of gifts no greater than \$10 in value, and only if such gifts are offered during any community activity (i.e. health fair). The nominal items must be offered to all individuals attending the community activity. The gifts must be directly and obviously health related or limited to printed materials, T-shirts, pens or pencils, caps, mugs, key chains, etc. All items must have prior written approval by the state agency and written proof of cost per unit must be provided by the health plan to the state agency prior to approval. Once an item is approved, it does not have to be re-approved for additional community activities. Advertising the availability of such gifts through mailings, TV or radio, posters, and other promotions or publicity is prohibited.
- 15) Not offer raffles or conduct lotteries. Door prizes may be offered within the parameters and limits specified for participation in community activities, programs, or events.
- 16) Request state agency prepared mandatory MC+ managed care materials from the state agency. The health plan and its subcontractors should make the general public aware of the MC+ program by providing any of the following:
- General MC+ eligibility information; or
 - MC+ applications to complete and mail.
- 17) Not conduct or participate in health plan enrollment, disenrollment, transfer, or opt out activities. The health plan and the providers shall not influence a member's enrollment. Prohibited activities include:
- Requiring or encouraging the member to apply for an assistance category not included in MC+ managed care;
 - Requiring or encouraging the member and/or guardian to use the opt out as an option in lieu of delivering health plan benefits;
 - Mailing or faxing health plan enrollment forms;
 - Aiding the member in filling out health plan enrollment forms;
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- Photocopying blank health plan enrollment forms for potential members;
 - Distributing blank health plan enrollment forms;
 - Participating in three way calls to the MC+ managed care enrollment helpline;
 - Suggesting a member transfer to another health plan; or
 - Other activities in which the health plan, its representatives, or in-network providers are engaged in activities to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan (their own or another).
- 18) Advise the health plan's subcontractors of these marketing guidelines and ensure that subcontractors adhere to them. No subcontract shall operate to relieve the health plan of its obligations. The health plan shall have written procedures to ensure subcontractor notification and compliance with these marketing guidelines.
 - 19) Use pre-approved MC+ managed care information and materials for presentations or interviews with print and electronic media.
 - 20) Not use testimonial materials and/or celebrity endorsements.
 - 21) Insert new language in the educational and marketing materials and substitute in a timely manner, as outlined by the state agency, any changes in Federal or State law or regulation, as amended, as the need arises.
 - 22) Make an effort to ensure that presentations shall be available to maximize consumer access to information, including presentation after normal work hours, and at sites other than the Family Support Division offices, such as WIC sites, Head Start centers, health fairs, etc.
 - 23) Make member education available on an ongoing basis to provide guidance on how to use a health plan, and how to assert certain rights with their health plan, if necessary.
 - 24) Market to the entire service area
 - 25) All marketing and educational material shall maintain a member's right to confidentiality. In particular, post cards must be folded to protect the confidentiality of the member.
 - 26) Not develop marketing materials that contain any assertion or statement (whether written or oral) that:
 - The recipient must enroll with the health plan in order to obtain benefits or in order not to lose benefits.
 - The health plan is endorsed by CMS, the Federal or State government or similar entity.

2.6.2 Health Plan Enrollment Procedures:

- a. The state agency reserves the right to suspend or limit enrollment into a health plan. In the event the health plan's enrollment reaches sixty-five (65) percent of the total MC+ managed care enrollment in the region, the health plan shall not be offered as a choice for enrollment nor shall the health plan receive members through the automatic assignment algorithm. However, the health plan may receive new members as a result of newborn enrollments, reassignments when a member loses and regains MC+ managed care eligibility within a sixty (60) day period, other family or case members are members of the health plan, for the member's continuity of care, or for just cause determined by
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the state agency. The state agency's evaluation of a health plan's enrollment market share shall take place on a calendar quarter.

- b. The state agency shall conduct enrollment activities for MC+ managed care eligibles. The health plan or its subcontractors shall not conduct or participate in eligibility or enrollment activities.
 - c. The health plan shall have written policies and procedures for enrolling these members within five (5) business days after receiving notification of the member's anticipated enrollment date from the state agency (e.g., if the health plan is informed of a new member on a Wednesday, it must contact the member by the following Tuesday).
 - d. The health plan shall enroll any MC+ managed care eligible who selects the health plan or is assigned with the health plan. The only exceptions shall be if:
 - 1) The health plan's specified enrollment limit has been reached.
 - 2) The member was previously disenrolled from the health plan as the result of a request for disenrollment by the health plan, as allowed herein.
 - e. **Enrollment of Program Newborns:** The health plan shall have written policies and procedures for enrolling the newborn children of members effective to the date of birth. Newborns of members enrolled at the time of the child's birth shall be automatically enrolled with the mother's health plan. The health plan shall have a procedure in place to refer newborns to the Family Support Division to initiate eligibility determinations. A mother of a newborn may choose a different health plan for her child; unless a different health plan is requested, the child shall remain with the mother's health plan.
 - 1) The mother's health plan shall be responsible for all medically necessary services provided under the comprehensive benefit package to the newborn child of an enrolled mother. The child's date of birth shall be counted as day one (1). The health plan shall provide services to the child until the child is disenrolled from the health plan. When the newborn is assigned a departmental client number (DCN), the health plan shall receive capitation payment for the month of birth and for all subsequent months the child remains enrolled with the health plan.
 - 2) In the case of an administrative lag in enrolling the newborn and costs are incurred during that period, the health plan shall hold the member harmless for those costs. The health plan shall be responsible for the cost of the newborn including medical services provided prior to completion of the State enrollment process.
 - f. **Changes in Status:** The health plan shall encourage its membership to report to the Family Support Division any changes in the status of families or members, including changes in family size, income, insurance coverage, and residence.
 - g. **Enrollment and Disenrollment Updates:** Every business day, the state agency shall make available, via electronic media, updates on members newly enrolled into the health plan, or newly disenrolled. The health plan shall have written policies and procedures for receiving these updates and incorporating them into the health plan and health care service subcontractors' management information system each day.
 - h. **Weekly Reconciliation:** On a weekly basis, the state agency shall make available, via electronic media, a listing of current members. The health plan shall reconcile this membership list against the health plan internal records within thirty (30) business days of receipt and shall notify the state agency of any discrepancies.
 - i. **Services for New Members:** The health plan shall make available the full scope of benefits to which a member is entitled immediately upon his or her enrollment.
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- j. **New Member Orientation:** The health plan shall have written policies and procedures for orienting new members to their benefits; the role of the primary care provider; how to utilize services; what to do in an emergent or urgent medical situation; how to file a grievance or appeal; and how to report suspected fraud and abuse.
- 1) **Member Responsibilities:** The health plan shall have written policies that address the members' responsibilities for cooperating with providers. These member responsibility policies must be supplied in writing to all providers and members. These written policies should address the members' responsibilities for:
- Providing, to the extent possible, information needed by providers in caring for the member.
 - Contacting their primary care provider as their first point of contact when needing medical care.
 - Following appointment scheduling processes.
 - Following instructions and guidelines given by providers.
- 2) **Member Rights:** The health plan shall have written policies regarding member rights as specified below:
- General Rule. Each health plan must comply with any applicable Federal and State laws that pertain to member rights and ensure that its staff and affiliated providers take those rights into account when furnishing services to members.
 - Dignity and privacy. Each member is guaranteed the right to be treated with respect and with due consideration for his or her dignity and privacy.
 - Receive information on available treatment options. Each member is guaranteed the right to receive information on available treatment options and alternatives, presented in a manner appropriate to the member's condition and ability to understand.
 - Participate in decisions. Each member is guaranteed the right to participate in decisions regarding his or her health care, including the right to refuse treatment.
 - Free from restraint or seclusion. Each member is guaranteed the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.
 - Copy of medical records. Each member is guaranteed the right to request and receive a copy of his or her medical records, and to request that they be amended or corrected, as specified in 45 CFR part 164.
 - Free exercise of rights. Each member is free to exercise his or her rights, and that the exercise of those rights does not adversely affect the way the health plan and its providers or the state agency treat the member.
- k. **Assignment of Primary Care Providers:** The health plan shall have written policies and procedures for assigning each of the health plan's members to a primary care provider. The process must include at least the following features:
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- 1) The health plan shall contact the member within five (5) business days from the date of the state agency's notification to the health plan of the member's anticipated enrollment date. To the extent provider capacity exists, the health plan shall offer freedom of choice to members in making a primary care provider selection.

At the time of the state agency's notification to the health plan, the health plan may assign a primary care provider taking into consideration factors such as current provider relationships, language needs, (to the extent they are known), and area of residence. When contacting the member, the health plan shall provide the member with the primary care provider's name, location, and telephone number. When contacting the member, the health plan shall provide options for selecting a primary care provider other than the primary care provider assigned to the member. The health plan shall inform the member he/she has fifteen (15) calendar days to choose another primary care provider if they do not approve of the primary care provider assigned to them, and if they have not notified the health plan of their preferred primary care provider within that time frame, the member will remain with the primary care provider previously assigned to the member.

- 2) Prior to becoming effective with the health plan, if a member does not select a primary care provider or the health plan has not already assigned a primary care provider to the member at the time of notification from the state agency of the member's anticipated enrollment date, the health plan shall make an automatic assignment, taking into consideration such known factors as current provider relationships, language needs (to the extent they are known), and area of residence. The health plan shall then notify the member in writing of his or her primary care provider's name, location, and office telephone number. The member must have a primary care provider assigned by the time the member is effective with the health plan. If circumstances are such that the member does not have a primary care provider assigned on the effective date with the health plan, the health plan shall not deny services or payment of any service. The health plan shall submit to the state agency the methodology utilized by the health plan to assign primary care providers to members.
- 3) Members with disabling conditions or chronic illnesses may request that their primary care providers be specialists, such as a psychiatrist, oncologist, obstetrician, gynecologist, or other such specialist. The health plan must have procedures for ensuring access to needed services for those members or the request shall be granted. The specialist must accept the member as a primary care patient and accept the responsibility of a primary care provider as specified herein. The health plan must communicate its decision to the member within ten (10) calendar days of request. The adequacy of these policies shall be reviewed by the state agency.
- 4) The health plan shall have written policies and procedures for notifying primary care providers of their assigned member prior to the member's effective date with the primary care provider.

1. **Changing Primary Care Providers:** The health plan shall have written policies and procedures for allowing members to select or be assigned to a new primary care provider within the health plan when such a change is mutually agreed to by the health plan and member. The health plan shall allow members at least two such changes per year, and shall inform members of the process for initiating these changes. However, children in COA 4 may change primary care providers at will. Possible reasons for a member to change primary care providers include, but are not limited to:

- 1) Accessibility — transportation problems, provider office hours, does not return phone calls, waiting times.
 - 2) Acceptability — sees too many doctors, uncomfortable with surroundings or location, provider or staff attitudes, lack of courtesy, following a member's initial visit to the primary care provider.
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- 3) Quality — treatment (medical), referral related, does not explain treatment plan/diagnosis. If provider problem, may request primary care provider changes and second opinion.
 - 4) Enrollment — primary care provider with whom the member has an established patient/provider relationship no longer participates in the health plan. In cases where the primary care provider no longer participates, the health plan shall allow members to select another primary care provider or make a re-assignment within fifteen (15) calendar days of the termination effective date.
 - 5) An act of cultural insensitivity that negatively impacts the member's ability to obtain care.
 - 6) A primary care provider change is ordered as part of the resolution to the grievance and appeal process. A member's right to request a change in a primary care provider through the grievance and appeal process or other means shall not be restricted.
- m. **Identification Cards:** The state agency shall issue a plastic, magnetic strip identification card to all Missouri MC+ eligibles. This card is not proof of eligibility, but to be used as a key for accessing the State's electronic eligibility verification systems by Medicaid enrolled providers. These systems shall contain the most current information available to the state agency, including specific information regarding health plan enrollment. There will be no health plan specific information printed on the card. In addition to the state agency issued card, the health plan should issue a membership card that contains information more specific to the health plan. The health plan issued membership card must be issued to the member prior to the member's effective date of coverage with the health plan. Upon selection or assignment of a health plan, the member's effective date shall be 15 calendar days in the future, thereby allowing the health plan to send the appropriate enrollment materials, such as the identification card, to the member prior to the effective date. Exceptions apply to this policy for newborns and emergency enrollments. The state agency recognizes those exceptions and such enrollment materials may be produced as expeditiously as possible, but no later than 15 calendar days from the notification of the enrollment. At a minimum, the health plan issued membership card must contain the member's name, identification number, primary care provider name and telephone number, instructions for emergencies, and other relevant toll free lines for access such as mental health, dental, pharmacy, and nurse advice lines.
- n. **Member Handbook:** The health plan shall mail a member handbook, or other written materials with information on how to access services, to all members within ten (10) business days of being notified of their future enrollment with the health plan. When there are program changes, the health plan shall notify the affected members at least thirty (30) calendar days before implementation of such change. On an annual basis, the health plan shall review the member handbook and shall document that such review occurred.
- 1) The member handbook must be written at no higher than a sixth grade level. Suggested reference material to determine whether this requirement is being met are:
 - Fry Readability Index
 - PROSE The Readability Analyst (software developed by Education Activities, Inc.)
 - Gunning FOG Index
 - McLaughlin SMOG Index
 - The Flesch-Kincaid Index or other word processing software approved by the state agency.
 - 2) At a minimum, the member handbook shall include the information and items listed below. The health plan may include some of the following information as inserts to the member
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handbook. The health plan shall include certain passages and language provided by the state agency in the member handbook. The health plan shall comply with all changes regarding member handbook content specified by the state agency in a timely manner as defined by the state agency.

- Table of contents.
 - Information about choosing and changing primary care providers, including notice of how to determine whether a participating provider is accepting new patients.
 - Information about what to do when family size changes.
 - Appointment procedures.
 - A description of all available health plan services and an explanation of any service limitations or exclusions from coverage and a notice stating that the health plan shall be liable only for those services authorized by the health plan.
 - A description of all available services outside the comprehensive benefit package. Such information shall include information on where and how members may access benefits not available under the comprehensive benefit package.
 - The definition of medical necessity used in determining whether benefits will be covered.
 - A description of all prior authorization or other requirements for treatments and services.
 - A description of utilization review policies and procedures used by the health plan.
 - An explanation of a member's financial responsibility for payment when services are provided by an out-of-network provider or by any provider without required authorization or when a procedure, treatment, or service is not covered by MC+ managed care.
 - Notice that a member may obtain an out-of network provider when the health plan does not have an in-network provider with appropriate training and experience to meet the particular health care needs of the member and the procedure by which the member can obtain such referral.
 - Notice that a member with a condition which requires ongoing care from a specialist may request a standing referral to such a specialist and the procedure for requesting and obtaining such a standing referral.
 - Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request a specialist responsible for providing or coordinating the member's medical care and the procedure for requesting and obtaining such a specialist.
 - Notice that a member with a life-threatening condition or disease or a degenerative and disabling condition or disease, either of which requires specialized medical care over a prolonged period of time, may request access to a specialty care center and the procedure by which such access may be obtained.
 - A description of the mechanisms by which members may participate in the development of the policies of the health plan.
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- Notice of all appropriate mailing addresses and telephone numbers to be utilized by members seeking information or authorization.
- Procedures for disenrollment, including an explanation of the member's right to disenroll with and without cause.
- How to contact member services and a description of its function.
- Information on grievance, appeal, and fair hearing procedures and timeframes. Such information includes:
 - a) The right to file grievances and appeals.
 - b) The requirement and timeframes for filing a grievance or appeal.
 - c) The availability of assistance in the filing process.
 - d) The toll-free numbers that the member can use to file a grievance or an appeal by phone.
 - e) The procedures for exercising the rights to appeal or request a State fair hearing.
 - f) That the member may represent himself or use legal counsel, a relative, a friend, or other spokesperson.
 - g) Must explain the specific regulations that support, or the change in Federal or State law that requires the action.
 - h) The fact that, when requested by the member -
 - Benefits will continue if the member files an appeal or a request for State fair hearing within the timeframes specified for filing; and
 - The member may be required to pay the cost of services furnished while the appeal is pending, if the final decision is adverse to the member.
 - i) The member's right to request a State fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.
 - A member may request a State fair hearing within 90 calendar days from the health plan's notice of action.
 - The state agency must reach its decisions within the specified timeframes:
 - 1) Standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the enrollee took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
 - 2) Expedited resolution (if the appeal was heard first through the health plan appeal process): within 3 working days from the state agency's receipt of a hearing request for a denial of a service that:
 - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or
 - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
 - 3) Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the health plan appeal process): within 3 working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.
 - j. Any appeal rights that the state chooses to make available to providers to challenge the failure of the organization to cover a service.
 - How to report suspected fraud and abuse activities.

- Pharmacy dispensing fee requirements (if applicable): The health plan must include a statement that care shall not be denied due to lack of payment of pharmacy dispensing fee requirements.
 - Provider network listing including a list of the names, specialty, telephone numbers, service site address of all providers available for selection, and in the case of physicians, board certification. The provider network listing can be a separate document apart from the member handbook.
 - The extent to which, and how, after-hours and emergency coverage are provided, including the following: (a) What constitutes an emergency medical condition, emergency services, and post-stabilization services; (b) The fact that prior authorization is not required for emergency services; (c) The process and procedures for obtaining emergency services, including use of the 911 telephone system or its local equivalent; (d) The locations of any emergency settings and other locations at which providers and hospitals furnish emergency services and post-stabilization services covered herein; (e) The fact that the member has a right to use any hospital or other setting for emergency care; and (f) The post-stabilization care services rules specified herein.
 - How to obtain emergency transportation and non-emergency medically necessary transportation.
 - EPSDT services including immunization and lead guidelines designated by the state agency.
 - Maternity, family planning, and sexually transmitted diseases services.
 - Mental health and substance abuse services, including information on how to obtain such services, the rights the member has to request such services, and how to access services when in crisis, including the toll free number to be used to access such services.
 - How to obtain services when out of the member's geographic region and for after-hours coverage.
 - Out-of-county and out-of-state moves.
 - Statement that the health plan shall protect its members in the event of insolvency. The health plan shall not hold its members liable for any of the following:
 - The debts of the health plan in the case of health plan insolvency;
 - Services provided to a member in the event the health plan failed to receive payment from the state agency for such service;
 - Services provided to a member in the event a health care provider with a contractual referral or other type arrangement with the health plan fails to receive payment from the state agency or the health plan for such services; or
 - Payments to a provider that furnishes covered services under a contractual referral or other type arrangement with the health plan in excess of the amount that would be owed by the member if the health plan had directly provided the services.
 - Inform the member that if he or she has a worker's compensation claim, or a pending personal injury or medical malpractice law suit, or has been involved in an auto accident, to immediately contact the health plan.
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- Inform the member that if he or she has another health insurance policy, all prepayment requirements must be met as specified by the other health insurance plan. The member must notify the health plan of any changes to their other health insurance policy. The member can contact the health plan with any questions.
 - Inform the member of the Health Insurance Premium Payment program which pays for health insurance for members when it is determined cost effective.
 - Contributions the member can make towards his or her own health, appropriate and inappropriate behavior, and any other information deemed essential by the health plan or the state agency including the member's rights and responsibilities.
 - Inform members that multilingual interpreters will be offered when needed and written information is available in prevalent languages and how to access those services.
 - Inform the member of the procedures that will be utilized to notify members affected by termination or change in benefits, services, or service delivery office/site.
 - Inform the member that the health plan shall provide information on the health plan's physician incentive plan to any member upon request. Enrollment materials/member handbooks should annually disclose to members their right to adequate and timely information related to physician incentives.
 - With respect to advance directives, inform the member of the following:
 - a) Their rights under the law of the state.
 - b) The health plan's policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of advance directives as a matter of conscience.
 - c) The health plan must inform members that complaints concerning noncompliance with the advance directive requirements may be filed with the State survey and certification agency.
 - Additional information that is available upon request, including the following:
 - a) Information on the structure and operation of the MC+ health plan.
 - Inform the member how to obtain one free copy of his or her medical records annually.
 - Inform the member how to request and obtain an Explanation of Benefits (EOB).
- o. The health plan shall submit the member handbook to the state agency for approval prior to distribution to members. The health plan shall make modifications in member handbook language if ordered by the state agency so as to comply with the member handbook requirements.
- p. The member must receive written notification of changes in health plan operations that affect them at least thirty (30) calendar days before the intended effective date of the change unless otherwise noted. Examples of such changes are as follows:
- 1) Network changes such as a new Pharmacy Benefit Manager, mental health subcontractor, or other major subcontractor. Notification is required to all members.
 - 2) Primary care provider or other provider seen on a regular basis leaves the network. The health plan shall provide written notice to the affected members within 15 calendar days after receipt or issuance of the termination notice.
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- 3) Comprehensive Benefit Package changes from what is explained in the member handbook. Notification is required to all members.
 - 4) Utilization Management Procedure changes from what is explained in the member handbook. Notification is required to all members.
 - 5) Prior Authorization Procedure changes from what is explained in the member handbook. Notification is required to all members.
 - 6) Advance directive policy changes as a result of changes in State law.
- q. All written member notifications must be prior approved by the state agency and written at no higher than a sixth grade level. The health plan shall include certain passages and language provided to the health plan by the state agency in the member notification. The health plan shall comply with all changes regarding member notification content specified by the state agency in a timely manner as defined by the state agency.
- r. **Transferring Members Between Health Plans:** It may be necessary to transfer a member between health plans for a variety of reasons. The health plan shall have written policies and procedures for transferring relevant member information, including medical records and other pertinent materials, to or from another health plan. Upon request, a copy of the member's medical records and supporting documentation must accompany disenrollment and transfer requests from the health plan. The state agency shall monitor, and approve or disapprove all transfer requests for just cause, within sixty (60) calendar days subject to medical record review. Possible reasons for a member to request a transfer include, but are not limited to:
- Member requests health plan transfer during open enrollment.
 - Member request health plan transfer during the first 90 days enrolled in the health plan.
 - Transfer is the resolution to a grievance or appeal.
 - Enrollment — primary care provider or specialist with whom the member has an established patient/provider relationship does not participate in the health plan but does participate in another health plan.
 - The member is pregnant and her primary care provider or obstetrician does not participate in the health plan but does participate in another health plan.
 - The member is a newborn and the primary care provider or pediatrician selected by the mother does not participate in the health plan but does in another health plan.
 - Transfer to another health plan is necessary to ensure continuity of care.
 - An act of cultural insensitivity that negatively impacts the member's ability to obtain care and cannot be resolved by health plan.
 - Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs.
- 1) Children in COA 4 shall be allowed automatic and unlimited changes in health plan choice as often as circumstances necessitate. Foster parents will normally have the decision making responsibility for which health plan shall serve the foster child residing with them; however, there will be situations where the Social Service worker or the courts shall select the health plan for a child in State custody or foster care placement.
- s. **Member Disenrollment:**
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- 1) The state agency has sole authority for disenrolling members from the health plan. The health plan may request disenrollment of members from health plan providers, subject to the conditions described below:
 - A persistent refusal of the member to follow prescribed treatments or comply with health plan requirements that are consistent with federal and state laws and regulations, as amended.
 - Consistently missed appointments without prior notification to the provider.
 - Fraudulent misuse of the MC+ managed care program, or abusive or threatening conduct.
 - Request of a home birth service.
 - 2) The health plan must not initiate disenrollment because of a medical diagnosis or the health status of a member. The health plan shall not request disenrollment because of the member's attempt to exercise his or her rights under the grievance system. The health plan shall not request disenrollment because of pre-existing medical conditions or high cost medical bills or an anticipated need for health care. The health plan shall not request a disenrollment due to behaviors resulting from a medical or mental illness/disorder.
 - 3) Prior to requesting a disenrollment or transfer of a member, the health plan shall document at least three interventions over a period of 90 calendar days which occurred through treatment, case management, and care coordination to resolve any difficulty leading to the request, unless the member has demonstrated abusive or threatening behavior in which case only one attempt is required. The health plan shall cite at least one of the above examples of good cause before requesting that the state agency disenroll that member. If the health plan intends to proceed with disenrollment during the ninety (90) calendar day period, the health plan must give a notice citing the appropriate reason to both the member and the state agency at least 30 calendar days before the end of the ninety (90) calendar day period. The health plan must document all notifications regarding requests for disenrollment.
 - Members shall have the right to challenge a health plan initiated disenrollment to both the state agency and the health plan through the appeal process within ninety (90) calendar days of the health plan's request to the state agency for disenrollment of the member. When a member files an appeal, the process must be completed prior to the health plan and the state agency continuing disenrollment procedures.
 - Within fifteen (15) working days of the final notification (after no appeal or a final hearing decision), members shall be enrolled in another health plan or transferred to another provider.
 - 4) If the health plan recommends disenrollment or transfers for reasons other than those stated above, the State shall consider the health plan to have breached the provisions and requirements of the contract.
 - t. **Reasons for Disenrollment:** The state agency may disenroll members from a health plan for any of the following reasons:
 - 1) Selection of another health plan during open enrollment, the first 90 calendar days of enrollment, or for just cause.
 - 2) Change of residence that places the member outside of the health plan's service area.
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- 3) To implement the decision of a hearing officer in a grievance proceeding by the member against the health plan, or by the health plan against the member.
- 4) Loss of eligibility for either Medicaid or MC+ managed care.

Paragraph 2.6.2 t. 5. inserted by Amendment #001

- 5) Member exercises choice to voluntarily disenroll as specified herein under Missouri MC+ Managed Care Program eligibility groups. This choice can be referred to as opt out.
- u. **Disenrollment Effective Dates:** Member disenrollments outside of the open enrollment process shall become effective on the date specified by the state agency. The health plan shall have written policies and procedures for complying with state agency disenrollment orders.

Paragraph 2.6.2 v. revised by Amendment #001

- v. **Hospitalization at the Time of Enrollment or Disenrollment:** With the exception of newborns, the health plan shall not assume financial responsibility for members who are hospitalized in an acute setting on the effective date of coverage until an appropriate acute inpatient hospital discharge. If the member is in the Medicaid fee-for-service program at the time of acute inpatient hospitalization on the effective date of coverage, the member shall remain in the fee-for-service program until an appropriate acute inpatient hospital discharge. Members, including newborn members, who are in another health plan at the time of acute inpatient hospitalization on the effective date of coverage, shall remain with that health plan until an appropriate acute inpatient hospital discharge. Members, including newborn members, who are hospitalized in an acute setting shall not be disenrolled from a health plan until an appropriate acute inpatient hospital discharge, unless the member is no longer Medicaid or MC+ managed care eligible or opts out.

For the purpose of a member moving from one health plan to another health plan, in addition to acute inpatient hospitalizations, admissions to facilities that provide a lower level of care in lieu of an acute inpatient admission may be considered as an acute inpatient hospitalization for purposes of this section. The state agency reserves the right to determine if such an admission qualifies as an acute inpatient hospitalization. Only acute inpatient hospitalization shall apply when a new member moves from the Medicaid fee-for-service program to MC+ managed care. The health plan shall provide timely notification to the state agency of a member's acute inpatient hospitalization on the effective date of coverage to effect a retroactive/prospective adjustment in the coverage dates for MC+ managed care.

2.7 Comprehensive Benefit Package:

Description of Comprehensive Benefit Package: The health plan shall assume the responsibility for all covered medical conditions of each MC+ managed care member as of the effective date of coverage. The health plan shall make the comprehensive benefit package available to members. Services outside the United States, District of Columbia, and the following territories: Northern Mariana Islands, American Samoa, Guam, Puerto Rico, and the Virgin Islands are not covered. Services must be provided according to the medical needs of the member. The health plan may manage specific services as long as the health plan provides services that are medically appropriate. The health plan shall have a process for allowing exceptions that is in accordance with 13 CSR 70-2.100. The health plan may develop criteria by which the health plan shall review future treatment options, set prior authorization criteria, or exercise other administrative options for the health plan's administration of medical care benefits. The health plan may place appropriate limits on a service on the basis of criteria such as medical necessity; or for utilization control, provided the services furnished can reasonably be expected to achieve their purpose. The health plan may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of the diagnosis, type of illness, or condition. Attachment 3 outlines the comprehensive benefit package for all members and the services they will receive.

2.7.1 The health plan shall include the following services within the comprehensive benefit package:

- a. Inpatient hospital services;
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- b. Outpatient hospital services;
- c. Emergency room services;
- d. Ambulatory surgical center, birthing center;
- e. Physician, advanced practice nurse, and certified nurse midwife services;
 - 1) The health plan shall provide certified nurse midwife services that are medically appropriate either through the health plan provider network or by other means outside the health plan provider network at the health plan's expense. If the member elects a home birth, the member shall be disenrolled from MC+ managed care according to the MC+ managed care home birth policy statement. The disenrolled member shall then receive services through the MC+ fee-for-service program.
- f. Maternity benefits for inpatient hospital and certified nurse midwife. The health plan shall provide coverage for a minimum of forty-eight (48) hours of inpatient hospital services following a vaginal delivery and a minimum of ninety-six (96) hours of inpatient hospital services following a cesarean section for a mother and her newly born child in a hospital or any other health care facility licensed to provide obstetrical care under the provision of Chapter 197, RSMo, as amended.

The health plan may authorize a shorter length of hospital stay for services related to maternity and newborn care if a shorter inpatient hospital stay meets with the approval of the attending physician after consulting with the mother and is in keeping with federal and state law, as amended. The physician's approval to discharge shall be made in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, or similar guidelines prepared by another nationally recognized medical organization and be documented in the member's medical record.

The health plan shall provide coverage for post-discharge care to the mother and her newborn. The first post-discharge visit shall occur within twenty-four (24) to forty-eight (48) hours. Post-discharge care shall consist of a minimum of two visits at least one of which shall be in the home, in accordance with accepted maternal and neonatal physical assessments, by a registered professional nurse with experience in maternal and child health nursing or a physician. The location and schedule of the post-discharge visits shall be determined by the attending physician. Services provided by the registered professional nurse or physician shall include, but not be limited to, physical assessment of the newborn and mother, parent education, assistance and training in breast or bottle feeding, education and services for complete childhood immunizations, the performance of any necessary and appropriate clinical tests, and submission of a metabolic specimen satisfactory to the State laboratory. Such services shall be in accordance with the medical criteria outlined in the most current version of the "Guidelines for Perinatal Care", or similar guidelines prepared by another nationally recognized medical organization. If the health plan intends to use another nationally recognized medical organization's guidelines, the state agency must approve prior to implementation of its use.

- g. Family Planning Services — If family planning services are sought out-of-network by a member, the health plan shall be financially liable for payment of those services in accordance with federal freedom of choice provisions.
 - h. Pharmacy benefits excluding protease inhibitors – pharmacy benefits are included in the comprehensive benefit package if the health plan included pharmacy benefits in its awarded proposal;
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- 1) The health plan shall submit the information regarding its pharmacy program to the state agency for prior approval in accordance with the MC+ Managed Care Policy Statements, as amended.
 - i. Dental services related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Adults age 21 and over receive treatment of a disease/medical condition without which the health of the recipient would be adversely affected through the Fee For Service program.
 - j. Laboratory, radiology, and other diagnostic services;
 - k. Prenatal case management;
 - l. One eye examination every 2 years;
 - m. Home health services;
 - n. Adult day health care services;
 - o. Personal care services;
 - p. Transportation services;
 - 1) The health plan shall provide emergency transportation (ground and air) for its members. The health plan shall provide non-emergency medical transportation to members who do not have the ability to provide their own transportation (such as their own vehicle, friends, or relatives) to and from services required herein as well as Medicaid/MC+ Fee-For-Service covered services not included in the comprehensive benefit package.
 - q. Hospice services;
 - r. Durable medical equipment limited to: prosthetic devices (with the exception of artificial larynx), respiratory equipment and oxygen (with the exception of CPAP, BiPAP, and nebulizers), wheelchairs, diabetic supplies and equipment, and ostomy supplies. Members with a Home Health Plan of Care receive all medically necessary durable medical equipment services during the plan of care coverage period.
 - s. Podiatry services with the exception of trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one to five; debridement of nail(s) by any method(s), six or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot.
 - t. Services provided by local public health agencies — The Department of Health and Senior Services and local public health agencies administer certain public health programs which are critical to the protection of the public's health and, therefore, must be made available to members at local public health agencies whether in-network or out-of-network. The health plan shall reimburse the local public health agency according to the most current Medicaid program fee schedule in effect at the time of service, unless otherwise negotiated. Such services shall include:
 - 1) All sexually transmitted disease (STD) services including screening, diagnosis, and treatment. In-network providers shall follow current Center for Disease Control (CDC) Sexually Transmitted Diseases Treatment Guidelines and the United States Department of Health and Human Services Chlamydia Control Project Screening Criteria, or their equivalent. The STD guidelines may be found on the Internet at: <http://www.dhss.mo.gov/STDSurveillance/>. STD screening, diagnosis, and treatment services shall include:
 - STD screening exam.
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- Screening, diagnosis, and treatment for the following STDs: gonorrhea, syphilis, chancroid, granuloma inguinale, lymphogranuloma venereum, genital herpes, genital warts, trichomoniasis, chlamydia (cervicitis), chlamydia (urethritis), hepatitis B, and others as may be designated by the state agency.
 - Screening, diagnosis, and treatment of vaginal or urethral discharge including non-gonococcal urethritis and mucopurulent cervicitis.
 - Evaluation and initiation of treatment of pelvic inflammatory disease (PID).
 - Diagnosis and preventive treatment of members who are reported as contacts/sex partners of any person and diagnosed with a STD. The member shall be given the option of seeing an in-network provider first.
 - The local public health agency shall encourage members to follow-up with their primary care provider; however, if the member chooses follow-up care at the local public health agency for confidentiality reasons, the health plan shall reimburse the local public health agency for follow-up office visits (not to exceed three visits per episode).
- 2) Human immunodeficiency virus (HIV) services relating to screening and diagnostic studies. In-network providers shall use current CDC HIV Counseling, Testing, Referral Standards, and Guidelines or their equivalent. The HIV guidelines may be found on the internet at: http://www.dhss.mo.gov/HIV_STD_AIDS/.
- 3) Tuberculosis services including screening, diagnosis, and treatment. In-network providers shall follow current CDC/American Thoracic Society Guidelines: Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children, or their equivalent, including the use of Mantoux PPD skin test to screen for tuberculosis. The Tuberculosis guidelines may be found on the Internet at: <http://www.dhss.mo.gov/Tuberculosis>.
- All members diagnosed with tuberculosis infection or tuberculosis disease shall be reported to the local public health agency.
 - All members receiving treatment for tuberculosis disease shall be referred to the local public health agency's tuberculosis contact person for directly observed therapy (DOT). The health plan shall communicate with the local public health agency's tuberculosis contact person to obtain information regarding the member's health status. The health plan shall communicate this information to the in-network provider. The health plan shall be responsible for care coordination and medically necessary follow-up treatment.
 - All laboratory tests for tuberculosis shall meet the standards established by the CDC/Missouri Department of Health and Senior Services. Sensitivity tests shall be performed on all initial specimens positive for M. Tuberculosis. Department of Health and Senior Services encourages all sputum specimens to be submitted to the Department of Health and Senior Services' Tuberculosis Reference Laboratory at the Missouri Rehabilitation Center. Positive cultures for M Tuberculosis isolated at private laboratories must be sent to the TB Reference Laboratory (Required by Missouri Rule 19 CSR 20-20.080).
- 4) **Childhood Immunizations:** In-network providers shall fully immunize their members following the most recent immunization recommendations designated by the state agency. The state agency shall provide the health plan's Medical Director with copies of the most recent recommendations upon contract award and upon request and when the recommendations change.
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- The health plan and its in-network providers must enroll and must obtain vaccines through the Missouri Department of Health and Senior Services Vaccines for Children (VFC) Program or any such vaccine supply program as designated by the state agency. Any time a member receives immunizations from a local public health agency, or at a Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) site, the health plan shall reimburse only the cost for administration at the current Medicaid program rates in effect at the time of the service, unless otherwise negotiated.
 - The health plan shall reimburse governmental public health agencies for the cost of both administration and vaccines not available through the VFC program or vaccine supply program as designated by the state agency when the vaccine is deemed medically necessary.
 - The health plan shall collaborate with the state agency and the Missouri Department of Health and Senior Services to determine the health plan's aggregate immunization level. The Missouri Department of Health and Senior Services, Immunization Program will offer consultation to the health plan to foster the exchange of immunization information, and to in-network providers for purposes of assessment, reminder/recall, and reporting.
 - The health plan shall establish, as a quality assessment and improvement measure, a target rate of 90% for the number of two (2) year olds immunized.
- 5) Childhood lead poisoning prevention services shall include screening, diagnosis, treatment, and follow-up as indicated. In-network providers shall follow the Centers for Medicare and Medicaid Services (CMS) (formerly the Health Care Financing Administration) guidelines in effect for the specific time period and CDC guidelines: Screening Young Children for Lead Poisoning and Managing Elevated Blood Lead Levels Among Young Children. The Department of Health and Senior Services shall provide the health plan's Medical Director with copies of current protocols and guidelines upon contract award or at any time upon request. If there is a discrepancy between guidelines, the state agency requires use of the HCY/EPSTD Lead Risk Assessment Guide developed in accordance with CMS guidelines. The HCY/EPSTD Lead Risk Assessment Guide may be used separately or in conjunction with the HCY Screening form.
- u. **Emergency Medical/Mental Health Services.** Emergency medical/mental health services means covered inpatient and outpatient services that are furnished by a provider that is qualified to furnish these services and are needed to evaluate or stabilize an emergency medical condition.
- 1) An emergency medical condition means a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) 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 the following:
- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
 - Serious impairment to bodily functions;
 - Serious dysfunction of any bodily organ or part;
 - Serious harm to self or others due to an alcohol or drug abuse emergency;
 - Injury to self or bodily harm to others; or
 - With respect to a pregnant woman having contractions: (1) that there is inadequate time to effect a safe transfer to another hospital before delivery, or (2) that transfer may pose a threat to the health or safety of the woman or the unborn.
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- 2) Post-stabilization care services means covered services, related to an emergency medical condition that are provided after a member is stabilized in order to maintain the stabilized conditions or to improve or resolve the member's condition.
- v. **Early Periodic Screening, Diagnosis, and Treatment Services:** The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid cover all medically necessary services listed in Section 1905 (a) of the Social Security Act to children from birth through age 20. In Missouri, this program is known as the Healthy Children and Youth (HCY) Program. In accordance with the health plan's written policies and procedures, the health plan shall conduct outreach and education of children eligible for the HCY/EPSDT program, provide the full HCY/EPSDT services to all eligible children and young adults under the age of 21, and conduct and document well child visits (screenings) using the State HCY/EPSDT screening form as amended. (The HCY screening form may be found on the Internet at: <http://manuals.momed.com/> Look under Missouri Medicaid Provider Manuals, Forms, List of Forms, Healthy Children and Youth Screening [HCY Screening].) The health plan shall provide the full scope of HCY/EPSDT services in accordance with the following:
- 1) The health plan shall conduct HCY/EPSDT well child visits on all eligible members under age twenty-one (21) to identify health and developmental problems. The state agency recognizes that the decision to not have a child screened is the right of the parent or guardian of the child. For those children that have not had well child visits in accordance with the periodicity schedule established by the state agency, the health plan shall document its outreach and educational efforts to the parent or guardian informing them of the importance of well child visits, that a well child visits is due, that appointment scheduling assistance is available, and that transportation (except to those children with ME Codes 71-75) is available. (The current periodicity schedule is contained in Attachment 3.) The health plan shall follow the MC+ fee-for-service policies for recognition of completion of all components of a full medical HCY/EPSDT well child visit service. A full HCY/EPSDT well child visits includes all of the components listed below. A partial well child visit includes the first six (6) components listed below. The last three (3) components are individual screens. An interperiodic screen is defined as any encounter with a health care professional acting within his or her scope of practice.
 - A comprehensive health and developmental history including assessment of both physical and mental health developments;
 - A comprehensive unclothed physical exam;
 - Health education (including anticipatory guidance);
 - Laboratory tests as indicated (appropriate according to age and health history unless medically contraindicated);
 - Appropriate immunizations according to age;
 - Verbal lead assessment beginning at age six (6) months and continuing through age seventy-two (72) months. Blood level testing is mandatory at twelve (12) and twenty-four (24) months or annually if residing in a high-risk area of Missouri as defined by Department of Health and Senior Services regulation 19 CSR 20-8.030;
 - Vision screening;
 - Hearing screening;
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- Dental screening (oral exam by primary care provider as part of comprehensive exam). Recommended that preventive dental services begin at age six (6) through twelve (12) months and be repeated every six (6) months.
- 2) If a suspected problem is detected during a well child visit, the child must be evaluated as necessary, using the required assessment protocol, for further diagnosis. This diagnosis is used to determine treatment needs.
 - 3) HCY/EPSTD requires coverage for all follow-up diagnostic and treatment services deemed medically necessary to ameliorate or correct a problem discovered during an HCY/EPSTD well child visits. Such medically necessary diagnosis and treatment services must be provided as long as they are Medicaid covered services as defined in the Social Security Act.
 - 4) The health plan shall establish a tracking system that provides information on compliance with HCY/EPSTD service provision requirements in the following areas:
 - Initial visit for newborns. The initial HCY/EPSTD well child visits shall be the newborn physical exam in the hospital.
 - Preventive pediatric visits according to the periodicity schedule inclusive of a verbal lead assessment and blood lead tests.
 - Diagnosis and/or treatment, or other referrals in accordance with HCY/EPSTD well child visit results.
 - The health plan shall ensure that the tracking system generates information consistent with the requirements regarding encounter data as specified elsewhere herein.
 - 5) The health plan shall have an established process for reminders, follow-ups, and outreach to members. This process shall include, but not be limited to, notifying the parent(s) or guardian(s) of children of the needs and scheduling of periodic well child visits according to the periodicity schedule. The health plan shall provide assistance to new members in accessing HCY/EPSTD well child visit services within ninety (90) calendar days of health plan enrollment. The health plan shall provide assistance to members in accessing subsequent HCY/EPSTD well child visits in accordance with the periodicity schedule. At the time of notification, the health plan shall offer transportation and scheduling assistance if necessary. For members with ME Codes 71 through 75, non-emergency medical transportation is not a covered benefit.
 - 6) The health plan should seek innovative, cooperative ways to enhance care coordination and delivery of HCY/EPSTD. This may include the use of a standardized data base system among health plans.
 - 7) The health plan shall report HCY/EPSTD well child visits through encounter data submissions in accordance with the requirements regarding encounter data as specified elsewhere herein. The state agency shall use such encounter data submissions and other data sources to determine health plan compliance with CMS requirements that 80 percent of eligible members under the age of twenty-one are receiving HCY/EPSTD well child visits in accordance with the periodicity schedule. The state agency shall use the participant ratio as calculated using the CMS 416 methodology for measuring the health plan's performance.
 - The health plan shall report HCY/EPSTD well child visits in accordance with the appropriate well child visits codes established by the state agency. HCY/EPSTD screening codes are identified in MC+ Managed Care Policy Statements. Services not reported as
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HCY/EPSTDT well child visits in accordance with the appropriate codes will not be counted toward the health plan's participant ratio.

- In the event the state agency uses other data sources submitted by the health plan, the health plan shall certify the data provided.
 - a. The data must be certified by one of the following:
 - 1) The health plan's Chief Executive Officer.
 - 2) The health plan's Chief Financial Officer.
 - 3) An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
 - b. The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the data.
 - c. The health plan must submit the certification concurrently with the data.

w. Mental health and substance abuse services:

- 1) For children covered under MC+ managed care within Category of Aid 4, mental health and substance abuse services, if medically necessary, shall not be the financial responsibility of the health plan and shall be provided in accordance with the requirements regarding coordination with services not included in the comprehensive benefit package as specified elsewhere herein.
 - For inpatients with dual diagnoses (physical and mental), the health plan shall be financially responsible for all inpatient hospital days if the primary, secondary, or tertiary diagnosis is a combination of physical and mental health. These admissions are subject to the prior authorization and concurrent review process identified by the health plan.
 - 2) All other members shall receive all medically necessary mental health and substance abuse services included in the comprehensive benefit package. The state agency, in conjunction with the Department of Mental Health, has developed community-based services with an emphasis on the least restrictive setting. The health plan shall consider, when appropriate, using such services in lieu of using an out-of-home placement setting for members.
 - 3) With the member's or the member's parent/guardian's consent, the health plan shall notify the member's primary care provider when a member is admitted for mental health or substance abuse services.
 - 4) The health plan shall have protocols for coordinating the diagnosis, treatment, and care between primary care providers and mental health and substance abuse providers which include the expected response time for consults between primary care providers and mental health and substance abuse providers.
 - 5) Services shall include, but not be limited to:
 - Inpatient hospitalization, when provided by acute hospital, private or state psychiatric hospital.
 - Outpatient services when provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, provisional licensed clinical social worker, licensed counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, or state certified mental health or substance abuse program. These services must include outreach efforts on an as needed
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basis that recognize the unique mental health challenges of some members. These efforts may include phone contacts and home visits.

- Crisis intervention/access services, which may include the provision of a 24-hour hotline staffed by qualified mental health professionals and qualified substance abuse counselors providing intake, evaluation and referral services, including services that are alternatives to out of the home placements and mobile crisis teams for on-site interventions.
 - Alternative services which are reasonable, cost effective, and related to the member's treatment plan.
- 6) The health plan is responsible for payment of mental health and substance abuse services defined herein that are court ordered, 96 hour detentions, and for involuntary commitments.
- 7) **Mental Health and Substance Abuse Services:** To ensure the continuity of care and the transition of members who have received mental health and substance abuse services from an out-of-network provider prior to enrollment with the health plan, the state agency encourages the out-of network provider to contact the health plan to make transition arrangements with the health plan. Upon enrollment, the health plan shall transition the member and provide the immediate continuation of mental health and substance abuse services. The health plan shall authorize out-of-network providers to continue ongoing mental health and substance abuse treatment, services, items, and prescriptions for new members until such time as the new member has been transferred appropriately to the care of an in-network provider.
- If the member transferred from an out-of-network provider to an in-network provider, the health plan shall secure the member's mental health and substance abuse medical records from the out-of-network provider. The health plan shall pay rates comparable to Medicaid, unless otherwise negotiated, to obtain these records.
 - **Mental Health Out-of-Network Referrals:** If the health plan believes that a child or youth may require residential services in order to receive appropriate care and treatment for a serious emotional disorder, the health plan may apply to the Missouri Division of Comprehensive Psychiatric Services (CPS) for placement in accordance with the MC+ managed care policy statement titled, Mental Health and Substance Abuse Fee-For-Service Coordination.
 - Services provided by a Community Psychiatric Rehabilitation provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program.
 - Targeted case management services for mental health services shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program.
- x. **Transplant Related Services:** The health plan shall permit and authorize and shall be financially responsible for any inpatient, outpatient, physician, and related support services including presurgery assessment/evaluation prior to the date of the actual bone marrow/stem cell or solid organ transplant surgery. The bone marrow/stem cell or solid organ transplant will be prior authorized by the state agency and must be performed at a state agency's approved transplant facility in accordance with the MC+ members' freedom of choice. The health plan shall be responsible for pre-transplant and post-transplant follow-up care and immuno-suppressive pharmacy products prescribed after the inpatient transplant discharge. To ensure continuity of care, the health plan must permit and authorize follow- up services and the health plan shall be responsible for the reimbursement of such services. The primary care provider must be allowed to refer a transplant patient to the performing transplant facility for follow-up transplant care. Reimbursement to out-of-network providers of transplant
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support services must be no less than the current Medicaid program rates in effect at the time of the services.

- 2.7.2 The health plan shall include all the services specified in the comprehensive benefit package with the exception of non-emergency medical transportation (NEMT), for uninsured children in ME Codes 71 through 75 (Refer to Attachment 1, COA 5).
- 2.7.3 In addition to the services listed in the Comprehensive Benefit Package, herein, the health plan shall include the following additional services for children under 21 years of age and pregnant women with ME codes 18, 43, 44, 45, and 61.
- a. Dental Services (Dental services for pregnant women age 21 and over with ME codes 18, 43, 44, 45, and 61 shall be limited to dentures and services related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Services to prepare the mouth for dentures, such as examinations, X-rays, or extractions will not be covered by the health plan. Ancillary denture services such as relining, rebasing, and repairs will not be covered by the health plan. All other Medicaid State Plan dental services for these pregnant women are covered through the Fee For Service Program);
 - b. Hearing aids and related services;
 - c. Optical services (Pregnant women age 21 and over with ME codes 18, 43, 44, 45, and 61 do not receive eyeglasses except for one pair following cataract surgery. Eye glasses for these pregnant women are covered through the Fee-For-Service program);
 - d. Comprehensive Day Rehabilitation (for certain persons with disabling impairments as the result of a traumatic head injury);
 - e. Durable medical equipment (including but not limited to: orthotic devices, artificial larynx, enteral and parenteral nutrition, walkers, wheelchair accessories and batteries, CPAP, BiPAP, and nebulizers);
 - f. Diabetes self management training for persons with gestational, Type I or Type II diabetes;
 - g. Podiatry services.
- 2.7.4 **Medically Necessary:** The health plan shall determine whether or not a service(s) furnished or proposed to be furnished is (are) reasonable and medically necessary for the prevention, diagnosis or treatment of a physical or mental illness or injury; to achieve age appropriate growth and development; to minimize the progression of disability; or to attain, maintain or regain functional capacity; in accordance with accepted standards of practice in the medical community of the area in which the physical or mental health services are rendered; and service(s) could not have been omitted without adversely affecting the member's condition or the quality of medical care rendered; and service(s) is (are) furnished in the most appropriate setting. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.
- a. In reference to medically necessary care, mental health services shall be provided in accordance with a process of mental health assessment that accurately determines the clinical condition of the member and the acceptable standards of practice for such clinical conditions. The process of mental health assessment shall include distinct criteria for children and adolescents.
 - b. The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that Medicaid provide medically necessary services to children from birth through age 20, which are necessary to treat or ameliorate defects, physical or mental illness, or conditions identified by an HCY/EPSTD screen.
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Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity.

2.8 Multilingual Services:

- 2.8.1 During the enrollment process, members shall be asked if English is their main language. If English is not the member's main language, the member shall be asked to identify that language. The information gathered by the state agency shall be shared with the health plan.
- 2.8.2 The health plan shall make interpreter services available as necessary to ensure that members are able to communicate with the health plan and providers and receive covered benefits. The health plan shall use certified interpreters. The health plan shall inform members of the availability of interpreter services. If the health plan has more than two hundred (200) members or five (5) percent of its program membership (whichever is less) who speak a single language other than English as a primary language, the health plan shall make available general services and materials, such as the health plan's member handbook in that language.
- 2.8.3 In addition, the health plan shall develop appropriate methods for communicating with visual and hearing impaired members and accommodating the physically disabled. The health plan shall offer members standard materials, such as the member handbook and enrollment materials in alternative formats (i.e., large print, Braille, cassette, and diskette) immediately upon request from members with sensory impairments.

2.9 Member Services:

- 2.9.1 **Member Services Staff:** The health plan shall provide adequately trained member services staff to operate at least nine (9) consecutive hours during the hours of 7:00 a.m. through 7:00 p.m. (i.e., 8:00 a.m. through 5:00 p.m.), Monday through Friday. The health plan may observe State designated holidays or the holidays designated in its awarded proposal for its operation of member services. The health plan's member services staff shall be responsible for the following:
- a. Explaining the operation of the health plan and assisting members in the selection of a primary care provider. Educating the family about managed care including the way services typically are accessed under managed care and the role of the primary care provider.
 - b. Specifying member's rights and responsibilities.
 - c. Explaining covered benefits.
 - d. Assisting members to make appointments and obtain services.
 - e. Arranging medically necessary transportation for members.
 - f. Handling, recording, and tracking member inquiries promptly and timely.
 - g. The health plan's member services staff must have available a complete and up-to-date list of the in-network providers in the health plan provider network. The health plan shall have a policy and procedure for regularly updating the provider listing. Member services staff must provide the following information to members requesting the names of providers:
 - 1) Whether the provider currently participates in the health plan;
 - 2) Whether the provider is currently accepting new patients; and
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- 3) Any restrictions on services, including any referral or prior authorization requirements the member must meet to obtain services from the provider.

h. The health plan's member services staff shall be trained on fraud and abuse policies and procedures.

2.9.2 **Toll-Free Telephone Number:** The health plan shall maintain a toll-free member services telephone number. The toll-free member services telephone or other toll-free voice and telecommunications device for the deaf members must be staffed twenty-four (24) hours per day to provide needed authorization of services during evenings and weekends and holidays.

2.10 Provider Services:

2.10.1 **Provider Services Staff:** The health plan shall provide adequately trained provider services staff to operate at least nine (9) consecutive hours during the hours of 7:00 a.m. through 7:00 p.m. (i.e., 8:00 a.m. through 5:00 p.m.) Monday through Friday. The health plan may observe State designated holidays or the holidays designated in its awarded proposal for its operation of provider services. If the health plan observes holidays different than the State's, the health plan must obtain the prior written approval of the state agency.

2.10.2 The health plan's provider services staff shall be responsible for the following:

- a. Establishing a mechanism by which providers may determine in a timely manner whether a member is covered by the health plan and the member's primary care provider assignment;
- b. Educating providers on the above mechanism's use;
- c. Educating and assisting providers with the health plan service accessibility standards including but not limited to prior authorization, denial, and referral procedures;
- d. Educating and assisting providers with claims submission and payment procedures;
- e. Educating providers about conditions under which members may directly access services including, but not limited to, mental health and substance abuse, family planning, and public health services;
- f. Educating providers about how a member can access emergency care and after-hour services;
- g. Educating providers about pharmacy benefits and formulary guidelines; and
- h. Handling provider inquiries and complaints.

2.10.3 The health plan shall develop, distribute, and maintain a provider manual. The health plan shall obtain and document the approval of the provider manual by the health plan's Medicaid Plan Administrator and Medical Director and shall review the provider manual at least annually and maintain documentation verifying such. The health plan shall issue a copy of the provider manual to providers at the time of inclusion in the provider network, and shall educate the provider as to its full content and usage.

- a. At a minimum, the provider manual shall contain, sections regarding:
 - 1) Specific covered health services for which the provider shall be responsible, including any limitations or conditions on services;
 - 2) Claims submission instructions and the procedure for review of denied claims;
 - 3) Prior authorization procedures, and referral procedures including exceptions, second, or third opinions;
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- 4) Primary care provider responsibilities;
 - 5) Specialist/ancillary provider responsibilities;
 - 6) Provider complaint, grievance, and appeal processes;
 - Any State-determined provider appeal rights to challenge the failure of the health plan to cover a service.
 - 7) Member Grievance System;
 - The member's right to file grievances and appeals and their requirements and timeframes for filing;
 - The availability of assistance in filing;
 - The toll-free numbers to file oral grievances and appeals;
 - The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the health plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits.
 - The member's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;
 - (a) A member may request a State fair hearing within 90 calendar days from the health plan's notice of action.
 - (b) The State must reach its decisions within the specified timeframes:
 - 1) Standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
 - 2) Expedited resolution (if the appeal was heard first through the health plan appeal process): within 3 working days from the state agency's receipt of a hearing request for a denial of a service that:
 - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or
 - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
 - 3) Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the health plan appeal process): within 3 working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.
 - 8) Procedure for obtaining member eligibility status;
 - 9) Appointment/access standards;
 - 10) Multilingual and TDD availability;
 - 11) Quality Assessment and Improvement;
 - 12) Provider Credentialing;
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- 13) Management and retention of medical records;
- 14) Confidentiality;
- 15) Advance directives; and
- 16) Fraud and abuse guidelines.

2.10.4 The health plan shall supply the state agency with the federal tax identification number and professional license number of each provider performing services for the health plan.

2.10.5 The health plan should specify in writing the following to out-of-network providers at the time a service is approved to be performed by the out-of-network provider:

- a. Claims submission instructions and the procedure for review of denied claims;
- b. Prior authorization procedures and referral procedures including exceptions, second, or third opinions;
- c. Provider complaint, grievance, and appeal procedures;
 - 1) Any State-determined provider appeal rights to challenge the failure of the health plan to cover a service.
- d. Member Grievance System;
 - The member's right to file grievances and appeals and their requirements and timeframes for filing;
 - The availability of assistance in filing;
 - The toll-free numbers to file oral grievances and appeals;
 - The member's right to request continuation of benefits during an appeal or State fair hearing filing and, if the health plan's action is upheld in a hearing, the member may be liable for the cost of any continued benefits.
 - The member's right to a state fair hearing, how to obtain a hearing, and representation rules at a hearing;
 - (a) A member may request a State fair hearing within 90 calendar days from the health plan's notice of action.
 - (b) The State must reach its decisions within the specified timeframes:
 - 1) Standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the member took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
 - 2) Expedited resolution (if the appeal was heard first through the health plan appeal process): within 3 working days from the state agency's receipt of a hearing request for a denial of a service that:
 - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or
 - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.

- 3) Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the health plan appeal process); within 3 working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.
- e. Procedure for obtaining member eligibility status;
- f. Multilingual and TDD availability; and
- g. Confidentiality.

2.11 Release for Ethical Reasons:

2.11.1 As a condition to participating in, or contracting with the health plan, the health plan may not:

- a. Require a provider to perform any treatment or procedure which is contrary to the provider's conscience, religious beliefs, or ethical principles or policies; or
- b. Prohibit a provider from making a referral to another health care provider licensed to provide care appropriate to the member's medical condition.

2.11.2 The health plan shall have a process by which the provider may refer a member to another health care provider licensed to provide care appropriate to the member's medical condition or withdraw from the case and the health plan shall assign the member to another provider licensed to provide care appropriate to the member's medical condition.

2.11.3 A health plan that is otherwise required to provide, reimburse for, or provide coverage of, a counseling or referral service because of the requirement herein may object to the service on moral or religious grounds. If the health plan objects to service on moral or religious grounds, the health plan must notify the state agency. Additionally, the health plan shall notify the state agency whenever the health plan adopts the policy during the term of the contract. The health plan agrees that such an objection and subsequent release from providing, reimbursing for, or providing coverage of, a counseling or referral service shall result in a reduction to the applicable capitation rates paid to the health plan to reflect such a release as outlined in paragraph 2.28.4.

- a. Information to potential members must be provided prior to enrollment regarding the health plan's release of provision of such service.
- b. The health plan shall be required to notify its members 30 calendar days prior to any change in its policy regarding coverage of a counseling or referral service.
- c. The health plan shall be required to notify its members of how and where to obtain the service.

2.12 Coordination With Services not Included in the Comprehensive Benefit Package:

The health plan is not obligated to provide or pay for any services not included in the comprehensive benefit package. However, the health plan must perform care coordination of covered services with services not included within the comprehensive benefit package. These services include, but are not limited to, the following:

2.12.1 School Based Services:

- a. When communities and school boards agree, schools may operate school based clinics to address unmet medical needs of children. The state agency supports the efforts of such communities. The health plan shall perform care coordination with school based clinic services with comprehensive benefit services that are the responsibility of the health plan. In addition, the health plan shall have a written process for coordination and collaboration with school based clinics.
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- b. The health plan shall not be financially liable for physical therapy (PT), occupational therapy (OT), or speech therapy (ST) included in an Individualized Family Service Plan (IFSP) developed under the First Steps Program or included in an Individual Education Plan (IEP) developed by the public school. First Steps is an early intervention program required by the Individuals with Disabilities Education Act (IDEA) — Part C (34 CFR 303 Early Intervention Program for Infants and Toddlers with Disabilities) which also defines the IFSP. IEP services are required by the IDEA Part B (34 CFR 300 and 301). IFSPs and IEPs will include therapies which are needed due to developmental and educational needs. The health plan shall be responsible for all other medically necessary therapy services that are not identified in an IEP or IFSP including maintenance and developmental therapy. The health plan shall be financially responsible for all other Medicaid reimbursable services identified in the IFSP or IEP and are medically necessary. The health plan shall be responsible for medically necessary equipment and supplies used in connection with PT, OT, and ST services for all members. Equipment and supplies are covered as a Durable Medical Equipment benefit. The health plan shall not delay the provision of therapies that are medically necessary pending completion of the IFSP or IEP.
 - 1) The First Steps program serves children from birth to age three (3) who are developmentally delayed or have diagnosed conditions associated with developmental disabilities. Enrollment in the First Steps program is voluntary at the choice of the child's parent or guardian. The intent of the program is, through early detection and intervention, to improve functioning or decrease deterioration in order to better prepare the child to participate in school. The Missouri Department of Elementary and Secondary Education (DESE) operates the First Steps program. Service Coordinators who contract with DESE are responsible for determining program eligibility. A multi-disciplinary team determines the child's service needs including if medical treatment is needed. The team shall include the child's physician. With the parent/guardian consent, the health plan shall refer children who are potentially eligible for First Steps services to the local First Steps office (System Point of Entry) or call the state-wide toll-free number, 866-583-2392, to make a referral.
 - 2) The health plan shall have written policies and procedures for promptly transferring medical and developmental data and for coordinating ongoing care with special education services.
 - c. Parents as Teachers (PAT) is a home-school-community partnership which supports parents in their role as their child's first and most influential teachers. Every parent of a child age 5 or under is eligible for PAT, regardless of income. PAT services include personal visits from certified parent educators, group meetings, developmental screenings, and connections with other community resources from the time the child is born until he/she enters kindergarten.
 - 1) PAT programs collaborate with other agencies and programs to meet families' needs, including Head Start, First Steps, the Women Infants and Children Program (nutrition services), local health departments, the Family Support Division, etc. Independent evaluations of PAT show that children served by this program are significantly more advanced in language development, problem solving, and social development at age 3 than comparison children, 99.5% of participating families are free of abuse or neglect, and early gains are maintained in elementary school, based on standardized tests.
 - 2) The PAT program is administered at the local level by each public school district in the state of Missouri. Families interested in PAT may contact their local district directly. PAT also accepts referrals from other sources including medical providers. Providers who have contact with families with children age 5 and under are encouraged to refer those families to PAT. Additional information about PAT is available at the Department of Elementary and Secondary Education's website at www.dese.state.mo.us. (Look under programs, then Early Childhood Education, then Parents as Teachers.)
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- 2.12.2 **Public Health Programs:** Services offered by the Department of Health and Senior Services and local public health agencies and the method of reimbursement shall include:
- a. **Environmental lead assessments** for health plan children with elevated blood levels shall be reimbursed directly by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program.
 - b. **State Public Health Laboratory Services to Members :** In cases where the health plan is required by law to use the State Public Health Laboratories (e.g., metabolic testing for newborns) and in cases where the State Public Health Laboratory and Department of Health and Senior Services designated local public health agency laboratories perform tests, other than those services listed herein, on members for public health purposes, the laboratory shall be reimbursed directly by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program, and such costs shall not be included in the Medicaid State plan capitated rates.
 - c. **Newborn Screening Collection Kits:** According to RSMo 191.331, health care providers must purchase pre-paid newborn screening collection kits from the Department of Health and Senior Services. The Department of Health and Senior Services sells the kit to providers. When the provider submits a specimen to the State Department of Health and Senior Services Laboratory, the laboratory shall process the test, determine if the member is MC+ eligible, and bill the state agency for the test.
 - d. **Special Supplemental Nutrition for Women, Infants and Children (WIC) Program** - Sections 1902(a)(11)(C) and 1902(a)(53) of the Social Security Act and Title 42, CFR 431.635 require coordination between the state agency and the WIC program. While WIC services are not the responsibility of the health plan, the in-network provider shall document and refer eligible members for WIC services. As part of the initial assessment of members, and as a part of the initial evaluation of newly pregnant women, the in-network providers shall provide and document the referral of pregnant, breast-feeding, or postpartum women, or a parent/guardian of a child under the age of five, as indicated, to the WIC Program. Upon contract award and upon request, the Department of Health and Senior Services shall provide the health plan with WIC program eligibility and referral criteria.
- 2.12.3 **Transplant Services:** Solid organ and bone marrow/stem cell transplant services are not included in the comprehensive benefit package as covered benefits. These services will be delivered for all populations through separate arrangements. Transplant services are defined as the hospitalization from the date of transplant procedure until the date of discharge, including solid organ or bone marrow/stem cell procurement charges, and related physician services associated with both procurement and the transplant procedure. The health plan shall be responsible for any services before and after this admission, including the evaluation that may be related to the condition, even though these services may be delivered out-of-network.
- a. According to 42 CFR 431.51, Medicaid must insure freedom of choice of providers for services provided to Medicaid beneficiaries when those services are paid on a fee-for-service basis outside the health plan. When in-network providers identify a member as a potential transplant candidate, the member must be referred to a transplant facility of their choice without regard to health plan preference.
- 2.12.4 **Comprehensive Substance Treatment Abuse and Rehabilitation (C-STAR)** programs are carved out of the MC+ managed care program. Services provided by a C-STAR Medicaid provider shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program. In order to ensure quality of care, the health plan and its mental health subcontractors shall maintain open and consistent dialogue with C-STAR providers. The health plan shall be responsible for care coordination of services included in the benefit package and C-STAR services in accordance with the MC+ managed care policy statement titled, Mental Health and Substance Abuse Fee-For-Service Coordination.
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2.12.5 **Mental Health Services for Category Of Aid 4:** For children covered under the health plan within the COA 4 group, the health plan shall not be financially responsible for the following medically necessary mental health and substance abuse services:

- a. **Inpatient Mental Health and Substance Abuse Services** shall be any psychiatric stay in an acute care hospital, or in a private or State psychiatric hospital. The health plan primary care provider and the child's caseworker shall coordinate services. Admissions must be in accordance with established guidelines of the Department of Social Services in conjunction with the Department of Mental Health. The Department of Social Services in conjunction with the Department of Mental Health will determine the appropriateness of inpatient placement, appropriate facility, alternative placement, and psychiatric diversion. The state agency's Medical Review Agency must certify medically necessary inpatient days for mental health and substance abuse services (billable on an inpatient hospital claim form) beyond the days deemed medically necessary for physical health.
- b. For inpatients with a dual diagnoses (physical and mental) identified at either admission or during the stay, the health plan shall be financially responsible for all inpatient hospital days if the primary, secondary, or tertiary diagnosis is a combination of physical and mental health. These admissions are subject to the health plan's prior authorization and concurrent review process.
- c. **Outpatient Mental Health and Substance Abuse Services** are those services not provided in an inpatient setting. Examples of appropriate settings are outpatient facility, office, or clinic setting. These services must be provided by a licensed psychiatrist, licensed psychologist, licensed clinical social worker, provisional licensed clinical social worker, licensed counselor, provisional licensed professional counselor, licensed psychiatric advanced practice nurse, licensed home health psychiatric nurse, or state certified mental health or substance abuse program. The services will be provided subject to Medicaid program benefits and limitations.

Paragraph 2.12.5 d. revised by Amendment #002

- d. **Comprehensive Community Support Services:** Comprehensive Community Support Services are provided to children in the custody of the Children's Division and are found to have behavioral conditions which require rehabilitative services at a residential treatment or specialized foster care level of care or who are being discharged from these two treatment levels, and who require comprehensive community support services in order to maintain the rehabilitation treatment outcome in a less restrictive environment. The Children's Division identifies children in the custody of the Children's Division qualifying for these services and authorizes provision of comprehensive community support. Comprehensive community support services include any medical or remedial service reasonable and necessary for maximum reduction of a behavioral disability and restoration of the child to his or her best possible functional level. Examples include, but are not limited to: Intake, Assessment, Evaluation and Treatment Planning; Community Support; Specialized Sexual Abuse Treatment; 24-hour Crisis Intervention and Stabilization; Intensive In-Home Services; Medication Management and Monitoring; Day Treatment/Psychosocial Rehabilitation; Therapeutic Counseling or Consultation Services not Covered Separately through the HCY or Physician's Services Program, Supported Independent Living and Transitional Living Services; and School-Based Behavioral Support Services not included in the IEP. The services will be provided subject to Medicaid program benefits and limitations. The health plan is not financially liable for comprehensive community support services.
- 2.12.6 **SAFE-CARE Exams:** Sexual Assault Forensic Examination and Child Abuse Resource Education (SAFE-CARE) examinations and related diagnostic studies which ascertain the likelihood of sexual or physical abuse performed by SAFE-CARE trained providers shall continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program. The state agency shall define which services will continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program when performed or requested by a SAFE-CARE trained provider. Other medically necessary services may be ordered by the SAFE-CARE provider by referring to an in-network provider when possible. The health plan shall be
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responsible for these services, regardless whether the SAFE-CARE provider is in or out of the health plan network.

- 2.12.7 **Pharmacy Services:** Pharmacy services not included in the health plan's awarded proposal shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program.
- 2.12.8 **Protease Inhibitors:** Protease inhibitors shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program.
- 2.12.9 **Abortion Services:** Abortion services subject to Medicaid program benefits and limitations shall continue to be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program.

Paragraph 2.12.10. revised by Amendment #001

- 2.12.10 **Mentally Retarded and Developmental Disabilities (MRDD) Waiver:** Home and community based waiver services for persons in the MRDD waiver are carved out of the MC+ managed care program. The health plan shall be responsible for MC+ managed care covered services for MRDD waiver clients enrolled in MC+ managed care, unless specifically excluded. The health plan shall be responsible for care coordination of services included in the benefit package and the Home and Community based waiver. The state agency shall identify the MRDD Waiver participants to the health plan. Information regarding MRDD Waiver Services may be found in Section 19 of the Missouri Medicaid MRDD Waiver Provider Manual and the Missouri Medicaid Provider Bulletins located on the internet at www.dss.mo.gov/dms/providers.htm.
- 2.12.11 **Home Birth Services:** In accordance with the MC+ managed care home birth policy statement, if a member elects a home birth the member shall be disenrolled from MC+ managed care. The disenrolled member shall then receive services through the MC+ fee-for-service program for the home birth.
- 2.12.12 **Services for Children in the Custody of the Jackson County Office of the Missouri Children's Division:** Under court order (G.L. v. Stangler, also called the Consent Decree), children in the custody of the Jackson County office of the Missouri Children's Division (CD) and residing in Cass, Clay, Henry, Jackson, Johnson, Lafayette, Platte, Ray, or St. Clair counties have additional medical care requirements.
 - a. In addition to the services outlined herein, the health plan shall provide the following services following the effective date of enrollment with the health plan. If the child is already enrolled with the health plan and enters custody, the health plan shall provide the following services from the time the child enters CD custody. The time frames for these examinations begin with the time and date the child enters CD custody.
 - 1) A physical examination within 36 hours. The 36 hour exam is due the next working day following entry into custody. (This shall be paid by Medicaid on a fee-for-service basis and arranged by CD if the child is not enrolled in a health plan at the time of entry into CD custody.) A complete physical examination may be replaced by partial physical examination if the CD caseworker and the provider agree that a complete physical examination is unnecessary, repetitive, or would cause undue stress for the child. If agreement is reached that a partial physical examination is adequate, the provider shall decide the scope of the partial physical examination. Agreement that a complete physical examination is not necessary shall be documented in the child's medical record. In all cases, if a child is enrolled with the health plan prior to the 36-hour deadline, the health plan shall be responsible for providing the examination. If the health plan does not provide the examination, the health plan shall reimburse the provider that performs the examination in accordance with the current Medicaid fee schedule. CD, the Medical Case Management Agency, and the health plan shall work together to establish a notification process so that the health plan receives notification of the enrollment of a Consent Decree-covered child in a timely manner.

- 2) Within 30 calendar days — Follow-up examinations recommended by the provider during the 36-hour examination; i.e.: hearing and eye exams, dental screens or a full HCY screen shall be done in accordance with the most recent periodicity schedule. A partial HCY screening may be administered if the child is current with his or her HCY screening schedule and the CD caseworker and provider agree that a full HCY screening is unnecessary, repetitive, or would cause undue stress for the child. If agreement is reached that a partial HCY screening is adequate, the provider shall decide the scope of the partial HCY screening. Agreement that a full HCY screening is not necessary shall be documented in the child's medical record.
 - b. Following the 30 calendar day screening requirements, the HCY schedule shall be followed for children up to five years of age with annual examinations after age five unless the child has physical health, mental health, or developmental health problems identified by the provider that require medically necessary treatment on a more frequent basis.
 - c. The health plan shall be responsible for determinations regarding medically necessary treatments, medically necessary appointments, and medically necessary services.
 - d. **Consent Decree Medical Case Management**: Children in the custody of the Jackson County office of the Missouri Children's Division and residing in Jackson County also receive targeted medical case management services. Medical case management services are intended to facilitate access to medical services for the targeted children. Although this medical case management will be provided through a separate contract between the Department of Social Services and a Medical Case Management agency, the health plan shall provide the medical care required by the Consent Decree and all services specified herein for children in State custody. Per the Consent Decree, G.L. v. Stangler Amended Revised Operational Guide; March 14, 2002, and the contract with Medical Case Management agencies, children are followed at three different levels: Category 1, well children; Category 2, children with behavioral or mental health needs; and Category 3, children with medical needs. Children identified as Category 2 and Category 3 will remain in targeted medical case management during the entire time they are in custody. Category 1 children will be enrolled for targeted medical case management only during the first 30 calendar days of custody. The medical case management services provided by the Medical Case Management Agency include, but are not limited to:
 - 1) Promoting the effective and efficient access to comprehensive medical services for the targeted children,
 - 2) Facilitating the coordination of medical services,
 - 3) Maintaining confidential centralized files for each child,
 - 4) Assisting in the education of CD staff, caregivers, and health care providers regarding the child's medical care,
 - 5) Providing information regarding the need for specialized health services,
 - 6) Coordinating and monitoring all primary and specialty care necessary for the child, and
 - 7) Ensuring that essential medical care received by the child complies with the Consent Decree, Part III.
 - e. The health plan and providers shall cooperate with the Medical Case Management Agency in securing medical histories and providing medical records as required by the Consent Decree. The health plan shall allow case managers to file an appeal immediately (or within 12 hours if a concern arises after regular business hours) to the health plan's MC+ Medical Director if a Consent Decree case managed child is denied services or has difficulty accessing services covered in the contract.
 - f. The health plan shall designate a person within the health plan as a primary contact for CD staff, caregivers, and health care providers for issues involving these targeted children. The health plan shall also participate and attend medical oversight meetings.
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2.13 Second Opinion: Members have a right to second opinions from qualified health care professionals, and the health plan shall have policies and procedures for rendering second opinions both in-network and out-of-network when requested by a member. The health plan's policies and procedures shall address whether there is a need for referral by the primary care provider or self-referral. The adequacy of these policies and procedures shall be examined during quality assessment reviews. Missouri Revised Statutes Section 208.152 states that certain elective surgical procedures require a second medical opinion be provided prior to the surgery. A third surgical opinion, provided by a third provider, shall be allowed if the second opinion fails to confirm the primary recommendation that there is a medical need for the specific surgical operation, and if the member desires the third opinion.

2.14 Service Accessibility Standards:

2.14.1 Twenty-Four Hour Coverage: The health plan shall provide coverage to members on a twenty-four (24) hour per day, seven (7) day per week basis. The health plan shall have written policies and procedures describing how members and providers can contact the health plan to receive individual instruction or authorization for treatment of an emergent or urgent medical, mental health, or substance abuse problem and instruction regarding receiving care when the member is out of the health plan's geographic area. The health plan must make the policies and procedures available in an accessible format upon request. The health plan must provide for direct contact with qualified clinical staff through a toll-free member or provider services telephone number and a telecommunication device for the deaf telephone number. Recorded messages are not acceptable. The health plan shall provide an accommodation, if needed, to ensure all members equal access to twenty-four hour per day health care coverage.

2.14.2 Prior Authorization:

- a. The health plan shall ensure that prior authorization requirements are not applied to emergency medical/mental health services as defined herein.
 - b. The health plan shall specify, in writing, the procedures for prior authorization of non-emergency services and the time frames in which authorizations will be processed (approved or denied) and providers and members are notified.
 - c. If the health plan requires a referral, assessment, or other requirement prior to the member accessing requested medical or mental health services, such requirements shall not be an impediment to the timely delivery of the medically necessary service. The health plan shall assist the member to make any necessary arrangements to fulfill such requirements (i.e., scheduling appointments, providing comprehensive lists of available providers, etc.). If such arrangements cannot be made timely, the requested services shall be approved.
 - d. The health plan shall ensure that its prior authorization procedures meet the following minimum requirements:
 - 1) All appeals and denials must be reviewed by a professional with experience or expertise comparable to the provider requesting the authorization.
 - 2) There is a set of written criteria for review based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate.
 - 3) Reasons for decisions are clearly documented and assigned a prior authorization number which refers to and documents approvals and denials.
 - 4) Documentation shall be maintained on any alternative service(s) approved in lieu of the original request.
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- 5) There is a well-publicized review process for both providers and members.
- 6) The review process is completed and communicated to the provider in a timely manner, as indicated below, or the denials shall be deemed approved. For the purpose of this section, “necessary information” includes the results of any face-to-face clinical evaluation or second opinion that may be required.
 - Approval or denial of non-emergency services when determined as such by emergency room staff shall be provided by the health plan within thirty (30) minutes of request.
 - Approval or denial shall be provided within twenty-four (24) hours of request for services determined to be urgent by the treating provider.
 - Approval or denial shall be provided within two (2) business days of obtaining all necessary information for routine services. The health plan shall notify the requesting provider within two business days following the receipt of the request of service regarding any additional information necessary to make a determination. In no case shall a health plan exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial.
 - Involuntary detentions (96 hour detentions or court ordered detentions) or commitments shall not be prior authorized.
- e. The health plan shall ensure that members are not without necessary medical supplies, oxygen, nutrition, pharmaceutical products, etc., and must have written procedures for making an interim supply of an item available.
- f. The health plan shall ensure that the member’s treatment regimens are not interrupted or delayed (i.e. physical, occupational, and speech therapy; psychological counseling; home health services; personal care, etc.) by the prior authorization process.
- g. If the health plan approves purchase of a custom or power wheelchair, eyeglasses, hearing aids, dentures (excluding orthodontic services), custom HCY/EPSTDT equipment, augmentative communication devices placed within six months of approval, etc. which is delivered or placed after enrollment in the health plan ends, the health plan shall be responsible for payment.
- h. If the health plan requires prior authorization for pharmacy products, the health plan shall provide a response by telephone or other telecommunication device within 24 hours of a request for prior authorization. Approvals must be granted for claims meeting established criteria approved by the state. The state will approve criteria that follows accepted national guidelines for appropriate product use. The criteria shall be based on medical and clinical information and Missouri-specific data, consistent with the predetermined standards set by one or more of the following:
 - The American Hospital Formulary Service — Drug Information
 - The United States Pharmacopoeia Drug Information
 - Peer-reviewed medical literature.

Specific details describing pharmacy prior authorization and step therapy criteria shall be made available to prescribers upon request. Prescribers shall be informed of the availability of the criteria when a prescription is denied. The health plan shall provide for the dispensing of at least a 72-hour supply or a sufficient supply to the next business day of a drug product that requires prior authorization in an emergency situation.

- i. If the health plan prior authorizes health care services, the health plan shall not subsequently retract its authorization after the services have been provided, or reduce payment for an item or service unless:
 - The authorization is based on material misrepresentation or omission about the treated person's health condition or the cause of the health condition; or
 - The health plan terminates before the health care services are provided; or
 - The covered person's coverage under the health plan terminates before the health care services are provided.

2.14.3 Travel Distance: The health plan shall comply with travel distance standards as set forth by the Department of Insurance in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. For those providers not addressed under 20 CSR 400-7.095, the health plan shall ensure members have access to those providers within a reasonable travel distance. For those providers addressed under 20 CSR 400-7.095 but not applicable to the MC+ Managed Care Program (e.g. chiropractors), the health plan shall not be held accountable for the distance standards for those providers.

Paragraph 2.14.4 revised by Amendment #002 and BAFO #001

2.14.4 Appointment Standards:

- a. The average waiting times for primary care appointments shall not exceed one hour from scheduled appointment time. This includes time spent both in the lobby and in the examination room prior to being seen by a provider. Providers can be delayed when they "work in" urgent cases, when a serious problem is found, or when the member had an unknown need that requires more services or education than was described at the time the appointment was made.
- b. The health plan shall have procedures in place that ensure:
 - 1) Urgent care appointments for illness injuries which require care immediately but do not constitute emergencies, within 24 hours (e.g. high temperature, persistent vomiting or diarrhea, symptoms which are of sudden or severe onset but which do not require emergency room services).
 - 2) Routine care, with symptoms, appointments must be available within one (1) week or five (5) business days whichever is earlier (e.g. persistent rash, recurring high grade temperature, nonspecific pain, fever).
 - 3) Routine care, without symptoms, appointments must be available within thirty (30) calendar days (e.g. well child exams, routine physical exams).

Paragraph 2.14.4 b. 4) revised by BAFO #001

- 4) For mental health and substance abuse services, aftercare appointments shall occur within seven (7) calendar days after hospital discharge.
 - c. For maternity care, the health plan shall be able to provide initial prenatal care appointments for enrolled pregnant members as follows:
 - 1) First trimester, must be available within seven (7) calendar days of first request.
 - 2) Second trimester, must be available within seven (7) calendar days of first request.
 - 3) Third trimester, must be available within three (3) calendar days of first request.
 - 4) High risk pregnancies, must be available within three (3) calendar days of identification of high risk to the health plan or maternity care provider, or immediately if an emergency exists.
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- d. Policies and Procedures: The health plan shall disseminate its appointment standards to the network. The health plan shall monitor the adequacy of its appointment standards to ensure the reduction of unnecessary use of emergency room visits.
 - 1) The health plan shall have written policies and procedures concerning educating the provider network about appointment standards. The health plan shall monitor compliance with appointment standards and shall have a corrective action plan when appointment standards are not met.
 - 2.14.5 The health plan shall have established written policies and procedures concerning how a member may obtain a referral to an out-of-network provider when the health plan does not have a health care provider with appropriate training or experience in the network to meet the particular health care needs of the member.
 - 2.14.6 The health plan shall have established written policies and procedures concerning how a member, with a condition which requires on-going care from a specialist, may request a standing referral to such a specialist.
 - 2.14.7 The health plan shall have established written policies and procedures concerning how a member, with a life-threatening condition or disease either of which requires a specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.
 - 2.14.8 In accordance with State law, the health plan must allow members direct access to the services of the in-network OB/GYN of their choice for the provision of covered services.
 - 2.14.9 In accordance with State law, the health plan must notify the member on an annual basis, in writing, of cancer screenings covered by the health plan and provide the current American Cancer Society guidelines for all cancer screenings.
 - 2.14.10 The health plan shall have policies and procedures concerning how it will appropriately work with an out-of-network provider and/or the previous health plan to effect a transfer of care to appropriate in-network providers when a newly enrolled member has an existing relationship with a provider that is not in the health plan's network. For continuity of care, there are instances in which care shall continue with the out-of-network provider (e.g. third trimester pregnancy, in the middle of a course of treatment for cancer, etc.)
 - 2.14.11 **Care Management:** The health plan shall provide care management to members. Care management is coordination of care provided to members.
 - a. The health plan shall coordinate and deliver services designed to achieve the following outcomes:
 - 1) Improved patient care;
 - 2) Improved health outcomes;
 - 3) Reduction of inappropriate inpatient hospitalization;
 - 4) Reduction of inappropriate utilization of emergent services;
 - 5) Lower total costs; and
 - 6) Better educated providers and patients.
 - b. The health plan should have the following components in the care management program:
 - 1) Use of clinical practice guidelines; 2) Provider and patient profiling;
 - 3) Specialized physician and other practitioner care targeted to meet members special needs;
 - 4) Provider education;
 - 5) Patient education;
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- 6) Claims analyses; and
 - 7) Quarterly and yearly outcome measurement and reporting. The reporting requirements specified in Attachment 6 will satisfy this component. (Definition used with permission of The Center for Case Management, 6 Pleasant Street, South Natick, MA 01760.)
- c. The health plan must have implemented and effective policies and procedures for case management, care coordination, and disease management:
- 1) Case management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patients/families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance outcomes. (Definition used with permission of The Center for Case Management, 6 Pleasant Street, South Natick, MA 01760.) Case management is understood as including, but not limited to the development of individualized treatment plans and ongoing communication and coordination with other systems of care. The treatment plans must be:
 - Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member;
 - Approved by the entity in a timely manner, if this approval is required; and
 - In accord with any applicable State quality assurance and utilization review standards.
 - 2) Care Coordination is a method of coordinating the provision of health care so as to improve its continuity and quality. (Definition used with permission of the Center for Health Care Strategies, Inc., Princeton, New Jersey. "Case Management in Managed Care For People With Developmental Disabilities: Models, Cost and Outcomes. January, 1999".)
 - 3) Disease Management is the process of intensively managing a particular disease or syndrome. Disease management encompasses all settings of care and places a heavy emphasis on prevention and maintenance. It is similar to case management, but more focused on a defined set of problems relative to an illness or syndrome. (Definition used with permission of Center for Health Care Strategies, Inc., Princeton, New Jersey, "Case Management in Managed Care For People With Developmental Disabilities: Models, Costs and Outcomes, January, 1999".)

2.14.12 Certification Review:

- a. The health plan shall specify, in writing, the procedures for obtaining initial, concurrent, and retrospective reviews for inpatient admissions and the time frames in which authorizations will be processed (approved or denied) and providers and members are notified. The health plan shall ensure that the procedures meet the following minimum requirements:
- A professional with experience or expertise comparable to the provider requesting the authorization must review all appeals and denials.
 - There are standard policies and procedures for inpatient hospital admissions, continued stay reviews, and retrospective reviews and for making determinations on certifications or extensions of stays based on sound medical evidence that is updated regularly and consistently applied and for consultations with the requesting provider when appropriate.
 - For inpatient hospital admissions, continued stay reviews, and retrospective reviews to specialty pediatric hospitals, the health plan must use the same criteria as Medicaid fee-for-service.
 - For psychiatric inpatient hospital admissions, continued stay reviews, and retrospective reviews, the health plan must use the same criteria as Medicaid fee-for-service (LOCUS/CALOCUS).
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- Reasons for decisions are clearly documented and assigned a certification number, which refers to and documents approvals and denials.
 - Documentation shall be maintained on any alternative service approved in lieu of the original request.
 - There are fair and unbiased policies and procedures for reconsideration requests when the attending physician, the hospital, or the member disagrees with the health plan's determination regarding inpatient hospital admission or continued stays.
 - There are written policies and procedures followed to address the failure or inability of a provider or a member to provide all necessary information for review. In cases where the provider or a member will not release necessary information, the health plan may deny certification of an admission.
 - There is a well-publicized review process for both provider and members.
 - To the extent known, inform inpatient providers of the enrollees recent health care service history at the time of authorization of a psychiatric inpatient admission. Such information shall include psychiatric inpatient admissions and emergency room visits for the prior year, psychiatric outpatient services for the prior six months, and medications for the prior 90 calendar days. Information about specific episodes of care shall include date, diagnosis, provider, and procedure. Services related to substance abuse or HIV disorders are exempt from this requirement.
- b. The review process shall be completed and communicated to the provider and member in a timely manner, as indicated below, or the denials shall be deemed approved. For the purpose of this section, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.
- Approval or denial for initial determinations shall be provided by the health plan within two (2) working days of obtaining all necessary information.
 - Approval or denial for concurrent review determinations shall be provided by the health plan within one (1) working day of obtaining all necessary information.
 - Approval or denial for retrospective review determinations shall be provided by the health plan within thirty (30) working days of receiving all necessary information.
 - The health plan shall notify the requesting provider within two (2) working days following the receipt of the request of service regarding any additional information necessary to make a determination.
 - In no case shall a health plan exceed fourteen (14) calendar days following the receipt of the request of service to provide approval or denial for an initial or concurrent review.

2.15 Member Grievance System: The health plan shall have a system in place for members which includes a grievance process, an appeal process, and access to the state agency's fair hearing system.

2.15.1 For purposes of the health plan's grievance system, the following definitions shall apply:

Action — The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or in part, of payment for a service; the failure of the health plan to provide services in a timely manner as defined in the appointment standards described herein; or the failure of the health plan to act within timeframes for the health plan's Prior Authorization review process specified herein.

Appeal — A request for review of an action, as action is defined in this section.

Appeal Process — The health plan's process for handling of appeals that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file an appeal, the process for resolution of an appeal, the right to access the State fair hearing system, and the timing and manner of required notifications.

Grievance — An expression of dissatisfaction about any matter other than an action, as action is defined in this section. 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 member's rights.

Grievance Process — The health plan process for handling of grievances that complies with the requirements specified herein, including, but not limited to, the procedural steps for a member to file a grievance, the process for disposition of a grievance, and the timing and manner of required notifications.

Grievance System — The overall system in place for members that includes a grievance process, an appeal process, and access to the State fair hearing system.

Inquiry - A request from a member for information that would clarify health plan policy, benefits, procedures, or any aspect of health plan function but does not express dissatisfaction.

2.15.2 **General Requirements:** The health plan shall develop and implement written policies and procedures that detail the operation of the grievance system and provides simplified instructions on how to file a grievance or appeal and how to request a state fair hearing.

- a. The policies and procedures must be approved by the state agency prior to implementation.
 - b. The policies and procedures shall be approved by the health plan's governing body and be the direct responsibility of the governing body.
 - c. The health plan shall distribute an information packet to members upon enrollment which contains the grievance system policies and procedures, specific instructions regarding how to contact the health plan's member services, and identifies the person from the health plan who receives and processes grievances and appeals. The health plan shall also distribute the information packet to all in-network providers at the time they enter into a contract and to out-of-network providers within ten (10) calendar days of prior approval of a service or the date of receipt of a claim whichever is earlier.
 - d. The policies and procedures shall identify specific individuals who have authority to administer the grievance system policies.
 - e. The grievance system policies and procedures shall be readily available verbally and in the member's primary language. In addition, the health plan shall demonstrate that they have procedures in place to notify all members in their primary language of grievance dispositions and appeal resolutions.
 - f. As part of the grievance system, the health plan shall ensure that health plan executives with the authority to require corrective action are involved in the grievance and appeal processes.
 - g. The health plan shall thoroughly investigate each grievance and appeal using applicable statutory, regulatory, contractual provisions, and the health plan's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.
 - h. The health plan shall probe inquiries so as to validate the possibility of any inquiry actually being a grievance or appeal. The health plan shall identify any inquiry pattern.
 - i. The health plan's grievance system shall not be a substitute for the State fair hearing process. The state agency shall maintain an independent State fair hearing process as required by federal law and regulation, as amended. The State fair hearing process shall provide members an opportunity for a State fair hearing before an impartial hearing officer. The parties to the State fair hearing include the health plan as well as the member and his or her representative or the representative of a deceased member's estate. The health plan shall comply with decisions reached as a result of the State fair hearing process. Health plan members shall have the right to request information regarding:
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- The right to request a State fair hearing.
 - The procedures for exercising the rights to appeal or request a State fair hearing.
 - Representing themselves or use legal counsel, a relative, a friend, or other spokesperson.
 - The specific regulations that support or the change in Federal or State law that requires the action.
 - The individual's right to request a state fair hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.
 - A State fair hearing within 90 calendar days from the health plan's notice of action.
- j. The State must reach its decisions within the specified timeframes:
- 1) Standard resolution: within 90 calendar days of the date the member filed the appeal with the health plan if the member filed initially with the health plan (excluding the days the enrollee took to subsequently file for a State fair hearing) or the date the member filed for direct access to a State fair hearing.
 - 2) Expedited resolution (if the appeal was heard first through the health plan appeal process): within 3 working days from the state agency's receipt of a hearing request for a denial of a service that:
 - Meets the criteria for an expedited appeal process but was not resolved using the health plan's expedited appeal timeframes, or
 - Was resolved wholly or partially adversely to the member using the health plan's expedited appeal timeframes.
 - 3) Expedited resolution (if the appeal was made directly to the State Fair Hearing process without accessing the health plan appeal process): within 3 working days from the state agency's receipt of a hearing request for a denial of a service that meets the criteria for an expedited appeal process.

2.15.3 Record Keeping and Reporting Requirements:

- a. The health plan shall log and track all inquiries, grievances, and appeals.
- b. The health plan shall maintain records of grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of grievance, date of decision, and the disposition. If the health plan does not have a separate log for MC+ managed care members, the log shall distinguish MC+ managed care members from other health plan members.
- c. The health plan shall maintain records of appeals, whether received verbally or in writing, that include a short, dated summary of the issues, name of the appellant, date of appeal, date of decision, and the resolution. If the health plan does not have a separate log for MC+ managed care members, the log shall distinguish MC+ managed care members from other health plan members.
- d. The health plan must report grievances and appeals to the state agency in the format and frequency specified by the state agency. The state agency shall provide the health plan with no less than ninety (90) days notice of any change in the format or frequency requested.
- e. The state agency may publicly disclose summary information regarding the nature of grievances and appeals and related dispositions or resolutions in consumer information materials.

2.15.4 Notice of Action Requirements:

- a. The health plan's notice must be in writing and must meet the language and content requirements specified herein to ensure ease of understanding.
- b. The health plan's notice must explain the following:
 - 1) The action the health plan has taken or intends to take.
 - 2) The reasons for the action.
 - 3) The member's or the provider's right to file an appeal.
 - 4) The member's right to request a State fair hearing.
 - 5) The procedures for exercising the rights to appeal or request a State fair hearing.
 - 6) That the member may represent himself or use legal counsel, a relative, a friend, or other spokesperson.
 - 7) Must explain the specific regulations that support, or the change in Federal or State law that requires the action.
 - 8) The member's right to request a state agency hearing, or in cases of an action based on change in law, the circumstances under which a hearing will be granted.
 - 9) The circumstances under which expedited resolution is available and how to request it.
 - 10) The member's right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.
- c. The health plan must mail the notice to the member within the following timeframes:
 - 1) For termination, suspension, or reduction of previously authorized covered services, at least ten (10) calendar days before the date of action. The health plan may mail a notice not later than the date of action under the following circumstances:
 - The health plan has factual information confirming the death of a member.
 - The health plan receives a clear written statement signed by the member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
 - The member's whereabouts are unknown and the post office returns health plan mail directed to the member indicating no forwarding address (refer to 42 CFR 431.231 (d) for procedures if the member's whereabouts become known).
 - The member's physician prescribes a change in the level of medical care.
 - The health plan may shorten the period of advance notice to 5 calendar days before date of action if the health plan has facts indicating that action should be taken because of probable fraud by the member and the facts have been verified, if possible, through secondary sources.
 - The member's admission to an institution where he is ineligible for further services.
 - The member has been accepted for Medicaid services by another local jurisdiction.
 - 2) For denial of payment decisions that result in member liability, at the time of any action affecting the claim.
 - 3) For service authorization decisions that deny or limit services, within the timeframes required by the service accessibility standards for prior authorization specified herein.

2.15.5 Grievance Process:

- a. A member may file a grievance either orally or in writing. A member's authorized representative including the member's provider may file a grievance on behalf of the member.
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- b. The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
- c. The health plan shall acknowledge receipt of each grievance in writing within ten (10) business days after receiving a grievance.
- d. The health plan shall ensure that the individuals who make decisions on grievances are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease:
 - 1) A grievance regarding denial of expedited resolution of an appeal.
 - 2) A grievance that involves clinical issues.
- e. The health plan shall dispose of each grievance and provide written notice of the disposition of the grievance, as expeditiously as the member's health condition requires but shall not exceed thirty (30) calendar days of the filing date.
- f. The health plan may extend the timeframe for disposition of a grievance for up to fourteen (14) calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest. If the health plan extends the timeframe, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.

2.15.6 Appeal Process:

- a. A member may file an appeal and may request a State fair hearing within 90 calendar days from the date on the health plan's notice of action. A provider, acting on behalf of the member and with the member's written consent, may file an appeal.
 - b. The member or provider may file an appeal either orally or in writing. Unless he or she requests expedited resolution, must follow an oral filing with a written, signed appeal.
 - c. The health plan shall give members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability.
 - d. Appeals shall be filed directly with the health plan's governing body, or its delegated representatives. The governing body may delegate this authority to an appeal committee, but the delegation must be in writing.
 - e. The health plan shall acknowledge receipt of each appeal in writing within ten (10) business days after receiving an appeal.
 - f. The health plan shall ensure that the individuals who make decisions on appeals are individuals who were not involved in any previous level of review or decision-making; and who, if deciding any of the following, are health care professionals who have the appropriate clinical expertise, as determined by the state agency, in treating the member's condition or disease:
 - 1) An appeal of a denial that is based on lack of medical necessity.
 - 2) An appeal that involves clinical issues.
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- g. The appeals process must provide that oral inquiries seeking to appeal are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution.
 - h. The appeals process must provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The health plan must inform the member of the limited time available for this in the case of expedited resolution.
 - i. The appeals process must provide the member and his or her representative opportunity, before and during the appeals process, to examine the member's case file, including medical records, and any other documents and records considered during the appeals process.
 - j. The appeals process must include as parties to the appeal the member and his or her representative or the legal representative of a deceased member's estate.
 - k. The health plan shall resolve each appeal and provide written notice of the appeal resolution, as expeditiously as the member's health condition requires but shall not exceed forty-five (45) calendar days from date the health plan receives the appeal. For expedited resolution of an appeal and notice to affected parties, the health plan has no longer than three (3) working days after the health plan receives the appeal. For notice of an expedited resolution, the health plan must also make reasonable efforts to provide oral notice.
 - l. The health plan may extend the timeframe for standard or expedited resolution of the appeal by up to fourteen (14) calendar days if the member requests the extension or the health plan demonstrates (to the satisfaction of the state agency, upon its request) that there is need for additional information and how the delay is in the member's interest. If the health plan extends the timeframe, it must, for any extension not requested by the member, give the member written notice of the reason for the delay.
 - m. The written notice of the appeal resolution must include the following:
 - 1) The results of the resolution process and the date it was completed.
 - 2) For appeals not resolved wholly in the favor of the members the right to request a State fair hearing, and how to do so; the right to request to receive benefits while the hearing is pending, and how to make the request; and that the member may be held liable for the cost of those benefits if the hearing decision upholds the health plan's action.
 - n. The health plan must establish and maintain an expedited review process for appeals when the health plan determines (for a request from the member) or the provider indicates (in making the request on the member's behalf) that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function. The health plan must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a member's appeal.
 - o. If the health plan denies a member's request for expedited resolution, it must transfer the appeal to the timeframe for standard resolution specified herein and must make reasonable efforts to give the member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.
 - p. Continuation of benefits while the health plan appeal and State fair hearing are pending.
 - 1) As used in this section, "timely" filing means filing on or before the later of the following:
 - Within ten (10) calendar days of the health plan mailing the notice of action.
 - The intended effective date of the health plan's proposed action.
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- 2) The health plan must continue the member's benefits if the member or the provider files the appeal timely; the appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized provider; the original period covered by the original authorization has not expired; and the member requests extension of the benefits.
- 3) If, at the member's request, the health plan continues or reinstates the member's benefits while the appeal is pending, the benefits must be continued until one of the following occurs:
 - The member withdraws the appeal.
 - Ten (10) calendar days pass after the health plan mails the notice, providing the resolution of the appeal against the member, unless the member, within the ten (10) calendar day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached.
 - A State fair hearing officer issues a hearing decision adverse to the member.
 - The time period or service limits of a previously authorized service has been met.
- 4) If the final resolution of the appeal is adverse to the member, that is, upholds the health plans action, the health plan may recover the cost of the services furnished to the member while the appeal is pending, to the extent that they were furnished solely because of the requirements of this section.
- q. If the health plan or the State fair hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the health plan must authorize or provide this disputed services promptly, and as expeditiously as the member's health condition requires.
- r. If the health plan or the State fair hearing officer reverses a decision to deny authorization of services, and the member received the disputed services while the appeal was pending, the health plan must pay for those services.

2.16 Provider Inquiries, Complaints, Grievances, and Appeals:

The health plan shall establish a complaint, grievance, and appeal process that guarantees the right for a review to any provider of medical services for a member of the health plan.

2.16.1 For purposes of this document, the following definitions shall apply:

Inquiry - A request from a provider regarding information that would clarify health plan policy benefits, procedures, or any aspect of health plan function that may be in question.

Complaint - A verbal or written expression by a provider which indicates dissatisfaction or dispute with health plan policy, procedure, claims, or any aspect of health plan functions. All complaints must be logged and tracked whether received by telephone, in person or in writing.

Grievance - A written request for further review of a provider's complaint that remains unresolved after completion of the complaint process.

Appeal - The formal mechanism which allows a provider the right to appeal a grievance decision.

2.16.2 The health plan shall develop written policies and procedures which detail the operation of the provider inquiry, complaint, grievance, and appeal process and provides instructions on how to file a complaint, grievance, or appeal.

- a. The policies and procedures must be approved by the state agency prior to implementation.
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- b. The policies and procedures shall be approved by the health plan governing body and be the direct responsibility of the governing body.
- c. The health plan shall distribute an information packet to providers containing the complaint, grievance, and appeal policies and procedures, specific instructions regarding how to contact the health plan's provider services, and identifies the person from the health plan who receives and processes complaints, grievances, and appeals. The health plan shall distribute the policies and procedures to in-network providers at time of subcontract and to out-of-network providers with the remittance advice of the processed claim.
- d. The process must be addressed in the provider manual.
- e. The policies and procedures shall identify specific individuals who have authority to administer the inquiry, complaint, grievance, and appeal process.

2.16.3 Provider Inquiry, Complaint, Grievance, and Appeal Process:

- a. **Inquiry:** The health plan shall operate a provider services function, which providers can use to ask questions, file inquiries and complaints, and get problems resolved. The health plan's provider services function shall be adequately staffed to receive telephone calls and meet personally with providers. The health plan shall identify a person from the health plan specifically designated to receive and process complaints, grievances, and appeals. The health plan shall probe the inquiries so as to validate the possibility of any inquiry actually being a complaint. The health plan shall identify any inquiry patterns.
 - b. **Complaint:** A complaint can be filed verbally or in writing within one year of the incident that resulted in a complaint. Complaints shall be resolved within ten (10) calendar days of their filing. The provider(s) and health plan should attempt to resolve complaints before proceeding to a grievance.
 - 1) At the time of the health plan's decision regarding a complaint, the health plan shall notify providers in writing of their right to file a grievance with the health plan. This notification must be prior approved by the state agency.
 - c. **Grievance:** The health plan shall provide a grievance process which providers can use to file their dissatisfaction with the complaint resolution. If a provider is dissatisfied with the complaint resolution, the provider may file a grievance in writing with the health plan within ninety (90) calendar days of the complaint resolution. The provider must deliver a written, substantiated disagreement with the complaint resolution to the health plan. The health plan must acknowledge the receipt of grievances in writing within ten (10) business days after receiving a grievance. Grievances shall be investigated by the health plan and reviewed by a designated authority within the health plan. The health plan shall reach decisions on grievances within thirty (30) calendar days of their filing date.
 - 1) At the time of the health plan's decision regarding a grievance, the health plan shall notify the provider in writing of their right to file an appeal with the health plan. This notification must be prior approved by the state agency.
 - d. **Appeal:** The health plan shall operate an appeals process through which providers can challenge a negative decision to their grievances. Providers shall have ninety (90) calendar days following written notification of a grievance decision to appeal. The appeal must be filed in writing either by the provider or the provider's representative, or through the provider's instruction to the health plan's representative that the provider wishes to appeal. The health plan shall acknowledge receipt of each appeal in writing within ten (10) business days after receiving an appeal. Appeals shall be filed directly to the health plan's governing body, or its delegated representatives (The governing body
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may delegate this authority to an appeal committee, but the delegation must be in writing.). The appeal process shall include an opportunity for providers or their representatives to present their cases in person to the appellate body. The health plan shall reach a final decision on an appeal and provide written notice of the appeal resolution within sixty (60) calendar days of receipt of the appeal, with extensions possible if approved by the state agency.

- e. **Expedited Review:** The health plan shall have a procedure for expedited review of the complaint or grievance if the standard time frame could seriously jeopardize the member's life, physical or mental health, or the member's ability to regain maximum function. The expedited review shall be resolved no later than 72 hours or as expeditiously as the member's physical or mental health requires.

2.16.4 As a part of the provider complaint, grievance, and appeal process, the health plan shall:

- a. Ensure that health plan executives with the authority to require corrective action are involved in the complaint, grievance, and appeal process.
- b. Thoroughly investigate each complaint, grievance, and appeal using applicable statutory, regulatory, contractual provisions, and the health plan's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

2.16.5 **Records/Reporting:**

- a. The health plan shall log and track all inquiries.
- b. The health plan shall maintain records of complaints that include a short, dated summary of each of the questions or problems, name of the complainant, date of complaint, the response, and the resolution. If the health plan does not have a separate log for in-network providers, the log shall distinguish in-network providers from other health plan providers.
- c. The health plan shall maintain grievance records that include a copy of the original grievance, the response, and the resolution. This system shall distinguish in-network providers from other health plan providers and identify the grievant and the date of filing.
- d. The health plan must report provider complaints, grievances, and appeals to the state agency in the format requested by the state agency.
- e. The health plans must maintain records of all provider complaints, grievances, appeals, and resolutions.

2.17 **Quality Assessment and Improvement:**

- 2.17.1 The state agency regulates the quality assessment and improvement functions of the health plan. The health plan therefore must comply with all the state agency's quality assessment and improvement programs as described herein. The health plan shall participate in the State's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds. The health plan shall be held accountable for the ongoing monitoring, evaluation, and actions as necessary to improve the health of its members and the care delivery systems for those members. The health plan shall be held accountable for the quality of care delivered by providers. The state agency's quality assessment and improvement program shall consist of internal monitoring by the health plan, oversight by federal and state governments, and evaluations by an independent, external review organization. The health plan shall have a quality assessment and improvement program which integrates an internal quality assessment process that conforms to Quality Improvement System for Managed Care (QISMC) and additional current standards and guidelines prescribed by CMS. The health plan shall adhere to the requirements contained within the state agency's, Quality Management Plan located in Attachment 6. The health plan shall have a quality assessment and improvement program composed of:
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- a. An internal system of monitoring, analysis, evaluation, and improvement of the delivery of care that includes care provided by all providers;
- b. Designated staff with expertise in quality assessment, utilization management and continuous quality improvement;
- c. Written policies and procedures for quality assessment, utilization management, and continuous quality improvement that are periodically analyzed and evaluated for impact and effectiveness;
- d. Results, conclusions, team recommendations, and implemented system changes which are reported to the health plan's governing body at least quarterly, and
- e. Reports that are evaluated, recommendations that are implemented when indicated, and feedback provided to providers and members.

2.17.2 **Internal Staff:** The health plan shall designate a Quality Assessment and Improvement and Utilization Management Coordinator(s). Specifically, the Quality Assessment and Improvement and Utilization Management Coordinator must:

- a. Be a registered nurse, nurse practitioner, or physician. The registered nurse or nurse practitioner must be licensed in the State of Missouri. The physician must be Missouri licensed and practice medicine in the United States. He/she must be board-certified, board-eligible, or have sufficient experience in his or her field or specialty to be determined competent by the health plan's Medical Director or the Credentials Committee.
 - b. Be responsible for assisting the governing body and their designee in the process of continually developing, implementing, evaluating, and improving the written quality assessment and improvement program. The continuous improvement process shall include care delivery objectives, specific activities implemented from issues identified as a result of the on-going monitoring process, systems methodologies for continuous tracking of care delivery, and provider review. The process must include a focus on health outcomes and action plans for improvement of those outcomes.
 - c. Be responsible for the health plan's utilization management and quality assessment committee, assist the governing board in directing the development and implementation of the health plan's internal quality assessment and improvement program, and monitor the quality of care that members receive.
 - d. Oversee the development of clinical care standards and practice guidelines and protocols for the health plan. The health plan must adopt practice guidelines that meet the following requirements:
 - 1) Are based on valid and reliable clinical evidence or a consensus of health care professionals in the particular field;
 - 2) Consider the needs of the members;
 - 3) Are adopted in consultation with contracting health care professionals; and
 - 4) Are reviewed and updated periodically as appropriate.
 - 5) Dissemination of the guidelines to all affected providers and, upon request, to members and potential members.
 - 6) Ensure that decisions for utilization management, member education, coverage of services, and other areas to which the guidelines apply should be consistent with the guidelines.
 - e. Review all potential quality of care problems, both physical and mental health, and oversee development and implementation of continuous assessment and improvement of the quality of care provided to members.
 - f. Maintain current medical information pertaining to clinical practice and guidelines.
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- g. Ensure that health education resources are available for the provision of proper medical care to members.
 - h. Utilize staff in an effective and efficient manner to monitor and assess care delivery.
 - i. Specify clinical or health services areas to be monitored.
 - j. Specify the use of quality indicators that are objective, measurable, and based on current knowledge and clinical experience for priority areas selected by the state agency as well as for areas the health plan selects.
 - k. Monitor and report on the management of the health plan's EPSDT program.
 - l. Monitor and report on the health plan's referral process for specialty and out-of-network services.
 - m. Ensure that all denied services are reviewed by a physician, physician assistant, or advanced nurse practitioner. The reason for the denial must be documented and logged. Any alternative services authorized must be documented. All denials must identify appeal rights of the member.
 - n. Monitor and report on the health plan's credentialing and recredentialing activities.
 - o. Monitor and report on the health plan's process for prior authorizing and denying services.
 - p. Monitor and report on the health plan's process for ensuring the confidentiality of medical records and member information.
 - q. Monitor and report on the health plan's process for ensuring the confidentiality of the appointments, treatments, and required state agency reporting of adolescent STDs.
 - r. Monitor provider for compliance that reports of disease and conditions are made to the State Department of Health and Senior Services in accordance with all applicable State statutes, rules, guidelines, and policies and with all metropolitan ordinances and policies.
 - s. Monitor provider for compliance that control measures for tuberculosis, STDs, and communicable diseases are carried out in accordance with applicable laws and guidelines and such measures are defined in the provider manual.
 - t. Serve as a liaison between the health plan and the in-network providers and communicate at least quarterly with the in-network providers, including oversight of provider education, in service training, and orientation. Newsletter, web sites, and other media may be used to meet this criteria.
 - u. Be available to the health plan's medical staff for consultation on referrals, denials, grievances and appeals, and problems.
 - v. Monitor and report at least annually 24-hour access and after hours availability of primary care providers.
- 2.17.3 In addition to internal monitoring of quality of care, the health plan shall submit to the state agency reports regarding the results of their internal monitoring, evaluation, and action plan implementation. The reports shall include targeted health indicators monitored by the state agency and specific quality data periodically requested by the federal government. The reports may be required on a monthly, quarterly or annual basis or as specified by the state agency. (Refer to the Quality Management Plan located at Attachment 6 for the current report format.) The report format shall be periodically reviewed and updated by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar
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days notice of any changes in the format requested. The health plan shall comply with all subsequent changes specified by the state agency. The health plan shall provide access to documentation, medical records, premises, and staff as deemed necessary by the state agency.

- 2.17.4 The state agency shall contract with independent, external evaluators to examine the quality of care provided by the health plan. The health plan shall provide access to documentation, medical records, premises, and staff as deemed necessary by the state agency for the independent external review.
- 2.17.5 **Internal Procedures:** The health plan shall have an internal written quality assessment and improvement program. The health plan shall include monitoring, assessment, evaluation, and improvement of the quality of care for all clinical and health service delivery areas. Emphasis should be placed on, but need not be limited to, clinical areas relating to maternity, pediatric and adolescent development, EPSDT, family planning, and well woman care, as well as on key access or other priority issues for members such as reducing the incidence of STDs, acquired immune deficiency syndrome, and smoking related illnesses. The health plan must have implemented mechanisms to assess the quality and appropriateness of care furnished to members with special health care needs. The health plan's quality review mechanisms shall address members with special needs as well as COA 1, COA 4, and COA 5 members in the written monitoring, assessment, evaluation, and improvement plan.
- a. Internal policies and procedures must:
- 1) Ensure that the utilization management and quality assessment committees have established operating parameters. The committees shall meet at least quarterly, on a regular schedule. Committee members must be clearly identified and representative of the health plan's providers. The committee shall be accountable to the Medical Director and governing body. The committees must maintain appropriate documentation of the committees' activities, findings, recommendations, actions, and follow up.
 - 2) Provide for regular utilization management and quality assessment reporting to the health plan management and health plan providers, including profiling of provider utilization patterns.
 - 3) Be developed and implemented by professionals with adequate and appropriate experience in quality assessment and improvement: quality assessment, utilization management, and continuous improvement processes.
 - 4) Provide for systematic data collection, analysis, and evaluation of performance and member results.
 - 5) Provide for interpretation of this data to practitioners.
 - 6) Provide timelines for correction, and assign a specific staff person to be responsible for ensuring compliance and follow up.
 - 7) Clearly define the roles, functions, and responsibilities of the quality assessment committee and the Medical Director.
- b. **Utilization Management:** The health plan shall have written utilization management policies and procedures that include protocols for denial of services, prior approval, hospital discharge planning, physician profiling, and concurrent, prospective, and retrospective review of claims that comply with federal and state laws and regulations, as amended. The utilization management policies and procedures must be clearly specified in provider contracts or provider manuals and consistently applied in accordance with the established utilization management guidelines. As part of the health plan's utilization management function, the health plan also must have processes to identify both over and under utilization problems for inpatient and outpatient services, undertake corrective action, and follow up. This review must consider the expected utilization of services regarding the
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characteristics and health care needs of the member population. In addition, the health plan shall use an emergency room log, or equivalent method, to track emergency room services. Compensation to individuals or entities that conduct utilization management activities shall not be structured so as to provide incentives for the individual or entity to deny, limit, or discontinue medically necessary services to any member.

- c. **Provider Credentialing:** The health plan shall have written credentialing and re-credentialing policies and procedures for determining and assuring that all in-network providers are licensed by the state in which they practice and qualified to perform their services. The health plan shall have written policies and procedures for monitoring the in-network providers, reporting the results of the monitoring process, and disciplining in-network providers found to be out-of-compliance with the health plan's medical management standards. The health plan shall use the Missouri Standardized Credentialing Form (MoSCF), pursuant to RSMo 354.442.1 (15) and 20 CSR 400.7.180, as amended.
- d. **Performance Improvement Projects:** The health plan must conduct performance improvement projects that are designed to achieve, through ongoing measurements and intervention, significant improvement, sustained over time, in clinical care and nonclinical care areas that are expected to have a favorable effect on health outcomes and member satisfaction. The health plan must report the status and results of each project to the state agency as requested. The performance improvement projects must involve the following:
 - 1) Measurement of performance using objective quality indicators.
 - 2) Implementation of system interventions to achieve improvement in quality.
 - 3) Evaluation of the effectiveness of the interventions.
 - 4) Planning and initiation of activities for increasing or sustaining improvement.
 - 5) Completion of the performance improvement project in a reasonable time period so as to generally allow information on the success of performance improvement projects in the aggregate to produce new information on quality of care every year.
 - 6) Performance measures and topics for performance improvement projects specified by CMS in consultation with the state agency and other stakeholders.
- e. **Member Incentives:** The health plan may offer member incentives with a value of \$30.00 or less per eligible member per month. All member incentives must be prior approved by the state agency. The purpose of the health plan's member incentives:
 - Must be directly related to a health plan quality initiative
 - Must be measurable via the quality activity
 - Cannot have any relationship to the health plan's marketing activities
 - Cannot be convertible to cash or redemption in any way for alcohol, tobacco products, firearms or ammunition.
 - 1) The health plan must monitor their member incentives program to ensure that the program has met the health plan's quality initiative and to evaluate on an ongoing basis the effectiveness of the member incentive program.
 - 2) The health plan must report the status and results of member incentives to the state agency as requested.

2.18 Community Health Assessment:

- 2.18.1 The health plan shall participate in a community health status assessment and improvement initiative as approved by the Department of Health and Senior Services. The health status assessment and improvement initiative shall be developed by a community-based coalition and include community
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benchmarks for measuring access, quality, and health status. The Department of Health and Senior Services shall provide a list of active community-based health status assessment and improvement initiatives to the health plan. If there is no approved health status assessment and improvement initiative in the health plan's region, the Department of Health and Senior Services shall provide technical assistance to the health plan to develop the health status assessment and improvement initiative. Participation in a health status assessment and improvement initiative shall include:

- a. Becoming a member of a community-wide planning coalition. Community means a geographic entity (a county(ies) for the most part) with broad based representation from community providers, businesses, local organizations, schools, etc. The Department of Health and Senior Services would notify the health plan of coalitions that meet the community standard. Where no such coalition exists, the Department of Health and Senior Services shall work with the health plan to develop one. The health plan shall not be required to be the lead agency in establishing a coalition.
- b. Assisting with the collection and/or analysis of relevant health data and information as defined by the coalition.
- c. Active involvement in the assessment process including prioritizing community problems.
- d. Active involvement in the development and implementation of the community strategic plan to implement health improvement programs.
- e. Providing feedback on the community strategic plan and its effectiveness.

2.19 State and Federal Reviews:

2.19.1 The health plan shall make available to the state agency or its outside reviewers, on an annual basis and on an as needed basis, medical and other records for review of quality of care, access, financial, and other issues. The state agency's quality assessment and improvement review may include but is not limited to:

- a. On-site visits and inspections of facilities;
 - b. Staff and member interviews;
 - c. Review of utilization, denial of services, and other areas that will indicate quality of care delivered to members;
 - d. Medical records reviews;
 - e. Financial records reviews;
 - f. Review of all quality assessment procedures, reports, committee activities and recommendations, and corrective actions;
 - g. Review of staff and provider qualifications;
 - h. Review of the complaint, grievance, and appeal process and resolutions;
 - i. Review of requests for transfers between primary care providers within each health plan;
 - j. Review of fraud and abuse detection, prevention, and review process, procedures, cases, and reports; and
 - k. Evaluation and analysis of coordination and continuity of care.
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2.19.2 **External Reviews:** The state agency contracts with independent external evaluators to examine the quality of care provided by the health plan. CMS designates an outside review agency to conduct an evaluation of the program and its progress toward achieving program goals. The health plan shall make available to CMS's outside review agency and the state agency's external evaluator medical and other records for review as requested. The health plan shall provide information for External Quality Reviews in the format specified by the state agency.

2.20 Financial Reporting:

2.20.1 The health plan shall not hold a member liable for the following:

- a. The debts of the health plan, in the event of the health plan's insolvency;
- b. Services provided to the member in the event the health plan fails to receive payment from the state agency for such services;
- c. Services provided to the member in the event a health care provider with a contractual, referral, or other arrangement with the health plan fails to receive payment from the state agency or health plan for such services; or
- d. Payments to a provider that furnishes covered services under a contractual, referral, or other arrangement with the health plan in excess of the amount that would be owed by the member if the health plan had directly provided the services.
- e. In the case of insolvency, the health plan shall continue to cover services to members during insolvency for the duration of period for which payment has been made by the state agency, as well as for inpatient admissions up until discharge.

2.20.2 **Financial Data Reporting:** The health plan shall submit unaudited semi-annual reports and an unaudited and audited annual report for their MC+ managed care book of business to the state agency. The health plan shall submit the semi-annual and annual reports in the format and audit guidelines specified by the state agency. The current report format and audit guidelines can be found in Attachment 10. Changes to the report format must be approved by the state agency prior to submission.

- a. The semi-annual and unaudited and audited annual reports must be certified by one of the following:
 - 1) The health plan's Chief Executive Officer.
 - 2) The health plan's Chief Financial Officer.
 - 3) An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
- b. The certification must attest, based on best knowledge, information, and belief, as follows:
 - 1) To the accuracy, completeness, and truthfulness of the data.
 - 2) To the accuracy, completeness, and truthfulness of the semi-annual and annual reports.
- c. The health plan must submit the certification concurrently with the semi-annual and annual reports.

2.20.3 **Physician Incentive Plan Requirements:** The Department of Health and Human Services published a federal regulation regarding physician incentive plans in the March 27, 1996, *Federal Register*. This regulation is designed to protect beneficiaries enrolled in Medicare and Medicaid Managed Care Organizations by placing certain limitations on physician incentive plans that could influence a physician's care decisions.

- a. In addition, the physician incentive plan regulation applies to all subcontractors, including any health care services subcontractors. The physician incentive plan regulation does not apply outside the scope of incentive plans for physicians providing services to Medicare or MC+ managed care members.
- b. The health plan shall not offer financial incentives to induce physicians to limit or reduce medically necessary services to a specific member. The health plan shall not offer non-financial incentives to limit or reduce medically necessary services to a specific member.
- c. A physician group is at “substantial” financial risk if more than 25% of its potential payment is at risk for services it does not provide.
 - 1) If the physician group is at “substantial” financial risk, the health plan shall provide adequate protection to limit financial losses. The health plan has the option of: 1) retaining the risk in its direct provider contracts, or 2) the MCO, intermediate entity, physician or physician group can reinsure the risk through a reinsurance carrier. Stop-loss protection must cover at least ninety percent (90%) of the costs of referral amounts that exceed 25% of the total potential payment on either a per member per year or an aggregate basis.

For the purposes of the PIP regulation, the term “physician” is defined as: Doctors of medicine, doctors of osteopathy, doctors of dental surgery or dental medicine, doctors of podiatric medicine, doctors of optometry, chiropractors, and any limited practice provider that provides services on State authority to perform such services.
 - 2) If the physician group is at “substantial risk”, the health plan must conduct annual member surveys. The health plan shall survey enrolled and disenrolled members with questions on satisfaction, quality, and access to services. The result should be submitted to the state agency.
- d. In compliance with the federal regulation, the health plan shall disclose to the members, upon request, whether the health plan used a physician incentive plan, what type of physician incentive plan it uses, whether stop-loss insurance is provided, and a summary of any survey results if a survey was required to be conducted.
- e. On an annual basis and in compliance with the federal regulation, the health plan must disclose physician incentive plans to CMS, and the state agency. The information to be disclosed shall include the following:
 - 1) Effective date of the physician incentive plan;
 - 2) The type of incentive arrangement;
 - 3) The amount and type of stop-loss protection;
 - 4) The patient panel size;
 - 5) If pooled, a description of the method;
 - 6) The computations of significant financial risk;
 - 7) Whether the health plan does not have a physician incentive plan; and
 - 8) Name, address, phone number, and other contact information for a person from the health plan who may be contacted with questions regarding the physician incentive plan.
- f. The health plan shall notify the state agency within five (5) business days of any change to the health plan or the subcontractors’ physician incentive plan(s).

2.20.4 The health plan shall provide quarterly reports to the state agency detailing third party savings in a format prescribed by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar days notice of any change in the format requested. These reports are due on the thirtieth (30) day following the close of the quarter. The health plan shall maintain records in such a manner as to ensure that all money collected from third party resources may be identified on behalf of members. The

health plan shall make these records available for audit and review and certify that all third party collections are identified and used as a source of revenue.

- a. The quarterly reports must be certified by one of the following:
 - 1) The health plan's Chief Executive Officer.
 - 2) The health plan's Chief Financial Officer.
 - 3) An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
- b. The certification must attest, based on best knowledge, information, and belief, as follows:
 - 1) To the accuracy, completeness, and truthfulness of the data.
 - 2) To the accuracy, completeness, and truthfulness of the quarterly reports.
- c. The health plan must submit the certification concurrently with the quarterly reports.

2.20.5 The health plan shall report the categories of all third party liability collections to the state agency and shall include a complete disclosure demonstrating its efforts to obtain payment from liable third parties and the amounts and nature of all third party payments recovered for members including, but not limited to, payments for services and conditions which are:

- a. Employment related injuries or illnesses;
- b. Related to motor vehicle accidents, whether injured as pedestrians, drivers, passengers, or bicyclists; and
- c. Contained in diagnosis codes 800 through 999 (ICD 9-M), with the exception of Code 994.6.

The reports must be certified by one of the following:

- a. The health plan's Chief Executive Officer.
- b. The health plan's Chief Financial Officer.
- c. An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.

The certification must attest, based on best knowledge, information, and belief, as follows:

- a. To the accuracy, completeness, and truthfulness of the data.
- b. To the accuracy, completeness, and truthfulness of the reports.

The health plan must submit the certification concurrently with the reports.

2.21 Operational Data Reporting:

2.21.1 To measure the MC+ managed care program's actual accomplishments in the areas of access to care, utilization, medical outcomes, health status, and satisfaction, the health plan shall provide the state agency with information concerning uniform utilization, quality assessment and improvement, member satisfaction, complaint, grievance, and appeal, and fraud and abuse detection data on a regular basis. On a periodic basis, the health plan shall make available clinical outcome data in areas of concern to the state agency. The health plan shall cooperate with the state agency in carrying out data validation steps.

2.21.2 The state agency shall provide report formats and variable definitions for the health plan to use in reporting operational data. Data elements and reporting requirements are outlined in the Performance Requirements segment. Final formats will be made available as finalized.

- 2.21.3 **Quarterly Complaint, Grievance, and Appeal Report:** On a quarterly basis, the health plan shall submit to the state agency a Quarterly Complaint, Grievance, and Appeal Report, in accordance with the State Management Plan included as Attachment 6.
- 2.21.4 **Quality Assessment and Improvement Evaluation and Reports:** The health plan shall submit an annual Quality Assessment and Improvement Evaluation and Report. The format will be periodically reviewed and updated by the state agency. The health plan shall comply with all changes as specified by the state agency. The state agency shall provide the health plan with no less than ninety (90) calendar days notice of any change in the format requested.
- 2.21.5 **Member Satisfaction Report:** The Department of Health and Senior Services has authority under RSMo 192.068, as amended, to collect the member satisfaction survey data from the health plan. To reduce duplication and ensure consistent survey methodology, the state agency shall rely upon the member satisfaction survey data from this process. The health plan shall submit member satisfaction data to the Department of Health and Senior Services in accordance with 19 CSR 10-5.010, as amended. The health plan shall use the survey instrument specified by the Department of Health and Senior Services and must fund the cost of the survey.
- 2.21.6 **Presentation of Findings:** The health plan shall obtain the state agency's approval prior to publishing or making formal public presentations of statistical or analytical material based on the health plan's MC+ managed care membership.
- 2.22 **Third Party Liability:** Third Party Liability is defined as any individual, entity, or program that is or may be liable to pay all or part of the health care expenses of a Medicaid beneficiary. Under Section 1902(a) (25) of the Social Security Act, the State is required to take all reasonable measures to identify legally liable third parties and treat third party liability as a resource of the Medicaid beneficiary.
- 2.22.1 **Coordination of Benefits:** By law, Medicaid is the payer of last resort. Therefore, the health plan shall be used as a source of payment for covered services only after all other sources of payment have been exhausted. The two methods used in the coordination of benefits are cost avoidance and post-payment recovery (i.e., "pay and chase"). The health plan shall act as an agent of the state agency for the purpose of coordination of benefits.
- a. If health plan has established the probable existence of liability of a third party health insurance carrier at the time a claim is filed, the health plan shall reject the claim and return it to the provider for a determination of the amount of liability except in certain defined situations referenced below. This rejection is called cost avoidance. If a service is medically necessary, the health plan shall ensure that its cost avoidance efforts do not prevent a member from receiving such service and that the member is not required to pay any cost-sharing for use of the other insurer's providers.
 - b. The establishment of liability takes place when the health plan receives confirmation from the provider or the third party health insurance carrier indicating the extent of liability taking into account any agreement between the provider and third party health insurance carrier regarding acceptance of the carrier's payment as payment in full with the exception of any patient cost-sharing. If the probable existence of a liable third party cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule. When the amount of liability is determined, the health plan shall pay the claim to the extent that payment allowed under the health plan's payment schedule exceeds the amount of the third party health insurance carrier's payment taking into account any agreement between the provider and the third party health insurance carrier regarding acceptance of the carrier's payment as payment in full with the exception of any patient cost-sharing. If a third party health insurance carrier (other than Medicare) requires the member to pay any cost-sharing (such as copayment, coinsurance, or deductible) the health plan shall pay the cost-sharing amounts, even if services were provided by an out-of-network provider. The health plan may require prior authorization of out-of-network services. The health plan's liability for such cost-
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sharing amounts shall not exceed the amount the health plan would have paid under the health plan's payment schedule for the service. The out-of-network provider must agree in writing to accept the amount of the health plan's payment as payment in full prior to the service being provided. If the out-of-network provider does not agree to accept the health plan's payment as payment in full, the health plan shall inform the member verbally and in writing that due to lack of such agreement, the member will be liable for the cost sharing amounts to the out-of-network provider or the member may seek services without charge from an in-network provider.

- 1) For additional clarity on establishment of the health plan's liability, the following examples are provided:
 - A provider submits a charge for \$100 to the health plan for which the health plan's allowable is \$80. The provider received \$75 from the third party insurance carrier. There is no agreement between the provider and third party insurance carrier that the amount paid by the carrier is payment in full. The provider normally bills all patients with this carrier the remaining balance of \$25. The provider would submit a claim to the health plan indicating the remaining balance of \$25 is owed after receiving \$75 from the third party carrier. The amount the health plan pays the provider is the difference between the health plan's allowable (\$80) and the carrier's payment (\$75) or \$5.
 - A provider has a charge of \$100.00. The third party carrier and provider have agreed that the amount paid by the carrier is payment in full except for any cost-sharing. The carrier has an allowable of \$50 with the remaining \$25 to be a contractual write-off. The member has a co-payment of \$25.00. The provider bills all patients with this carrier only the co-payment amount. The provider bills the health plan the \$25 co-payment. The health plan's liability is not \$30 (\$80-\$50) in this situation as there exists an agreement between the provider and third party carrier that there is no liability by the patient other than cost-sharing. The health plan's pays the provider \$25 as the co-payment does not exceed its allowable of \$80.
 - c. The requirement of cost avoidance applies to all covered services except claims for labor and delivery and postpartum care (costs associated with the inpatient hospital stay for labor and delivery and postpartum care must be cost avoided); prenatal care for pregnant women; preventive pediatric services; or if the claim is for a service that is provided to a member on whose behalf child support enforcement is being carried out by the Missouri Department of Social Services, Family Support Division. For these services, the health plan shall provide such service and then recover payment from the third party health insurance carrier ("pay and chase").
 - d. The health plan may retain up to 100 percent of its third party collections if all of the following conditions exist:
 - 1) Total collections received do not exceed the total amount of the health plan's financial liability for the member.
 - 2) There are no payments made by the state agency related to fee-for-service.
 - 3) Such recovery is not prohibited by Federal or State law.
 - e. The state agency shall provide the health plan with a daily file of third party health insurance carrier information (other than Medicare) for the purpose of updating the health plan's files. The state agency shall continue to perform verification of the health insurance information. The state agency does not warrant that the information is complete or accurate. The file is to be considered a "lead" file to assist the health plan in identifying legally liable third parties. The health plan shall timely notify the state agency of any known changes, additions, or deletions of coverage in a format prescribed by the state agency.
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- f. The state agency shall annually perform a data match with the United States Department of Defense to identify members covered by TRICARE. The state agency shall provide the health plan with the results of the data match annually and in a format specified by the state agency. The health plan shall perform post-payment recovery and cost avoidance activities as appropriate based on the information supplied by the data match.

2.22.2 Casualty/Tort: The health plan shall act as an agent of the state agency for purposes of third party reimbursement pursuant to RSMo 208.215, as amended. In addition to coordination of benefits, the health plan shall pursue reimbursement in the following circumstances: Workers' Compensation, Tortfeasors, Motorist Insurance, and Liability/Casualty Insurance.

- a. The health plan shall take action to identify those paid claims for members that contain diagnosis codes 800 through 999 (ICD 9-CM), with the exception of 994.6, for the purpose of determining the legal liability of third parties so that the health plan may process claims under the third party liability payment procedures specified in 42 CFR 433.139 (b) through (f), as amended.
- b. The state agency shall perform a data match with the Department of Labor, Division of Workers' Compensation to identify members that the Division of Workers' Compensation has a record of a work-related injury claim. The state agency shall provide the health plan with the results of the data match monthly and in a format specified by the state agency. The health plan shall perform post payment recovery and cost avoidance activities as appropriate based on the information supplied by the data match. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule.
- c. The state agency shall perform a data match with the State Traffic Accident Reporting System (STARS) of the Missouri Highway Patrol to identify members that the STARS system has a record of a member involved in a motor vehicle accident. The state agency shall provide the health plan with the results of the match monthly and in a format specified by the state agency. The health plan shall perform further validation activities when using information supplied by the data match to ensure the member is in fact the person referenced in the match. If the probable existence of third party liability cannot be established or third party benefits are not available to pay the member's medical expenses at the time the claim is filed, the health plan shall pay the full amount allowed under the health plan's payment schedule.
- d. The health plan shall perform all research, investigations, and payment of lien-related costs, including but not limited to, attorney fees and costs related to such cases.
- e. If a member initiates a legal action as a result of an injury that occurred during the health plan contract period, the health plan may file a lien for reimbursement for medical services provided to treat the injury that occurred during the contract period even after the contract period has ended.
- f. If the health plan initiates a lien during the contract period but the case remains unsettled at the end of the contract period, the health plan may continue pursuit of the action for the medical services related to the injury that were provided during the contract period.
- g. If the member enrolls with a new health plan while legal action is pending, each health plan may file separate liens to recover reimbursement for medical services related to the injury that were provided during the respective contract periods.

2.23 Reinsurance: The state agency will not administer a reinsurance program funded from capitation payment withholdings.

2.24 Reserving: As part of its accounting and budgeting function, the health plan shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. The health plan should reserve

funds by major categories of service (e.g., hospital inpatient; hospital outpatient) to cover both incurred but not reported, and reported but unpaid claims. As part of its reserving methodology, the health plan should conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

2.25 Claims Processing and Management Information System:

- 2.25.1 The health plan shall have a Claims Processing and Management Information System (MIS) capable of meeting the MC+ managed care program requirements and maintaining satisfactory performance throughout the life of the contract. The health plan shall have the capability to transmit and receive data, support provider payments, and data reporting requirements as specified herein. The health plan shall have the capability to process claims, retrieve and integrate enrollment data, assign primary care providers, maintain provider network data, and submit encounter data. The Claims Processing and MIS should be of sufficient capacity to expand as needed due to member enrollment or program changes.
- 2.25.2 The health plan shall transmit encounter data and all required files in accordance with the Health Plan Record Layout Manual, as amended. The health plan shall maintain an encounter overall acceptance rate of at least 95 % as measured by the state agency.
- a. The health plan shall submit encounter data for all services provided including those services that are reimbursed by the health plan through a capitated arrangement or other subcontracted arrangement.
- 1) The encounter data must be certified by one of the following:
- The health plan's Chief Executive Officer.
 - The health plan's Chief Financial Officer
 - An individual who has delegated authority to sign for, and who reports directly to, the health plan's Chief Executive Officer or Chief Financial Officer.
- 2) The certification must attest, based on best knowledge, information, and belief, as to the accuracy, completeness, and truthfulness of the encounter data.
- 3) The health plan must submit the certification concurrently with the encounter data.
- b. The health plan shall transmit primary care provider assignments and changes or additions to the provider demographic file.
- 2.25.3 The health plan shall accept claims electronically from all providers. The health plan shall make every effort to encourage providers to submit claims electronically using HIPAA compliant formats.
- 2.25.4 The health plan shall employ or have available, the resources necessary to make modifications to claims processing edits or expansion of MIS capabilities as a result of changes in MC+ managed care policies and/or procedures. The state agency shall make every effort to give the health plan 60 calendar days notice of changes in the MC+ managed care program that may require the health plan to make system changes in order to comply.

Paragraph 2.25.5 inserted by Amendment #001

- 2.25.5 **Timeliness of Claim Adjudication Report:** On a quarterly basis, the health plan shall submit to the state agency a "Timeliness of Claims Adjudication Report" in accordance with the quarterly reporting schedule outlined in Attachment 6 in a format specified by the state agency.

2.26 Records Retention:

- 2.26.1 The health plan shall maintain books and records relating to MC+ managed care services and expenditures, including reports to the state agency and source information used in preparation of these reports. The books and records shall include, but are not limited to, financial statements, records relating to quality of care, medical records, and prescription files.
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- 2.26.2 The health plan shall also comply with all standards for record keeping specified by the state agency.
- 2.26.3 The health plan shall maintain and retain all financial and programmatic records, supporting documents, statistical records, and other records of members for five (5) years. If any litigation, claim, negotiation, audit or other action involving the records has been started before the expiration of the five (5) year period, the health plan shall retain the records until completion of the action and resolution of all issues which arise from it or until the end of the regular five (5) year period, whichever is later.
- 2.26.4 The health plan shall retain the source records for the health plan's data reports for a minimum of five (5) years and must have written policies and procedures for storing this information.
- 2.26.5 **Medical Records:** The health plan shall have written policies and procedures for the maintenance of medical records so that the records are documented accurately and in a timely manner, are readily accessible, and permit prompt and systematic retrieval of information. Complete medical records shall include but are not limited to medical charts, health status screens, prescription files, hospital records, physician specialists, consultant and other health care professionals' findings, and other documentation sufficient to disclose the quantity, quality, appropriateness, and timeliness of services provided. The health plan shall make such medical records available to duly authorized representatives of the state agency and the United States Department of Health and Human Services to evaluate, through inspections or other means, the quality, appropriateness, and timeliness of services performed. The health plan must have procedures to provide for prompt transfer of member records upon request to other in-network or out-of-network providers for the medical management of the member.
- a. In accordance with Senate Bill No. 1024, enacted by the General Assembly of the State of Missouri, Section A., Chapter 334, RSMo, amended to be known as Section 334.097, physicians shall maintain an adequate and complete patient record for each patient and may maintain electronic records provided the record keeping format is capable of being printed for review. An adequate and complete patient record shall include documentation of the following information:
- Identification of the patient, including name, birthdate, address and telephone number;
 - The date or dates the patient was seen;
 - The current status of the patient, including the reason for the visit;
 - Observation of pertinent physical findings;
 - Assessment and clinical impression of diagnosis;
 - Plan for care and treatment, or additional consultations or diagnostic testing, if necessary. If treatment includes medication, the physician shall include in the patient record the medication and dosage of any medication prescribed, dispensed or administered; and
 - Any informed consent for office procedures.
- 1) Patient records remaining under the care, custody, and control of the physician shall be maintained by the physician, or the physician's designee, for a minimum of seven (7) years from the date of when the last professional service was provided.
 - 2) Any correction, addition, or change in any patient record made more than forty-eight hours after the final entry is entered in the record and signed by the physician shall be clearly marked and identified as such, and the date, time, and name of the person making the correction, addition, or change shall be included, as well as the reason for the correction, addition, or change.
 - 3) A consultative report shall be considered an adequate medical record for a radiologist, pathologist, or a consulting physician.
- b. The member's medical record is the property of the provider who generates the record. Upon the written request of a member, guardian, or legally authorized representative of a member the health
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plan shall furnish a copy of the medical records of the member's health history and treatment rendered. Such medical records shall be furnished within a reasonable time of the receipt of the written request. Each member is entitled to one free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

- c. The health plan shall provide the state agency with access to all members' medical records, whether electronic or paper, within thirty (30) calendar days of receipt of written request at no charge. The health plan shall provide the state agency with access to a single or small volume of medical records within five (5) calendar days of receipt of written request at no charge. The health plan shall provide the state with immediate access for on-site review of medical records. For on-site review of medical records, the state agency may provide the health plan with an advance notice of a partial list of medical records. The health plan shall fax or send by overnight mail to the state agency all medical records involving an emergency or urgent care issue when requested by the state agency at no charge. Access to record requirements applies to the health plan and all providers.
- d. The health plan shall have written standards for documentation on the medical record for legibility, accuracy, and plan of care.
- e. The health plan shall require its providers to maintain medical records in a detailed and comprehensive manner which conforms to good professional medical practice, permits effective professional medical review and medical audit processes, and facilitates an adequate system for follow-up treatment. Medical records must be legible, signed and dated.
- f. When a member changes primary care providers, upon request, his or her medical records or copies of medical records must be forwarded to the new primary care provider within ten (10) business days from receipt of request or prior to the next scheduled appointment to the new primary care provider whichever is earlier.
- g. The state agency is not required to obtain written approval from a member before requesting the member's record from the provider.
- h. If the state agency requests, the health plan shall gather all medical records from their providers.

2.27 Health Plan Disputes With Other Providers: All disputes between the health plan and any affiliated or unaffiliated provider, or between the health plan and any other subcontractors, shall be solely between such provider or subcontractors and the health plan. The health plan shall indemnify, defend, save and hold harmless the State of Missouri, the Department of Social Services and its officers, employees and agents and enrolled MC+ managed care members from any and all actions, claims, demands, damages, liabilities, or suits of any nature whatsoever arising out of the contract because of any breach of the contract by the health plan, its subcontractors, agents, providers or employees, including but not limited to any negligent or wrongful acts, occurrence of omission of commission or negligence of the health plan, its subcontractors, agents, providers or employees.

2.28 Rate Adjustments for Performance Based on HCY/EPSDT Participant Ratio and Remedies for Violation, Breach, or Non-Compliance of Contract Requirements:

2.28.1 Rate Adjustments for Performance Based on HCY/EPSDT Participant Ratio: In accordance with CMS guidelines, the state agency requires 80 percent of eligible members to have HCY/EPSDT well child visits and, accordingly, has included an 80 percent participant ratio in the rates paid to the health plan. In accordance with CMS 416 reporting methodology, the state agency shall measure the health plan's performance regarding the percentage of eligible members having HCY/EPSDT well child visits (participant ratio). The state agency applies state specific criteria to the CMS methodology to reflect the MC+ managed care program. The state specific criteria reflects performance by Category of Aid and rate cell, the measurement schedule in Attachment 11, and recognition of a month to be greater than 27 days.

The participant ratio is defined as the number of total eligibles receiving at least one initial or periodic well child visit divided by the number of total eligibles who should receive at least one initial or periodic well child visit. The current HCY/EPSTD Measurement Schedule is reflected in Attachment 11. The state agency reserves the right to amend the HCY/EPSTD Measurement Schedule and shall give the health plan prior written notice of such amendment.

- a. In the event that the HCY/EPSTD participant ratio is not equal to 80 percent of eligible members having an HCY/EPSTD well child visit as calculated using the HCFA 416 reporting methodology, the state agency shall with five (5) calendar days prior notice make a pro rata adjustment to the monthly capitation payment to the health plan for each percentage point above or below 80 percent, but not to exceed 100 percent. This pro rata adjustment shall be based on the portion of the monthly capitation payment related to HCY/EPSTD well child visits and shall be applied to each rate cell in which well child visits are required. Refer to Attachment 13. The state agency shall continue making such adjusted monthly capitation payments until the next scheduled measurement.
- b. If the health plan is new to a MC+ managed care region, the health plan shall agree that its capitation rate shall reflect the average participant ratio of the MC+ managed care health plans that are not new to the region by rate cell and category of assistance for the applicable measurement period reflected in Attachment 11. Beginning January 2007, the new health plan shall agree that their future capitation rates shall be adjusted by the health plan's actual 12-month HCY/EPSTD participant ratio.

2.28.2 Adjustments for Performance Based on HEDIS Performance Ratings : The health plan's results of HEDIS performance measures as identified in Attachment 6 shall annually be rated by the state agency as high (HI), average (AV), low (LO), Not Applicable (NA), or Not Reported (NR). This rating shall be determined by computing the statewide average of all health plans in all regions and determining whether a health plan's individual results, from a statistical level of confidence, vary from the statewide average and to what degree the results are precise and accurate. Those HEDIS performance measures that are rated as high shall be assigned a numeric value of three (3). Those HEDIS performance measures that are rated as average shall be assigned a numeric value of two (2). Those HEDIS performance measures that are rated as low shall be assigned a numeric value of one (1). Any performance measure that according to HEDIS specifications should not be reported shall be rated as Not Applicable and shall be assigned a value of zero (0). Any performance measure not reported due to the health plan's failure shall be rated as Not Reported and assigned a value of negative one (-1). The state agency shall then total the numeric value of each HEDIS measure. The HEDIS measures relating to the CAHPS member satisfaction shall not be included in the total. The state agency shall use only combined measures, where applicable, when computing the total. The totals are then averaged ignoring values of zero (0) and rounded to the nearest whole number. The health plan shall maintain a minimum performance standard of an overall score of average with a value of two (2).

- a. The first annual rating shall occur upon receipt of the HEDIS measures due June 30, 2007.
 - b. The second annual rating shall occur upon receipt of the HEDIS measured due June 30, 2008.
 - c. The third annual rating shall occur upon receipt of the HEDIS measured due June 30, 2009.
 - d. The first time a health plan achieves an average of low with a value of one (1), the health plan shall develop and implement a corrective action to improve the substandard performance.
 - 1) The state agency shall inform enrollees in enrollment materials that the health plan failed to achieve the minimum performance standard.
 - 2) The state agency shall reduce the random auto assignment percentage assigned to the health plan by one half (1/2). The random auto assignment percentage that was removed from the low performing health plan shall be distributed to the highest rated health plan(s) within the same MC+ Managed Care region.
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- e. The first time a health plan achieves an average of high with a value of three (3), the state agency shall inform enrollees in enrollment materials that the health plan(s) achieved above the minimum performance standard.
 - f. The second time a health plan achieves an average of low with a value of one (1), the health plan shall develop and implement a corrective action to improve the substandard performance.
 - 1) The state agency shall inform enrollees in enrollment materials that the health plan failed to achieve the minimum performance standard.
 - 2) The state agency shall reduce the random auto assignment percentage assigned to the health plan by one half (1/2). The random auto assignment percentage that was removed from the low performing health plan shall be distributed to the highest rated health plan(s) within the same MC+ Managed Care region.
 - g. The second time a health plan achieves an average of high with a value of three, the state agency shall inform enrollees in enrollment materials that the health plan or health plans achieved above the minimum performance standard.
 - h. The third time a health plan achieves an average of low with a value of one (1), the state agency shall with five (5) calendar days prior notice make a .25 percent reduction to the total amount paid the health plan in monthly capitation payments.
 - 1) The state agency shall inform enrollees in enrollment materials that the health plan failed to achieve the minimum performance standard.
 - 2) The reduction of total monthly capitation payments from any low performing health plan shall be distributed equally to the health plan(s) rated high within the same MC+ Managed Care region.
 - i. The third time a health plan achieves an average of high with a value of three (3), the state agency shall inform enrollees in enrollment materials that the health plan achieved above the minimum performance standard.
- 2.28.3 **Federal Sanctions:** Section 1903(m)(5)(A) and (B) of the Social Security Act vests the Secretary of the Department of Health and Human Services with the authority to deny Medicaid payments to a health plan for members who enroll after the date on which the health plan has been found to have committed one or more of the violations identified below. Therefore, whenever, and for so long as, federal payments are denied, the state agency shall deduct the total amount of federal payments denied from the next monthly capitation payment made to the health plan.
- a. Substantial failure to provide required medically necessary items or services when the failure had adversely affected (or has substantial likelihood of adversely affecting) a member,
 - b. Discrimination among members with respect to enrollment, re-enrollment, or disenrollment on the basis of the member's health status or requirements for health care services,
 - c. Misrepresentation or falsification of certain information, or
 - d. Failure to comply with the requirements for physician incentive plans as specified herein.
- 2.28.4 **Liquidated Damages for Failure to Provide Covered Services :** In the event the state agency determines the health plan failed to provide one or more of the covered services, the state agency shall direct the health plan to provide such service. If the health plan continues to refuse to provide the covered
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service(s), the state agency shall authorize the member to obtain the covered service from another source and shall notify the health plan in writing that the health plan shall be charged the actual amount of the cost of such service. In such event, the charges to the health plan shall be obtained by the state agency in the form of deductions of that amount from the next monthly capitation payment made to the health plan. With such deductions, the state agency shall provide a list of the members from whom payments were deducted, the nature of the service(s) denied, and payments the state agency made or will make to provide the medically necessary covered services.

2.28.5 Remedies for Failure to Perform Administrative Services: Whenever the state agency determines that the health plan has failed to perform an administrative function required per the requirements of the contract, the state agency shall notify the health plan of the health plan's failure to perform required administrative services pursuant to the requirements of the contract and shall give the health plan five (5) working days to develop an acceptable action plan for correcting the administrative services failure. For the purposes these provisions, "administrative services" are defined as any contract requirements other than the actual provision of covered services.

- a. If the health plan submits an action plan for correcting the failure and if the plan is acceptable to the state agency, no action shall be taken at that time, provided that the health plan implements the corrective action as approved by the state agency.
- b. If the health plan fails to submit an action plan within the five working days or if the health plan does not implement the corrective action plan within the time frame stated in the action plan, the state agency shall withhold payment from the next capitation payment due the health plan as stated below:
 - 1) The amount withheld shall be up to three percent (3%) of the total amount of the next capitation payment due the health plan.
 - 2) The state agency shall continue to withhold up to three percent (3%) until successful correction of the administrative services failure by the health plan.
 - 3) After successful correction of the administrative services failure, the state agency shall pay the health plan the total amount of all payments withheld.
- c. If the health plan implements the corrective action according to the approved plan but does not successfully correct the administrative services failure within the time frame approved in the action plan, the state agency shall withhold payment from the next capitation payment due the health plan according to the same provisions as stated above.

2.28.6 Remedies for Failure to Comply with Marketing Requirements: In the event the state agency determines that the health plan has failed to comply with any of the marketing requirements of the contract, one or more of the remedial actions listed below shall apply. The state agency shall notify the health plan in writing of the determination of the non-compliance, of the action(s) that must be taken, and of any other conditions related thereto such as the length of time the remedial actions shall continue and of the corrective actions that the health plan must perform.

- a. The state agency shall require the health plan to recall the previously authorized marketing materials.
 - b. The state agency shall suspend enrollment of new members to the health plan.
 - c. The state agency shall deduct the amount of capitation payment for members enrolled as a result of non-compliant marketing practices from the next monthly capitation payment made to the health plan and shall continue to deduct such payment until correction of the failure.
 - d. The state agency shall require the health plan to contact each member who enrolled during the period while the health plan was out of compliance, in order to explain the nature of the non-compliance and inform the member of his or her right to transfer to another health plan.
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- e. The state agency shall prohibit future marketing activities by the health plan for an amount of time specified by the state agency.
 - 2.28.7 **Attorney Fees:** In the event the state agency should prevail in any legal action arising out of the performance or non-performance of the contract, the health plan shall pay, in addition to any damages, all expenses of such action including reasonable attorney's fees and costs. The term "legal action" shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.
 - 2.28.8 **Remedial Actions:** The state agency may pursue all remedial actions with the health plan that are taken with fee-for-service providers. The state agency will work with the health plan and the health plan providers to change and correct problems and will recoup funds only if the health plan fails to correct a problem within a timely manner.
 - 2.28.9 In addition to above referenced described rate adjustments and remedies, if the state agency determines that the health plan is not taking proper action to correct the identified failures, the state agency shall have the right to implement any other legal processes deemed necessary including cancellation of the contract, recovery of damages, suspension of enrollment to the health plan, etc.
 - 2.28.10 **Intermediate Sanctions.** The state agency may establish and specify intermediate sanctions that may be imposed when a health plan acts or fails to act as specified below. The state agency may require a corrective action plan, as referenced in section 2.28.5, to be developed and approved by the state agency in situations where intermediate sanctions may be imposed. The state agency shall approve and monitor implementation of such a plan and set appropriate timelines to bring activities of the health plan into compliance with state and federal regulations. The state agency may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, the state agency shall give the health plan timely written notice that explains the basis and nature of the sanction and any other due process protections that the state agency elects to provide.
 - a. Fails substantially to provide medically necessary services that the health plan is required to provide, under law or under the contract, to a member covered under the contract.
 - b. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
 - c. Acts to discriminate among members on the basis of their health status or need for health care services.
 - d. Misrepresents or falsifies information that it furnishes to CMS or to the state agency.
 - e. Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
 - f. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
 - g. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the state agency or that contain false or materially misleading information.
 - h. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.
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- i. Violates any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations.

2.28.11 Intermediate Sanctions: Types. The types of intermediate sanctions that the state agency may impose upon the health plan include:

- a. Civil monetary penalties in the following specified amounts:
 - 1) A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
 - 2) A maximum of \$100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or the state agency.
 - 3) A maximum of \$15,000 for each member the state agency determines was discriminated against based on the member's health status or need for services (subject to the \$100,000 limit above).
 - 4) A maximum of \$25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The state agency shall return the amount of overcharge to the affected member(s).
- b. Appointment of temporary management for a health plan as provided in 42 CFR 438.706.
- c. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
- d. Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.
- e. Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the state agency is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
- f. Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.

2.28.12 Sanction by Centers for Medicare and Medicaid Services: Special Rules for MCOs and Denial of Payment. Payments provided for under the contract for new members when, and for so long as payment for those members is denied by CMS in accordance with the requirements in 42 CFR 438.730.

2.28.13 Special Rules for Temporary Management. The state agency shall specify the circumstances under which the sanction of temporary management will be imposed upon the health plan.

- a. Optional: Temporary management may be imposed by the state agency only if it finds that:
 - 1) There is continued egregious behavior by the health plan, including, but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of sections 1903(m) and 1932 of the Act; or
 - 2) There is substantial risk to members' health; or
 - 3) The sanction is necessary to ensure the health of the health plan's members while improvements are made to remedy violations under 42 CFR 438.700 or until there is an orderly termination or reorganization of the health plan.
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- b. Required: The state agency shall impose temporary management if it finds that the health plan has repeatedly failed to meet substantive requirements in section 1903(m) or section 1932 of the Act. The state agency shall also grant members the right to terminate enrollment without cause and shall notify the affected members of their right to terminate enrollment.
- c. The state agency's election to appoint temporary management shall not act as an implied waiver of the state agency's right to terminate the contract, suspend enrollment, or to pursue any other remedy available to the state agency under the contract.

2.28.14 Termination of a Health Plan Contract:

- a. Nothing in this section shall limit the state agency's right to terminate the contract or to pursue any other legal or equitable remedies. Pursuant to 42 CFR 438.708, the state agency may terminate the contract as a sanction and enroll that health plan's members in other health plans or provide their benefits through other options included in the state plan if the state agency, at its sole discretion, determines that the health plan has failed to:
 - 1) Carry out the substantive terms of the contract.
 - 2) Meet applicable requirements in sections 1932, 1903(m) and 1905(t) of the Act.
- b. After a state agency notifies the health plan that it intends to terminate the contract, the state agency may do the following:
 - 1) Give the health plan's members written notice of the state agency's intent to terminate the contract.
 - 2) Allow members to disenroll immediately without cause.
- c. Before terminating a health plan's contract under 42 CFR 438.708, the state agency shall provide the health plan a pre-termination hearing. The state agency shall:
 - 1) Give the health plan written notice of its intent to terminate, the reason for termination, and the time and place of hearing;
 - 2) Give the health plan (after the hearing) written notice of the decision affirming or reversing the proposed termination of the contract, and for an affirming decision, the effective date of termination; and
 - 3) For an affirming decision, give members of the health plan notice of the termination and information, consistent with 42 CFR 438.10, on their options for receiving Medicaid services following the effective date of termination.

2.29 Access to Premises: During normal business hours (defined as 8:00 a.m. through 5:00 p.m., Monday through Friday, except State designated holidays), the health plan shall allow duly authorized agents or representatives of the Federal or State government access to the health plan's premises or the health plan's subcontractor's premises to inspect, audit, monitor, or otherwise evaluate the performance of the health plan or its subcontractors.

2.30 Advance Directives:

- 2.30.1 The health plan shall maintain written policies and procedures related to advance directives. At the time of enrollment, the health plan shall provide written information to all adult members regarding the member's rights under the Missouri law to make decisions concerning medical care.
 - 2.30.2 As part of recertification, the health plan shall audit records of primary care provider, hospitals, home health agencies, personal care providers, and hospices to determine whether the provider is following the policies and procedures related to advance directives.
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2.30.3 The health plan shall provide education to the health plan's staff and members on issues concerning advance directives.

2.30.4 The above provisions shall not be construed to prohibit the application of any Missouri law which allows for an objection on the basis of conscience for any provider or agent of such provider.

2.31 Fraud and Abuse:

Paragraph 2.31.1 revised by BAFO #001

2.31.1 The following definitions are taken from "Guidelines for Addressing Fraud and Abuse in Medicaid Managed Care", A Product of the National Medicaid Fraud and Abuse Initiative, Health Care Financing Administration National Initiative, October 2000. These definitions are provided to assist the health plan in preventing, coordinating, detecting, investigating, enforcing, and reporting fraud and abuse:

Medicaid Managed Care Fraud: Any type of intentional deception or misrepresentation made by an entity or person in a capitated MCO, PCCM program, or other managed care setting with the knowledge that the deception could result in some unauthorized benefit to the entity, himself, or some other person.

Medicaid Managed Care Abuse: Practices in a capitated MCO, PCCM program, or other managed care setting 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 or contractual obligations for health care. The abuse can be committed by an MCO, contractor, subcontractor, provider, State employee, Medicaid beneficiary, or Medicaid managed care enrollee, among others. It also includes beneficiary practices in a capitated MCO, PCCM program, or other managed care setting that result in unnecessary cost to the Medicaid program or MCO, contractor, subcontractor, or provider. It should be noted that Medicaid funds paid to an MCO, then passing to subcontractors, are still Medicaid funds from a fraud and abuse perspective

2.31.2 The health plan shall implement internal controls, policies, and procedures designed to prevent, detect, review, report to the state agency, and assist in the prosecution of fraud and abuse activities by providers, subcontractors, and members. The policies and procedures shall articulate the health plan's commitment to comply with all applicable Federal and State standards. In order to implement the above, the health plan must submit a written fraud and abuse plan to the state agency for approval prior to implementation. Any changes to the approved fraud and abuse plan must have state agency approval prior to implementation.

a. The health plan's fraud and abuse plan must include, but is not limited to the following components:

- 1) The designation of a compliance officer and a compliance committee that are responsible for the health plan's fraud and abuse program and activities. The compliance officer is supervised by and reports to the Chief Executive Officer (CEO), health plan administrator, or the governing body;
 - 2) Provision for a data system, resources and staff to perform the fraud, abuse, and other compliance responsibilities;
 - 3) Procedures for internal prevention, detection, reporting, review, and corrective action;
 - 4) Procedures for prompt response to detected offenses;
 - 5) Procedures for reporting to the state agency, including timelines and use of state approved forms;
 - 6) Written standards for organizational conduct;
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- 7) A compliance committee that periodically meets and documents review of compliance issues. These issues include fraud, abuse, and regulatory and contractual compliance.
 - 8) Effective training and education for the compliance officer and the organization's employees, management, board members, and subcontractors;
 - 9) Inclusion of information about fraud and abuse identification and reporting in provider and member materials; and
 - 10) Enforcement of standards through well-publicized disciplinary guidelines.
- b. The health plan's fraud and abuse activities should include, but not be limited to the following:
- 1) Conducting regular reviews and audits of operations to guard against fraud and abuse;
 - 2) Assessing and strengthening internal controls to ensure claims are submitted and payments are made properly;
 - 3) Educating employees, network providers, and beneficiaries about fraud and abuse and how to report it;
 - 4) Effective organizational resources to respond to complaints of fraud and abuse;
 - 5) Establishing procedures to process fraud and abuse complaints;
 - 6) Establishing procedures for reporting information to the state agency; and
 - 7) Developing procedures to monitor utilization/service patterns of providers, subcontractors, and beneficiaries.

Paragraph 2.31.3 revised by BAFO #001

- 2.31.3 The health plan must quarterly report suspected fraud or abuse cases to the state agency. The health plan must initiate an immediate investigation to gather facts regarding the suspected fraud or abuse. In addition, the health plan shall provide reports of its investigative, corrective, and legal activities to the state agency in accordance with contractual and regulatory requirements.
- 2.31.4 The health plan and its subcontractors shall cooperate fully in any state reviews or investigations and in any subsequent legal action. The health plan must implement corrective actions in instances of fraud and abuse detected by the state agency, or other authorized agencies or entities.
- 2.31.5 The health plan must also provide a quarterly report of fraud and abuse activities to the state agency. The report must be submitted in accordance with state agency guidelines contained within the fraud and abuse policy statement. An annual evaluation of the effectiveness of the fraud and abuse program must be provided to the state agency. This evaluation must be a component of the annual evaluation of the effectiveness of the quality assessment and improvement program.
- 2.31.6 **Identification of Debarred Individuals or Excluded Providers in Health Plans:** The health plan shall exclude providers from the health plan network that have been identified as having Office of Inspector General (OIG) sanctions, having failed to renew license or certification registration, having a revoked professional license or certification, or have been terminated by the state agency. The health plan can access debarred and OIG sanction information on the Internet. The health plan should also access information from the Professional Registration Boards Internet site to identify State initiated terminations. The state agency or its authorized agent shall conduct a periodic review to determine if appropriate exclusions and corrective action have occurred.
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- 2.31.7 **Health Plan Pharmacy Lock-In:** The health plan must submit its lock-in policies and procedures to the state agency for approval prior to implementation. The policies and procedures must include the member and provider communication documents that shall be utilized for the lock-in process. The lock-in policy must comply with the requirements located in 13 CSR 70-4.070, Title XIX Recipient Lock-In Program.

The health plan must provide services in accordance with the requirements located in Attachment 3, Managed Care Policies Governing MC+ Services. If the health plan determines inappropriate utilization of pharmacy services by a member, the health plan may restrict the member to obtaining pharmacy services from one pharmacy provider. The health plan must initiate an investigation to identify the extent of the fraud or abuse. When a member is suspected of fraud or abuse (i.e., presenting an altered prescription), the health plan should notify the state agency within ten (10) calendar days of identification of the suspected activity in accordance with 2.31.2 and 2.31.3.

- 2.31.8 **Member Explanation of Benefits (EOB):** The health plan must provide an EOB to members upon request. The EOB will consist of a list of services that were billed to the health plan. The list shall contain paid and unpaid claims; for any unpaid claims, the list shall provide the reason the claim was not paid.

2.32 Other Requirements:

- 2.32.1 Unless otherwise specified herein, the health plan shall furnish all materials, labor, facilities, equipment, and supplies necessary to perform the service required herein.
- 2.32.2 Within five (5) business days after issuance of the Notice of Award by the Division of Purchasing and Materials Management, the health plan shall submit a written identification and notification to the state agency of the name, title, address, and telephone number of one (1) individual within its organization as a duly authorized representative to whom all correspondence, official notices, and requests related to the health plan's performance under the contract shall be addressed. The health plan shall have the right to change or substitute the name of the individual described above as deemed necessary provided that the state agency is notified immediately.
- 2.32.3 The health plan shall understand and agree that the contract, in part, shall implement the MC+ managed care program. Therefore, the health plan shall conform to such requirements or regulations as the United States Department of Health and Human Services issues.
- 2.32.4 If the state agency receives written notice from the United States Department of Health and Human Services that the health plan does not meet the definition of a Health Maintenance Organization as set forth in the Medicaid State Plan and 42 CFR 434 or receives written notice from the Department of Insurance that the health plan does not have a certificate of authority to establish or operate a HMO, the Division of Purchasing and Materials Management may cancel the contract with the health plan pursuant to contract cancellation provisions contained herein.
- 2.32.5 In the event that changes in federal or state law require the Division of Purchasing and Materials Management to modify the contract, a written amendment shall be issued to the health plan pursuant to provisions for contract amendment stated herein.
- a. The terms of the contract and any amendment thereto must receive the approval of the United States Department of Health and Human Services. The United States Department of Health and Human Services failure to approve a provision of the contract shall render the provision null and void. The contract is contingent on the health plan meeting the definition of a Health Maintenance Organization as set forth in the Medicaid State Plan and 42 CFR 434.
- 2.32.6 The health plan shall guarantee and certify that no State of Missouri legislator or State of Missouri employee holds a controlling interest in the health plan.
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- 2.32.7 The health plan shall guarantee and certify that no funds paid to the health plan by the state agency shall be used for the purpose of influencing or attempting to influence an officer or employee of any Federal or State agency, a member of the United States Congress, or State Legislature. The health plan shall disclose if any funds other than those paid to the health plan by the state agency have been used or will be used to influence the persons or entities indicated above and will assist the state agency in making such disclosures to CMS.
- 2.32.8 Termination or cancellation of the contract does not eliminate the health plan's responsibility to the state agency for overpayments made to the health plan. If the contract is terminated or canceled, the health plan shall return to the state agency any payments advanced to the health plan for coverage of members for periods after the date of contract termination or cancellation. The health plan shall return such payments to the state agency within ninety (90) calendar days of contract termination/cancellation.
- a. If the contract is terminated, the health plan shall promptly supply all information necessary for the reimbursement of any outstanding claims.
- 2.32.9 In the event the contract is canceled, the state agency shall notify all members of the date of cancellation and process by which the members will continue to receive contract services and the health plan shall be responsible for all expenses related to said notification under these circumstances. In the event the contract is terminated by mutual consent, the state agency shall notify all members of the date of termination and process by which the members will continue to receive contract services; and the state agency shall be responsible for all expenses relating to said notification.
- 2.32.10 The health plan shall have a written policy regarding the illegality of sexual harassment. At a minimum, the policy shall include:
- a. The definition of sexual harassment under federal and state law, as amended;
- b. The health plan's internal complaint process including penalties;
- c. The legal recourse, investigative, and complaint process available for members through the state agency and for employees through the Missouri Commission on Human Rights; and
- d. Instructions on how to contact the state agency and the Missouri Commission on Human Rights.
- 2.32.11 The health plan shall understand and agree that the State of Missouri (its departments and employees) does not maintain commercial liability insurance.
- 2.32.12 If the performance of any part of the contract is prevented, hindered or delayed by fire, flood or an act of God, then the health plan or the state agency shall be excused from such performance during the continuance of such events. This clause shall not become operative until the party whose performance is hindered notifies the other party of the occurrence and the reasons for the delay.
- 2.32.13 Members are the intended beneficiaries of the contracts and as such are entitled to the remedies accorded to third party beneficiaries under the law.
- 2.32.14 The health plan is prohibited from using MC+ managed care funds for services provided in the following circumstances:
- a. Non-emergency services provided by or under the direction of an excluded individual,
- b. Any funds not used under the Assisted Suicide Funding Restriction Act of 1997,
- c. Any amount expended for roads, bridges, stadiums, or any other item.
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2.32.15 The Missouri Department of Insurance regulates the health plans licensed in Missouri including their financial stability. Therefore, the health plan must comply with all Department of Insurance applicable standards.

2.33 Invoicing and Payment Requirements: On a monthly basis, as near as practical to the fifth day of the calendar month following the month for which services have been performed and for which payment is being made, the state agency shall make payments to the health plan via electronic funds transfer in accordance with the following:

- 2.33.1 For each member enrolled on the first of the month, the state agency shall pay the health plan the firm fixed per member, per month net capitation amount specified on the specific region's Pricing Page for the Category of Aid Rate Subgroup for the member. The per member, per month net capitation amount shall reflect any reduction or increase pursuant to the health plan's performance in screening 80 percent of eligible members as measured in accordance with the CMS 416 reporting methodology.
- a. The state agency shall pro-rate the net capitation amount when the member's birth date necessitates a change to a different Category of Aid or Rate Subgroup in a given month.
 - b. For members enrolled at any time after the beginning of the month's payment cycle, the state agency shall pro-rate the net capitation amount for the first partial month.
 - c. For members whose enrollment lapses for any period of a month in which a capitation payment was made due to loss of eligibility, death, or other circumstance, the state agency shall adjust its next monthly capitation payment to recoup the portion of the capitation payment to which it is due a refund.
 - d. Any payment pro-rations shall be on a daily basis.
- 2.33.2 The health plan shall accept capitation payments as specified herein and must have written policies and procedures for receiving and processing the capitation payments.
- 2.33.3 The health plan shall agree and understand that the capitation payments specified herein shall be the only payments made to the health plan for all services required herein and that no other payment or reimbursement for any reason whatsoever shall be made to the health plan. In exchange for the capitation payments, the health plan shall be liable or "at risk" for the costs of all covered services.
- 2.33.4 In the event that the Missouri General Assembly appropriates funds expressly for the services required herein, the State of Missouri shall amend the contract. In such event, the health plan shall pass fee increases to its providers commensurate with the Missouri General Assembly's intent. It must clearly be the intent of the Missouri General Assembly that increases be added during an ongoing contract period for any such amendment to take place

2.34 Business Associate Provisions:

- 2.34.1 Health Insurance Portability and Accountability Act of 1996 (HIPAA) — The state agency is subject to and must comply with provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and all regulations promulgated pursuant to authority granted therein. The health plan constitutes a "Business Associate" of the state agency as such term is defined in the Code of Federal Regulations (CFR) at 45 CFR 160.103. Therefore, the term, "health plan" as used in this section shall mean "Business Associate."
- a. The health plan shall agree and understand that for purposes of the Business Associate Provisions contained herein, terms used but not otherwise defined shall have the same meaning as those terms defined in 45 CFR parts 160 and 164, including, but not limited to the following:
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- 1) "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.
 - 2) "Security Rule" shall mean the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 164, subpart C.
 - 3) "Individual" shall have the same meaning as the term "individual" in 45 CFR 164.501 and shall include a person who qualifies as a personal representative in accordance with 45 CFR 164.502 (g).
 - 4) "Protected Health Information" shall mean individually identifiable health information:
 - (1) Except as provided in paragraph (2) of this definition, that is: (i) Transmitted by electronic media; or (ii) Maintained in electronic media; or (iii) Transmitted or maintained in any other form or medium.
 - (2) Protected Health Information excludes individually identifiable health information in (i) Education records covered by the Family Educational Rights and Privacy Act, as amended, 20 U.S.C. 1232g; (ii) Records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) Employment records held by a covered entity [state agency] in its role as employer.
 - 5) "Electronic Protected Health Information" shall mean information that comes within paragraphs (1)(i) or (1)(ii) of the definition of protected health information as specified above.
- b. The health plan shall agree and understand that wherever in this document the term Protected Health Information is used, it shall also be deemed to include Electronic Protected Health Information.
 - c. The health plan shall agree the state agency must comply with 45 CFR 160 and 45 CFR 164, as currently in effect and as may be amended at some later date, and that to achieve such compliance, the health plan must appropriately safeguard Protected Health Information (as that term is defined in 45 CFR 164.501), which the health plan receives from or creates or receives on behalf of the state agency. To provide reasonable assurance of appropriate safeguards, the health plan shall comply with the business associate provisions stated herein.
 - d. The state agency and the health plan agree to amend the contract as is necessary for the state agency to comply with the requirements of the Privacy Rule and HIPAA requirements.

2.34.2 Permitted uses and disclosures of Protected Health Information:

- a. The health plan may use or disclose Protected Health Information to perform functions, activities, or services for, or on behalf of, the state agency as specified in the contract, provided that such use or disclosure would not violate the Privacy Rule as the Privacy Rule applies to the state agency.
- b. The health plan may use Protected Health Information to report violations of law to appropriate Federal and State authorities, consistent with 45 CFR 164.502(j)(1) and shall notify the state agency by no later than ten (10) calendar days after the health plan becomes aware of the disclosure of the Protected Health Information.
- c. If required to properly perform the contract and subject to the terms of the contract, the health plan may use or disclose Protected Health Information if necessary for the proper management and administration of the health plan's business.
- d. If the disclosure is required by law, the health plan may disclose Protected Health Information to carry out the legal responsibilities of the health plan.
- e. The health plan may use Protected Health Information to provide Data Aggregation services to the state agency as permitted by 45 CFR 164.504(e)(2)(i)(B).

2.34.3 Obligations of the Health plan:

- a. The health plan shall not use or disclose Protected Health Information other than as permitted or required by the contract or as otherwise required by law.
 - b. The health plan shall use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for by the contract. Such safeguards may include, but shall not be limited to:
 - 1) Workforce training on the appropriate uses and disclosures of Protected Health Information pursuant to the terms of the contract.
 - 2) Policies and procedures implemented by the health plan to prevent inappropriate uses and disclosures of Protected Health Information by its workforce.
 - 3) Any other safeguards necessary to prevent the inappropriate use or disclosure of Protected Health Information.
 - c. With respect to Electronic Protected Health Information, the health plan shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic Protected Health Information that health plan creates, receives, maintains or transmits on behalf of the state agency.
 - d. The health plan shall require that any agent or subcontractor to whom the health plan provides any Protected Health Information received from, created by, or received by the health plan pursuant to the contract, also agrees to the same restrictions and conditions stated herein that apply to the health plan with respect to such information.
 - e. By no later than ten (10) calendar days of receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the health plan shall make the health plan's internal practices, books, and records, including policies and procedures and Protected Health Information, relating to the use and disclosure of Protected Health Information received from, created by, or received by the health plan on behalf of the state agency available to the state agency and/or to the Secretary of the Department of Health and Human Services or designee for purposes of determining compliance with the Privacy Rule.
 - f. The health plan shall document any disclosures and information related to such disclosures of Protected Health Information as would be required for the state agency to respond to a request by an individual for an accounting of disclosures of Protected Health Information in accordance with 45 CFR 164.528. By no later than five (5) calendar days of receipt of a written request from the state agency, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, the health plan shall provide an accounting of disclosures of Protected Health Information regarding an individual to the state agency.
 - g. In order to meet the requirements under 45 CFR 164.524, the health plan shall, within five (5) calendar days following a state agency request, or as otherwise required by state or federal law or regulation, or by another time as may be agreed upon in writing by the state agency, provide the state agency access to the Protected Health Information in an individual's Designated Record Set. However, if requested by the state agency, the health plan shall provide access to the Protected Health Information in a Designated Record Set directly to the individual for whom such information relates.
 - h. At the direction of the state agency, the health plan shall promptly make any amendment(s) to Protected Health Information in a Designated Record Set pursuant to 45 CFR 164.526.
 - i. The health plan shall report to the state agency's Security Officer any security incidents no later than five (5) calendar days of becoming aware of such incident. For purposes of this paragraph, security
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incident shall mean the unauthorized access, use, modification or destruction of information or interference with systems operations in an information system.

- j. By no later than five (5) calendar days after the health plan becomes aware of any use or disclosure of the Protected Health Information not permitted or required as stated herein, the health plan shall notify the state agency's Privacy Officer, in writing, of the unauthorized use or disclosure and shall take immediate action to stop the unauthorized use or disclosure. The health plan shall include a description of any remedial action taken to mitigate any harmful effect of such disclosure. The health plan shall also provide the state agency's Privacy Officer with a proposed written plan of action for approval that describes plans for preventing any such future unauthorized uses or disclosures.

2.34.4 Obligations of the State Agency:

- a. The state agency shall notify the health plan of limitation(s) that may affect the health plan's use or disclosure of Protected Health Information, by providing the health plan with the state agency's notice of privacy practices in accordance with 45 CFR 164.520.
- b. The state agency shall notify the health plan of any changes in, or revocation of, authorization by an Individual to use or disclose Protected Health Information.
- c. The state agency shall notify the health plan of any restriction to the use or disclosure of Protected Health Information that the state agency has agreed to in accordance with 45 CFR 164.522.
- d. The state agency shall not request the health plan to use or disclose Protected Health Information in any manner that would not be permissible under the Privacy Rule as the Privacy Rule applies to the state agency.

2.34.5 Expiration/Termination/Cancellation — Except as provided in the subparagraph below, upon the expiration, termination, or cancellation of the contract for any reason, the health plan shall return to the state agency or shall destroy all Protected Health Information received by the health plan from the state agency, or created or received by the health plan on behalf of the state agency, and shall not retain any copies of such Protected Health Information. This provision shall also apply to Protected Health Information that is in the possession of subcontractors or agents of the health plan.

- a. In the event the health plan determines and the state agency agrees that returning or destroying the Protected Health Information is not feasible, the health plan shall extend the protections of the contract to the Protected Health Information for as long as the health plan maintains the Protected Health Information and shall limit the use and disclosure of the Protected Health Information to those purposes that made return or destruction of the information infeasible. If at any time it becomes feasible to return or destroy any such Protected Health Information maintained pursuant to this paragraph, the health plan must notify the state agency and obtain instructions from the state agency for either the return or destruction of the Protected Health Information.

2.34.6 Breach of Contract – In the event the health plan is in breach of contract with regard to the business associate provisions included herein, the health plan shall agree and understand that in addition to the requirements of the contract related to cancellation of contract, if the state agency determines that cancellation of the contract is not feasible, the State of Missouri may elect not to cancel the contract, but the state agency shall report the contractual breach to the Secretary of the Department of Health and Human Services.

3. GENERAL CONTRACTUAL REQUIREMENTS:

- 3.1 Contract :** A binding contract shall consist of: (1) the RFP, amendments thereto, and any Best and Final Offer (BAFO) request(s) with RFP changes/additions, (2) the health plan's proposal including any BAFOs and (3) the Division of Purchasing and Materials Management's acceptance of the proposal by "notice of award" or by "purchase order". All Exhibits and Attachments included in the RFP shall be incorporated into the contract by reference.
- 3.1.1 The notice of award does not constitute a directive to proceed. Before providing equipment, supplies and/or services, the health plan must receive a properly authorized purchase order unless the purchase is equal to or less than \$3,000. Purchases equal to or less than \$3,000 may be processed with a purchase order at the discretion of the state agency.
- 3.1.2 The contract expresses the complete agreement of the parties and performance shall be governed solely by the specifications and requirements contained therein.
- 3.1.3 Any change to the contract, whether by modification and/or supplementation, must be accomplished by a formal contract amendment signed and approved by and between the duly authorized representative of the health plan and the Division of Purchasing and Materials Management or by a modified purchase order prior to the effective date of such modification. The health plan expressly and explicitly understands and agrees that no other method and/or no other document, including correspondence from the state agency, acts, and oral communications by or from any person, shall be used or construed as an amendment or modification to the contract.
- 3.2 Contract Period:** The original contract period shall be as stated on page 1 of the Request for Proposal (RFP). The contract shall not bind, nor purport to bind, the state for any contractual commitment in excess of the original contract period. The Division of Purchasing and Materials Management shall have the right, at its sole option, to renew the contract for two (2) additional one-year periods, or any portion thereof. In the event the Division of Purchasing and Materials Management exercises such right, all terms and conditions, requirements and specifications of the contract shall remain the same and apply during the renewal period, pursuant to the following:
- 3.2.1 The state agency will include in each year's budget request to the Office of Administration, Division of Budget and Planning, a rate change based on the state agency's review of recent health plan financial experience, medical trends from other state Medicaid programs and national trend indices (CPI/DRI), and pharmacy market trends including specific drug introductions and expiring patents. The rate changes will be reflective of anticipated programmatic changes.
- 3.2.2 If the State of Missouri elects to renew the contract for the first renewal option, the health plan shall accept the amount appropriated by the Governor and the Missouri General Assembly.
- 3.2.3 If the State of Missouri elects to renew the contract for the second renewal option and if the health plan intends to renew the contract for the second renewal option, the State of Missouri and the health plan shall negotiate the firm, fixed rates applicable to the second renewal period. The State of Missouri shall commence such negotiation process approximately six months prior to the expiration of the first renewal period. Individual negotiations shall be conducted with each health plan in accordance with the negotiation provisions provided elsewhere herein.
- a. The health plan must submit information which establishes and supports the actuarial soundness of the proposed rates and a certification of said soundness from an Associate of the Society of Actuaries (ASA), a Fellow of Society of Actuaries (FSA), or a Member of the American Academy of Actuaries (MAAA).
- b. If the State of Missouri and the health plan are unable to agree upon the firm, fixed rates for the second renewal period, the pending contract renewal shall be canceled. In the event of such, the
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State of Missouri reserves its right to extend the contract at the current firm, fixed rates for no more than 180 days from the date such determination is made.

- c. If the health plan does not intend to renew the contract for the second renewal option and does not desire to enter into the negotiation process, the health plan shall provide written notification to the State of Missouri of such within at least 180 calendar days prior to the expiration of the contract period.
- 3.2.4 During the second and final renewal option, the State of Missouri may issue a public notice of the pending contract expiration and the upcoming opportunity to contract with the State of Missouri for MC+ managed care services. If no health plans, other than the health plans the State of Missouri currently contracts with, indicate interest in contracting with the State of Missouri for such, the State of Missouri may elect to renew the contract with the health plan for the continuation of the MC+ managed care services. In the event of such, the State of Missouri and the health plan shall negotiate the firm, fixed rates applicable to the renewal period. The State of Missouri shall have the option of issuing such notification on an annual basis.
- 3.3 Price:** All prices shall be as indicated on the specific region's Pricing Page. The state shall not pay nor be liable for any other additional costs including but not limited to taxes, shipping charges, insurance, interest, penalties, termination payments, attorney fees, liquidated damages, etc.
- 3.4 Termination:** The Division of Purchasing and Materials Management reserves the right to terminate the contract at any time, for the convenience of the State of Missouri, without penalty or recourse, by giving written notice to the health plan at least thirty (30) calendar days prior to the effective date of such termination. In the event of termination pursuant to this paragraph, all documents, data, reports, supplies, equipment, and accomplishments prepared, furnished or completed by the health plan pursuant to the terms of the contract shall, at the option of the Division of Purchasing and Materials Management, become the property of the State of Missouri. The health plan shall be entitled to receive just and equitable compensation for services and/or supplies delivered to and accepted by the State of Missouri pursuant to the contract prior to the effective date of termination.
- 3.5 Transition:**
- 3.5.1 Upon expiration, termination, or cancellation of the contract, the health plan shall assist the state agency to insure an orderly transfer of responsibility and/or the continuity of those services required under the terms of the contract to an organization designated by the state agency, if requested in writing. At a minimum, the health plan shall perform the following related to transition:
- a. For a period not to exceed ninety (90) calendar days after the expiration, termination, or cancellation of the contract, the health plan shall continue providing any part or all of the services in accordance with the terms and conditions, requirements, and specifications of the contract for a price not to exceed those prices set forth in the contract.
 - b. In addition, for 365 calendar days after expiration, termination, or cancellation of the contract, the health plan shall provide those administration functions that cannot be completed prior to the expiration, termination, or cancellation of the contract due to the nature of the function. Such administrative functions, shall include, but are not limited to, payment of claims for service dates prior to expiration, termination, or cancellation of the contract; operation of the member grievance system and provider complaints, grievances, and appeals; operational data reporting, financial reporting, and communication links with the state agency.
 - c. The health plan shall deliver, FOB destination, all records, documentation, reports, data, recommendations, master, or printing elements, etc., which were required to be produced under the terms of the contract to the state agency and/or to the state agency's designee within thirty (30) days after receipt of the written request.
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- d. The state agency, at its sole option, may discontinue enrolling new membership to the health plan, on a date specified by the state agency, prior to expiration, cancellation, or termination of the contract.

3.6 Health Plan Liability: The health plan shall be responsible for any and all personal injury (including death) or property damage as a result of the health plan's negligence involving any equipment or service provided under the terms and conditions, requirements and specifications of the contract. In addition, the health plan assumes the obligation to save the State of Missouri, including its agencies, employees, and assignees, from every expense, liability, or payment arising out of such negligent act.

- a. The health plan also agrees to hold the State of Missouri, including its agencies, employees, and assignees, harmless for any negligent act or omission committed by any subcontractor or other person employed by or under the supervision of the health plan under the terms of the contract.
- b. The health plan shall not be responsible for any injury or damage occurring as a result of any negligent act or omission committed by the State of Missouri, including its agencies, employees, and assignees.
- c. Under no circumstances shall the health plan be liable for any of the following: (1) third party claims against the state for losses or damages (other than those listed above); (2) loss of, or damage to, the state's records or data; or (3) economic consequential damages (including lost profits or savings) or incidental damages, even if the health plan is informed of their possibility.

3.7 Insurance: The health plan shall understand and agree that the State of Missouri cannot save and hold harmless and/or indemnify the health plan or employees against any liability incurred or arising as a result of any activity of the health plan or any activity of the health plan's employees related to the health plan's performance under the contract. Therefore, the health plan shall maintain adequate liability insurance in the form(s) and amount(s) sufficient to protect the State of Missouri, its agencies, its employees, its clients, and the general public against any loss, damage, and/or expense related to his/her performance under the contract.

- a. The insurance coverage shall include, but shall not necessarily be limited to, general liability, professional liability, etc. In addition, automobile liability coverage for the operation of any motor vehicle must be maintained if the terms of the contract require any form of transportation services.
- b. The limits of liability for all types of coverage shall not be less than \$2,000,000 per occurrence.
- c. The health plan shall provide written evidence of the insurance to the state agency. Such evidence shall include, but shall not necessarily be limited to: effective dates of coverage, limits of liability, insurer's name, policy number, endorsement by representatives of the insurance company, etc. Evidence of self-insurance coverage or of another alternate risk financing mechanism may be utilized provided that such coverage is verifiable and irrevocably reliable. The evidence of insurance coverage must be submitted before or upon award of the contract. The contract number must be identified on the evidence of insurance coverage.
- d. In the event the insurance coverage is canceled, the state agency must be notified immediately.

3.8 Subcontractors: Any subcontracts for the products/services described herein must include appropriate provisions and contractual obligations to ensure the successful fulfillment of all contractual obligations agreed to by the health plan and the State of Missouri and to ensure that the State of Missouri is indemnified, saved, and held harmless from and against any and all claims of damage, loss, and cost (including attorney fees) of any kind related to a subcontract in those matters described in the contract between the State of Missouri and the health plan.

- 3.8.1 The health plan shall expressly understand and agree that he/she shall assume and be solely responsible for all legal and financial responsibilities related to the execution of a subcontract.
- 3.8.2 The health plan shall agree and understand that utilization of a subcontractor to provide any of the products/services in the contract shall in no way relieve the health plan of the responsibility for providing the products/services as described and set forth herein. The health plan must obtain acknowledgement from the State of Missouri prior to establishing any new subcontracting arrangements and before changing any subcontractors.
- 3.8.3 All subcontracts for health care services must be in writing and shall comply with all provisions of the contract and shall include at least the items listed below. In addition, all subcontractors shall comply with the applicable provisions of federal and state laws and regulations, as amended, and policies. Before any delegation of any functions and responsibilities to any subcontractor, the health plan shall evaluate the prospective subcontractor's ability to perform the activities to be delegated. The health plan shall have policies and procedures to monitor the performance of health care service subcontractors to ensure that such subcontractors comply with the provisions of the RFP. The health plan shall prepare and issue an annual report to the state agency regarding the results of its monitoring activities in previous calendar year for each health care service subcontractor and any corrective actions implemented as a result of its monitoring activities. The annual report shall be due by November 30 of each year. In addition, the health plan shall fully investigate and timely respond to issues involving subcontractors upon request of the state agency.
- a. A description of services to be provided or other activities performed. This description shall be in such form as to permit the state agency to ascertain definitively which contractual obligations have been subcontracted.
 - b. Provision(s) for release to the health plan of any information necessary for the health plan to perform any of its obligations under the contract including but not limited to compliance with all reporting requirements (for example encounter data reporting requirements), timely payment requirements, and quality assessment requirements.
 - c. The provision available to a health care provider to challenge or appeal the failure of the health plan to cover a service.
 - d. Provision(s) that (1) the subcontractor's facilities and records shall be open to inspection by the health plan and appropriate federal and state agencies and, (2) the medical records, or copies thereof, shall be provided to the health plan, upon request, for transfer to subsequent subcontractors for review by the state agency.
 - e. Provisions that require each health care provider to maintain comprehensive medical records for a minimum of five years.
 - f. A provision that when no member co-payment is required, the subcontractor shall look solely to the health plan for compensation for services provided to member.
 - g. Provision(s) that prohibit any financial incentive arrangement to induce subcontractors to limit medically necessary services. A description of all financial incentive arrangements shall be included in the subcontract. In the event of a change to these financial incentive arrangements, the subcontractor shall immediately notify the health plan of such change so the health plan can meet its requirement to notify the state agency.
 - h. Provisions that the health plan may not prohibit, or otherwise restrict, a health care professional acting within the lawful scope of practice, from advising or advocating on behalf of a member who is his or her patient:
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- 1) For the member's health status, medical care, or treatment options, including any alternative treatment that may be self-administered.
 - 2) For any information the member needs in order to decide among all relevant treatment options.
 - 3) For the risks, benefits, and consequences of treatment or non-treatment.
 - 4) For the member'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.
- i. Provisions that subcontractors shall not conduct or participate in health plan enrollment, disenrollment, transfer, or opt out activities. The subcontractors shall not influence a member's enrollment. Prohibited activities include:
- 1) Requiring or encouraging the member to apply for an assistance category not included in MC+ managed care;
 - 2) Requiring or encouraging the member and/or guardian to use the opt out provision as an option in lieu of delivering health plan benefits;
 - 3) Mailing or faxing health plan enrollment forms;
 - 4) Aiding the member in filling out health plan enrollment forms;
 - 5) Photocopying blank health plan enrollment forms for potential members;
 - 6) Distributing blank health plan enrollment forms;
 - 7) Participating in three way calls to the MC+ managed care enrollment helpline;
 - 8) Suggesting a member transfer to another health plan; or
 - 9) Other activities in which subcontractors are engaged in to enroll a member in a particular health plan or in any way assisting a member to enroll in a health plan.
- j. If a subcontract is with a federally qualified health center (FQHC) or rural health clinic (RHC) to provide services to members under a prepayment arrangement, a provision that the state agency shall reimburse the FQHC or RHC 100% of its reasonable cost for covered services.
- k. All hospital subcontracts must require that the hospital subcontractor notify the health plan of births where the mother is a member. The subcontracts must specify which entity is responsible for notifying the Family Support Division of the birth.
- l. For contracted services, the subcontractor shall follow the claim processing requirements set forth by RSMo 376.383 and 376.384, as amended.
- m. Provisions in accordance with federal and state laws and regulations, as amended, and policy regarding termination of the subcontract between the health plan and the subcontractor.
- n. Provisions that in the event of the subcontractor's insolvency or other cessation of operations, covered services to members shall continue through the period for which a capitation payment has been made to the health plan or until the member's discharge from an inpatient facility, whichever time is greater.
- o. The health plan and its subcontractors shall establish reasonable timely filing requirements for claims to be filed by a provider for reimbursement. The subcontractor shall inform its provider network of the timely filing requirements.
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- 1) In the case of capitated arrangements with providers, the subcontractor shall establish reasonable reporting of encounters to the health plan in sufficient detail to meet the health plan's encounter data reporting requirements.
 - 2) In the case of services provided by out-of-network providers, the health plan shall comply with state law regarding timely filing requirements.
- p. Provision for revoking the subcontract agreement or imposing other sanctions if the subcontractor's performance is inadequate.
- q. The health plan shall agree and understand that consumer protection shall be integral to the MC+ managed care program. All contracts between the health plan and providers shall ensure that the provider complies with the consumer protection provisions outlined in the marketing guidelines.
- r. Provision(s) that entitle each member to one free copy of his or her medical records annually. The fee for additional copies shall not exceed the actual cost of time and materials used to compile, copy, and furnish such records.

3.9 Assignment:

- 3.9.1 The health plan shall not transfer any interest in the contract, whether by assignment or otherwise, without the prior written consent of the Division of Purchasing and Materials Management.
- 3.9.2 The health plan shall agree and understand that, in the event the Division of Purchasing and Materials Management consents to a financial assignment of the contract in whole or in part to a third party, any payments made by the State of Missouri pursuant to the contract, including all of those payments assigned to the third party, shall be contingent upon the performance of the prime health plan in accordance with all terms and conditions, requirements and specifications of the contract.

3.10 Substitution of Personnel: The health plan agrees and understands that the State of Missouri's agreement to the contract is predicated in part on the utilization of the specific individual(s) and/or personnel qualifications identified in the proposal. The health plan further agrees that any substitution made pursuant to this paragraph must be equal or better than originally proposed.

3.11 Health Plan Status: The health plan represents himself or herself to be an independent health plan offering such services to the general public and shall not represent himself/herself or his/her employees to be an employee of the State of Missouri. Therefore, the health plan shall assume all legal and financial responsibility for taxes, FICA, employee fringe benefits, workers compensation, employee insurance, minimum wage requirements, overtime, etc., and agrees to indemnify, save, and hold the State of Missouri, its officers, agents, and employees, harmless from and against, any and all loss; cost (including attorney fees); and damage of any kind related to such matters.

3.12 Coordination: The health plan shall fully coordinate all contract activities with those activities of the state agency. As the work of the health plan progresses, advice and information on matters covered by the contract shall be made available by the health plan to the state agency or the Division of Purchasing and Materials Management throughout the effective period of the contract.

3.13 Property of State:

- 3.13.1 All reports, documentation, and material developed or acquired by the health plan as a direct requirement specified in the contract shall become the property of the State of Missouri.
- 3.13.2 The health plan shall agree and understand that all discussions with the health plan and all information gained by the health plan as a result of the health plan's performance under the contract, including member information, medical records, data, and data elements established, collected, maintained, or used
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in the administration of the contract shall be confidential and that no reports, documentation, or material prepared as required by the contract shall be released to the public without the prior written consent of the state agency.

- a. The health plan shall provide safeguards that restrict the use or disclosure of information concerning members to purposes directly connected with the administration of the contract.
- b. The health plan shall not disclose the contents of member information or records to anyone other than the state agency, the member or the member's legal guardian, or other parties with the member's written consent.
- c. In complying with the requirements of this section, the health plan and the state agency shall follow the requirements of 42 Code of Federal Regulations Part 431, Subpart F, as amended, regarding confidentiality of information concerning applicants and members of public assistance and 42 Code of Federal Regulations Part 2, as amended, regarding confidentiality of alcohol and drug abuse patient records.
- d. The health plan shall have written policies and procedures for maintaining the confidentiality of data, including medical records, member information, and appointment records for adult and adolescent STDs and adolescent family planning services.

3.14 Performance Security Deposit: The health plan must furnish a performance security deposit in the form of an original bond issued by a surety company authorized to do business in the State of Missouri (no copy or facsimile is acceptable), check, cash, bank draft, or irrevocable letter of credit to the Office of Administration, Division of Purchasing and Materials Management within thirty (30) days after award of the contract and prior to performance of service under the contract.

- a. The performance security deposit must be made payable to the State of Missouri in an amount equal to the in the amount of \$1,000,000. In the event the health plan is awarded a contract for more than one region, the health plan shall provide a separate performance security deposit in the amount of \$1,000,000.00 for each region.
- b. The contract number and contract period must be specified on the performance security deposit.
- c. In the event the Division of Purchasing and Materials Management exercises an option to renew the contract for an additional period, the health plan shall maintain the validity and enforcement of the security deposit for the said period, pursuant to the provisions of this paragraph, in an amount stipulated at the time of contract renewal
- d. Additionally, during the 365 day transition period, the health plan shall maintain the validity and enforcement of the performance security deposit for performance of the administrative functions pursuant to the provisions of this paragraph, in an amount stipulated via written notification by DPMM.

3.15 Federal Funds Requirements — The health plan shall understand and agree that the contract may involve the use of federal funds.

3.15.1 Steven's Amendment — In accordance with the Departments of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act, Public Law 101-166, Section 511, "Steven's Amendment", the health plan shall not issue any statements, press releases, and other documents describing projects or programs funded in whole or in part with Federal money unless the prior approval of the state agency is obtained and unless they clearly state the following as provided by the state agency:

- a. The percentage of the total costs of the program or project which will be financed with Federal money;
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- b. The dollar amount of Federal funds for the project or program; and
- c. The percentage and dollar amount of the total costs of the project or program that will be financed by nongovernmental sources.

3.16 Terminology

3.16.1 All references to the term “contractor” as used in the Terms and Conditions attached hereto shall mean “health plan”.

4. PROPOSAL SUBMISSION INFORMATION

4.1 Submission of Proposals:

4.1.1 ELECTRONIC SUBMISSION OF PROPOSALS THROUGH THE ON-LINE BIDDING WEB SITE IS NOT AVAILABLE FOR THIS RFP.

4.1.2 Proposal Security Deposit Required: The offeror must furnish a proposal security deposit in the form of an original bond (copies or facsimiles shall not be acceptable), check, cash, bank draft, or irrevocable letter of credit to the Office of Administration, Division of Purchasing and Materials Management by the proposal opening date and time. The Request for Proposal number must be specified on the proposal security deposit.

- a. The proposal security deposit must be made payable to the State of Missouri in the amount of \$500,000 for each proposed region.
- b. Any proposal security deposit submitted shall remain in force until such time as the health plan submits a performance security deposit pursuant to the contract requirements specified elsewhere herein. Failure to submit a performance security deposit in the time specified or failure to accept award of the contract shall be deemed sufficient cause to forfeit the proposal security deposit.
- c. If the proposal security deposit is submitted in the form of cash or a check, it will be deposited. However, the Division of Purchasing and Materials Management shall issue a check in the same amount as the offeror's proposal security deposit to the offeror either once the performance security deposit is received if the offeror is awarded the contract, or at the time of award of the contract if the offeror is not awarded a contract.

4.1.3 When submitting a proposal, the offeror should include nine (9) additional copies along with their original proposal. The front cover of the original proposal should be labeled "original" and the front cover of all copies should be labeled "copy".

- a. In addition the offeror should provide one (1) copy of their entire proposal, including all attachments, in Microsoft compatible format on diskette(s) or CD(s).
- b. Both the original and the copies should be printed on recycled paper and double sided.
- c. Imaging Ready — In addition, all proposals are scanned into the Division of Purchasing and Materials Management imaging system after a contract is executed, or all proposals are rejected.
 - 1) The scanned information will be able to be viewed through the Internet from the Public Record Search system. Therefore, the offeror is advised not to include personal identifying information such as social security numbers in the proposal.
 - 2) In preparing a proposal, the offeror should be mindful of document preparation efforts for imaging purposes and storage capacity that will be required to image the proposals. Glue bound materials should not be used.

4.1.4 To facilitate the evaluation process, the offeror is encouraged to organize their proposal into distinctive sections that correspond with the individual evaluation categories described herein. The offeror is cautioned that it is the offeror's sole responsibility to submit information related to the evaluation categories and that the State of Missouri is under no obligation to solicit such information if it is not included with the proposal. The offeror's failure to submit such information may cause an adverse impact on the evaluation of the proposal.

- a. Each distinctive section should be titled with each individual evaluation category and all material related to that category should be included therein.
 - b. The proposal should be page numbered.
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- c. The signed page one from the original RFP and all signed amendments should be placed at the beginning of the proposal.

4.1.5 The offeror should complete and submit Exhibit A, Miscellaneous Information.

4.1.6 Offeror's Contacts:

- a. Offerors and their agents (including subcontractors, employees, consultants, or anyone else acting on their behalf) must direct all of their questions or comments regarding the RFP, the evaluation, etc. to the buyer of record indicated on the first page of this RFP. The buyer may be contacted via e-mail or phone as shown on the first page, or via facsimile to 573-526-9817.
- b. Offerors and their agents may not contact any other state employee regarding any of these matters during the solicitation and evaluation process. Inappropriate contacts are grounds for suspension and/or exclusion from specific procurements. Offerors and their agents who have questions regarding this matter should contact the buyer of record.
- c. Offerors are advised that any questions received less than three weeks prior to the RFP opening date may not be answered.

4.2 Competitive Negotiation of Proposals — The offeror is advised that under the provisions of this Request for Proposal, the Division of Purchasing and Materials Management reserves the right to conduct negotiations of the proposals received or to award a contract without negotiations. If such negotiations are conducted, the following conditions shall apply :

4.2.1 Negotiations may be conducted in person, in writing, or by telephone.

4.2.2 Negotiations will only be conducted with potentially acceptable proposals. The Division of Purchasing and Materials Management reserves the right to limit negotiations to those proposals which received the highest rankings during the initial evaluation phase. All offerors involved in the negotiation process will be invited to submit a best and final offer.

4.2.3 Terms, conditions, prices, methodology, or other features of the offeror's proposal may be subject to negotiation and subsequent revision. As part of the negotiations, the offeror may be required to submit supporting financial, pricing and other data in order to allow a detailed evaluation of the feasibility, reasonableness, and acceptability of the proposal.

- a. The offeror must submit information which establishes and supports the actuarial soundness of the proposed rates and a certification of said soundness from an Associate of the Society of Actuaries (ASA), a Fellow of Society of Actuaries (FSA), or a Member of the American Academy of Actuaries (MAAA).
- b. The offeror shall understand that the decision of the State of Missouri regarding whether or not a rate is within actuarially sound rate ranges and does not exceed the cost to the state agency of providing those same services on a fee-for-service basis shall be final and without recourse.

4.2.4 The mandatory requirements of the Request for Proposal shall not be negotiable and shall remain unchanged unless the Division of Purchasing and Materials Management determines that a change in such requirements is in the best interest of the State of Missouri.

4.3 Evaluation and Award Process:

4.3.1 After determining that a proposal was submitted by a responsible and reliable offeror and after confirming that the offeror is responsive to the mandatory requirements stated in the Request for Proposal, a subjective evaluation and an objective analysis of the proposals shall be conducted in accordance with the evaluation criteria stated below and further described elsewhere herein. .

a. Objective Criteria:

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|------------------------------|-----------|
| 1) Cost Evaluation | 20 points |
| 2) Blind/Sheltered Workshops | 5 points |

b. Subjective Criteria:

- | | |
|-----------------------------------|-----------|
| 1) Organizational Experience | 45 points |
| 2) Proposed Method of Performance | 30 points |

4.3.2 After an initial screening process, a question and answer conference, interview, and/or negotiation discussion may be conducted with the offeror, if deemed necessary by the Division of Purchasing and Materials Management. In addition, the offeror may be asked to make an oral presentation of their proposal during the conference. Attendance cost at the conference shall be at the offeror's expense. All arrangements and scheduling shall be coordinated by the Division of Purchasing and Materials Management.

4.3.3 Separate evaluations shall be conducted by each area (East, Central, and West). One subjective evaluation shall be conducted as identified in the Subjective Criteria section of the RFP and points assigned accordingly. Two separate cost evaluations shall be conducted as identified in the Objective Criteria, Evaluation of Cost. The first evaluation of cost shall be for those offerors proposing to include pharmacy services from the MC+ managed care benefit package benefits and points assigned accordingly. The second evaluation of cost shall be for those offerors proposing to exclude the pharmacy services from the MC+ managed care benefit package and points assigned accordingly. For auto assign purposes, the sum of the subjective points and cost points for all offerors in an area will be grouped together.

Paragraph 4.1.1 renumbered correctly by Amendment #001

4.3.4 The State of Missouri shall award multiple contracts.

4.4 Offeror's Organization (Responsible and Reliable):

4.4.1 If the offeror is not Federally qualified, the offeror must disclose the following information on certain types of business transactions the offeror has with a "party in interest" as defined in the Public Health Services Act.

- a. Any sale, exchange, or lease of any property between the offeror and a "party in interest";
 - b. Any lending of money or other extension of credit between the offeror and a "party in interest"; and
 - c. Any furnishing for consideration of goods, services (including management services), or facilities between the offeror and a "party in interest". This does not include salaries paid to employees for services provided in the normal course of their employment.
 - d. If the offeror has operated previously in the commercial or Medicare markets, the offeror must disclose the information listed below regarding business transactions for the previous year. The offeror must report all of the offeror's business transactions, not just the transactions relating to serving the Medicaid enrollment.
 - 1) The name of the "party in interest" for each business transaction;
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- 2) A description of each business transaction and the quantity or units involved;
 - 3) The accrued dollar value of each business transaction during the fiscal year; and
 - 4) Justification of the reasonableness of each business transaction.
- e. For purposes of the above information, a “party in interest” shall be defined as:
- 1) Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than 5% of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5% of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;
 - 2) Any organization in which a person as described above is director, officer, or partner; has directly or indirectly a beneficial interest of more than 5% of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than 5% of the assets of the HMO.
 - 3) Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
 - 4) Any spouse, child, or parent of a person as described in above.
- 4.4.2 The offeror must provide full and complete information by disclosing the following related to the identity of each “person or corporation with an ownership or control interest” in the offeror, or any health service subcontractor in which the offeror has a 5% or more ownership interest for the prior 12-month period. The offeror may satisfy this requirement by providing a completed Form CMS-855 (Medicare and Other Federal Health Care Programs Provider/Supplier Enrollment Application).
- a. The name and address of each person with an ownership or controlling interest of 5% or more in the offeror or in any subcontractor in which the offeror has direct or indirect ownership of 5% or more;
 - b. A statement as to whether any such person with ownership or control interest is related to any other of the persons named with ownership or control interest; as spouse, parent, child, or sibling, and
 - c. The name of any other organization in which the person also has ownership or control interest. This is required to the extent that the offeror can obtain this information by requesting it in writing. The offeror must keep copies of all of these requests and responses to them, make them available upon request, and advise the State of Missouri when there is no response to a request.
 - d. For purposes of providing the above information, the offeror shall understand that a “person with an ownership or control interest” shall mean a person or corporation that (1) owns directly or indirectly, 5% or more of the offeror’s capital or stock or received 5% or more of its profits; or (2) has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the offeror or by its property or assets, and that interest is equal to or exceeds 5% of the total property and assets of the offeror, or (3) is an officer or director of the offeror (if it is organized as a corporation) or is a partner in the offeror (if it is organized as a partnership).
 - 1) The percentage of direct ownership or control is calculated by multiplying the percent of interest which a person owns by the percent of the offeror’s assets used to secure the obligation (e.g., if a person owns 10 percent of a note secured by 60 percent of the offeror’s assets, the person owns 6% of the offeror).
 - 2) The percentage of indirect ownership or control is calculated by multiplying the percentages of ownership in each organization (e.g., if a person owns 10 percent of the stock in a corporation which owns 80 percent of the stock of the offeror, the person owns 8% of the offeror).
 - e. Financial statements for all owners with 5% or more shall be submitted.
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- 4.4.3 The offeror must provide the following financial information pertaining to the offeror's organization (the legal entity that is submitting the proposal and that will be the party responsible for any contract awarded).
- a. Audited financial statements and balance sheets for the previous three (3) years, or as many years up to three (3) years that the entity has been in operation. If the offeror has not been in operation for at least one year, the offeror must submit unaudited financial statements and balance sheets. If the offeror is an existing Health Maintenance Organization, a financial statement must be submitted on the form as prescribed by the National Association of Insurance (NAIC) and must include an actuarial certification.
 - b. Financial plan for the offeror's current fiscal year.
 - c. Information about the offeror's financial forecasts for the contract period and possible contract renewal periods. These forecasts shall include at least income statements and enrollment forecasts.
 - d. Names and addresses of independent auditors.
 - e. Documentation of insurance coverage such as a list of the insurers used (including contact person and address) and the type and amounts of each policy held.
 - f. Proof of reinsurance.
 - g. Documentation of any outstanding litigation and malpractice settlements since January 1, 1998.
- 4.4.4 Debarment Certification — The offeror certifies by signing the signature page of this original document and any amendment signature page(s) that the offeror is not presently debarred, suspended, proposed for debarment, declared ineligible, voluntarily excluded from participation, or otherwise excluded from or ineligible for participation under federal assistance programs. The offeror should complete and return the attached certification regarding debarment, etc., Exhibit B with the proposal. This document must be satisfactorily completed prior to award of the contract.
- 4.4.5 Business Compliance — The offeror must be in compliance with the laws regarding conducting business in the State of Missouri. The offeror certifies by signing the signature page of this original document and any amendment signature page(s) that the offeror and any proposed subcontractors are presently in compliance with such laws. The offeror shall provide documentation of compliance upon request by the Division of Purchasing and Materials Management. The compliance to conduct business in the state shall include, but not necessarily be limited to:
- a. Registration of business name (if applicable)
 - b. Certificate of authority to transact business/certificate of good standing (if applicable)
 - c. Taxes (e.g., city/county/state/federal)
 - d. State and local certifications (e.g., professions/occupations/activities)
 - e. Licenses and permits (e.g., city/county license, sales permits)
 - f. Insurance (e.g., worker's compensation/unemployment compensation)

4.5 Confirmation of Compliance with Requirements:

The offeror must submit all of the following information in order to determine if the offeror satisfies the mandatory requirements of the Request for Proposal. The State of Missouri reserves the right to reject any offeror's proposal which does not include the required information.

In addition, the offeror should address the requirements contained in the Performance Requirements section of the RFP. Specifically, the offeror should address the individual requirements in the

Performance Requirements section of the RFP and provide a description of how, when, by whom, with what, to what degree, why, where, etc., the requirement will be satisfied.

The offeror should not provide a separate response to both the Performance Requirements section and this section. Rather, the offeror's response to the following items should be included within the offeror's response to the Performance Requirements.

To the extent possible, the specific paragraph number of the applicable section of the Performance Requirements is provided with the following items and is denoted in parenthesis. The State does not guarantee that all references have been provided.

- 4.5.1 The offeror shall submit proof that the offeror has a Certificate of Authority from the Missouri Department of Insurance to operate a Health Maintenance Organization in each county specified herein. *(2.1.2.a)*
- a. If the offeror does not currently have a certificate for a certain county, the offeror shall provide documentation that the offeror has or will submit an application to the Department of Insurance for such certification.
- 4.5.2 Physician Incentive Plans: The offeror must provide a minimum of the following information regarding each of the offeror's physician incentive plans (PIP) and each of the offeror's subcontractor's PIPs with their downstream providers, if the PIPs place the providers at significant financial risk (SFR). *(2.20.3)*
- a. Effective date of the physician incentive plan,
 - b. The type of incentive arrangement,
 - c. The amount and type of stop-loss protection,
 - d. The patient panel size,
 - e. If the patient panel is pooled, provide a description of the method,
 - f. The computations of significant financial risk, and
 - g. The name, address, telephone number, and other contact information for a person from the offeror's organization who may be contacted with questions regarding the physician incentive plan.

If the offeror does not have any PIPs with the health care service providers, the offeror must confirm in the proposal that no such arrangements exist. If the offeror's subcontractors do not have any PIPs with their downstream providers, the offeror must confirm in the proposal that no such arrangements exist and maintain documentation that demonstrates that no such arrangements exist.

4.5.3 Networks

- a. The offeror shall submit documentation demonstrating that the offeror's networks comply with travel distance access standards as set forth by the Department of Insurance in 20 CSR 400-7.095 regarding Provider Network Adequacy Standards. For any demonstrated access that differs from these standards, the offeror must submit proof of approval of the differences by the Department of Insurance. *(2.14.3)*
 - b. The offeror shall provide documentation verifying that the offeror's network has adequate capacity. Such documentation shall include, but it is not limited to, appointment availability, 24 hour/7 days a week access, sufficient experienced providers to serve special needs populations, waiting times, open panels, and PCP to member ratios. *(2.3.1)*
 - c. The offeror shall describe how it will provide tertiary care providers including trauma centers, burn centers, level III (high risk) nurseries, rehabilitation facilities, and medical sub-specialists available twenty-four (24) hours per day in the region. If the offeror does not have a full range of tertiary care providers, the offeror shall describe how the services will be provided including transfer protocols and arrangements with out of network facilities. *(2.3.17)*
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- 4.5.4 The offeror shall list each proposed health care service subcontractor to whom the offeror proposes to delegate contract requirements. Examples include, but are not limited to, mental health services, vision, dental, or pharmacy. The offeror shall describe the services and activities that will be provided by such health service subcontractor. (3.8.3)
- 4.5.5 Personnel/Staffing: The offeror shall submit information related to the qualifications of the proposed personnel concerning their experience in serving the Medicaid population including education, training, and previous work assignments. In particular, the offeror must submit the following:
- a. Resumes, job descriptions, and full time equivalent status for the offeror's Medicaid Plan Administrator, medical director, quality assessment and improvement and utilization management coordinator, special programs coordinator, mental health coordinator, and chief financial officer. (2.2.2)
 - b. Information for other personnel, including dental consultant, grievance and appeal coordinator, MIS director, and compliance officer. (2.2.1)
 - c. Information on staffing levels, job descriptions, and qualifications for prior authorization staff, concurrent review staff, member services staff, and providers service staff. (2.2.1)
- 4.5.6 Claims Payment Processes — The offeror must submit the following information regarding the offeror's claims payment processes: (2.25)
- a. Information describing the offeror's claim adjudication processes — The offeror shall provide a flow chart or written description that details the flow of claims from receipt until payment. Information shall be provided documenting the offeror's audit trail of all claims that enter the system and any review processes that are in place.
 - b. The offeror shall document the offeror's past and current performance with regard to the timely payment to in-network and out-of-network providers.
 - c. A description of the offeror's claims processing and management information system functions, including, but not limited to information about the offeror's liability management practices regarding its "Incurred But Not Reported Claims" and "Received But Unadjudicated Claims".
- 4.5.7 Additional Benefits — The offeror must provide a listing, description, and conditions under which it will offer additional benefits to its members. Examples of such services are nurse advice lines; non-emergency transportation (NEMT) for those members who do not have NEMT as part of their benefit package; sponsorship in youth programs such as Boy Scouts or YMCA; or smoking cessation programs. This is not an exhaustive list of such services but only provides examples of the types of services that may qualify as an additional benefit. (2.6.1.a. 13))
- a. Member Services and Provider Services — The offeror shall describe the hours of operation, holiday schedule, member and provider communication and education plans, and staff training plans for member services and provider services. (2.9 and 2.10)
 - b. Member Grievance System — The offeror shall describe the offeror's member grievance system being sure to address the grievance process, the appeal process, expedited resolution process, and process for ensuring that members receive proper notice of action. (2.15)
 - c. Release for Ethical Reasons — The offeror must state if reimbursement for, or provider coverage, of a counseling or referral service will be objected to based on moral or religious grounds. (2.11.3)
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4.6 Objective Criteria:

4.6.1 Preference for Organizations for the Blind and Sheltered Workshops — Pursuant to 34.165 RSMo, a five (5) bonus point preference shall be granted to offerors including products and/or services manufactured, produced or assembled by a qualified nonprofit organization for the blind established pursuant to 41 U.S.C. sections 46 to 48c or a sheltered workshop holding a certificate of approval from the Department of Elementary and Secondary Education pursuant to section 178.920 RSMo. Five bonus points will be added to the total evaluation points for offerors qualifying for the preference.

- a. If the offeror is an organization for the blind or sheltered workshop, the offeror should provide evidence of qualifications (i.e., copy of certificate or certificate number).
- b. If the offeror is utilizing an organization for the blind or a sheltered workshop as a subcontractor, the offeror should submit: (1) a letter of intent signed by the organization for the blind or sheltered workshop describing the products/services they will provide and indicating their commitment to aid the contractor's performance under the prospective state contract and (2) evidence that the subcontractor qualifies as an organization for the blind or sheltered workshop.
- c. A list of Missouri sheltered workshops can be found at the following internet address:
<http://www.dese.mo.gov/divspeced/shelteredworkshops/index.html>.

4.6.2 Evaluation of Cost:

- a. The objective evaluation of cost shall be computed by using the firm, fixed Per Member Per Month (PMPM) Net Capitation Rates for each Category of Aid Rate Subgroup as quoted by the offeror on the Pricing Pages multiplied by the corresponding projected member months stated in UPL/Rate Development Process (see Attachment 9). The State shall not consider awarding a contract to any offeror with a rate for any Category of Aid rate subgroup which exceeds the State's Maximum Net Capitation Rate listed in Column 1 on the Pricing Page.
- b. Requirements promulgated by the federal government stipulate that the State of Missouri can only contract for services at rates that are within actuarially sound rate ranges. The actuarial soundness of rates differing from those of the state shall be reviewed by the State of Missouri during the formal evaluation of proposals.
- c. The offeror must submit information which establishes and supports the actuarial soundness of the proposed rates and a certification of said soundness from an Associate of the Society of Actuaries (ASA), a Fellow of Society of Actuaries (FSA), or a Member of the American Academy of Actuaries (MAAA).
- d. The offeror shall understand that the decision of the State of Missouri regarding whether or not a rate is within actuarially sound rate ranges shall be final and without recourse.
- e. Cost points shall be calculated based on the sum from the above calculation using the following formula:

$$\frac{\text{Lowest Responsive Offeror's Price}}{\text{Compared Offeror's Price}} \times 20 = \text{Cost evaluation points}$$

4.7 Subjective Criteria:

- 4.7.1 Organizational Experience: The offeror's organization and the offeror's health care service subcontractor's organizations shall be subjectively judged. Therefore, the offeror should submit sufficient information to document successful and reliable experience in past/current performances of the offeror and the offeror's health care service subcontractor's. The offeror should document experience with a Missouri Medicaid population, or if not available, document experience with another State's Medicaid population.
- a. The offeror should document its experience in positively impacting the healthcare status of Missouri Medicaid population, or if not available, another State's Medicaid population. Examples of areas of interest include, but are not limited to the following:
- 1) EPSDT
 - 2) Lead
 - 3) Children with special health care needs
 - 4) Asthma
 - 5) Reduction of inappropriate utilization of emergent services
 - 6) Case management
 - 7) Pre-natal care
 - 8) Dental
 - 9) Mental health
 - 10) Partnering with stakeholders (e.g. community based service providers, local public health agencies, schools, state agencies, FQHCs, consumer groups, etc.) for delivery of care
 - 11) Reduction of racial and ethnic health care disparities to improve health status
 - 12) Complaints, Grievances, and Appeals
 - 13) Denials
 - 14) Access
- b. The offeror should provide a description of focus studies performed, quality improvement projects, and any improvements the offeror has implemented and their outcomes. Such outcomes should include cost savings realized, process efficiencies, and improvements to member health status. Such descriptions should address such activities since 1998. The offeror should address how issues and root causes were identified, and what was changed.
- 4.7.2 Proposed Method of Performance —
- a. The offeror's proposed Quality Improvement Programs shall be subjectively evaluated. Therefore, the offeror should address the Quality Improvement Programs proposed to be implemented during the term of the contract. The offeror should address how the proposed Quality Improvement Programs will expand the quality improvement services beyond what the offeror is currently providing (as addressed in response to item 4.7.1 a. and b.) and the difference between the offeror's current programs and the proposed programs. The offeror should also indicate how the proposed Quality Improvement Program will improve the health care status of the Missouri Medicaid population. The offeror should address the rationale for selecting the particular programs including the identification of particular health care problems and issues within the Missouri Medicaid population that each program will address and the underlying cause(s) of such problems and issues. The proposed Quality Improvement programs may include, but is not necessarily, limited to the following:
- 1) New innovative programs and processes.
 - 2) New contracts and/or partnerships being established to enhance the delivery of health care such as contracts/partnerships with school districts.
 - 3) The continuation, expansion, and/or increase of the current quality improvement programs as listed in response to 4.7.1 a. and b.
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b. Economic Impact to Missouri:

- 1) The offeror should provide a description of the proposed services that will be performed and/or the proposed products that will be provided by Missourians and/or Missouri products.
 - 2) The offeror should provide a description of the economic impact returned to the State of Missouri through tax revenue obligations.
 - 3) The offeror should provide a description of the company's economic presence within the State of Missouri, including employee status.
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5. PRICING PAGES

5.1 Instructions for Completing Pricing Page: The offeror shall provide firm, fixed prices for providing all required services for all specified counties within a region pursuant to the requirements of this Request for Proposal. The offeror must choose to include Pharmacy services as a MC+ managed care benefit or choose to exclude Pharmacy services from the MC+ managed care benefit package. The offeror shall provide either a firm, fixed Per Member Per Month (PMPM) Net Capitated Rate for each Category of Aid rate subgroup with Pharmacy services included in the MC+ managed care benefit package or a firm, fixed PMPM Net Capitated Rate for each Category of Aid rate subgroup with Pharmacy services excluded from the MC+ managed care benefit package. All costs associated with providing the required services shall be included in the offeror's quoted rates.

If the offeror is proposing to provide services for the Western region, the offeror must complete Pricing Page 5.2.

If the offeror is proposing to provide services for the Eastern region, the offeror must complete Pricing Page 5.3.

If the offeror is proposing to provide services for the Central region, the offeror must complete Pricing Page 5.4.

5.1.1 Requirements promulgated by the federal government stipulate that the State of Missouri can only contract for services at rates that are actuarially sound. Column 1A on the Pricing Pages lists the State's Maximum Net Capitation Rate for each Category of Aid rate subgroup with Pharmacy service costs included in the MC+ managed care benefit package. Each rate listed in Column 1A is actuarially sound, compliant with federal regulations, and is the maximum amount that the State will allow. Column 2A on the Pricing Pages lists the State's maximum Net Capitation Rate for each Category of Aid rate subgroup with Pharmacy service costs excluded from the MC+ managed care benefit package. Each rate listed in the Column 2A is actuarially sound, compliant with federal regulations, and is the maximum amount that the State will allow.

5.1.2 To assist the offeror in completion of the Pricing Page, the offeror should use the information provided in Attachment 9. However, the offeror is advised that this information should not be used as the only source of information in making pricing decisions. The offeror is solely responsible for research, preparation, and documentation of the offeror's proposal including the offeror's rates as quoted on the Pricing Page.

5.1.3 The offeror must complete either Column 1B or 2B on the Pricing Page by providing a firm, fixed PMPM rate for each Category of Aid rate subgroup.

a. The offeror's firm, fixed rates must not include:

- 1) Estimates for services which are not the offeror's responsibility.
- 2) Cost of marketing as an administrative expense.
- 3) Cost for Pharmacy services, if the offeror chooses to exclude Pharmacy services from the MC+ managed care benefit package.

b. The offeror's firm, fixed rates shall be net of Third Party Liability recoveries.

c. The offeror should calculate medical expenses by specific Category of Aid rate subgroup and make adjustments for administrative, profit, and contingency and risk charges to obtain the proposed Firm Fixed Net Capitation rates.

d. The offeror's firm, fixed PMPM Net Capitated Rate for each Category of Aid rate subgroup must not exceed the State's Maximum Net Capitation Rate listed in Column 1A or 2A. The State shall

not consider awarding a contract to an offeror with any quoted rate which exceeds the State's Maximum Net Capitation Rate list in Column 1A or 2A.

*****The Pricing Pages are a separate link in Excel Format that must be downloaded separately from the Division of Purchasing and Materials Management's Internet web site at: <https://www.moolb.mo.gov>. There is separate tab in the excel spreadsheet for each region.

EXHIBIT A**MISCELLANEOUS INFORMATION****Organizations for the Blind or Sheltered Workshop**

If the offeror qualifies as either a nonprofit organization for the blind or a sheltered workshop, or if the offeror is proposing to include products and/or services manufactured, produced, or assembled by such an organization, the offeror should identify the name of the organization in the space below and should attach all supporting documentation, as referenced elsewhere herein.

Name & Address of Organization for Blind/Sheltered
Workshop:

Outside United States

If any products and/or services offered under this RFP are being manufactured or performed at sites outside the continental United States, the offeror MUST disclose such fact and provide details in the space below or on an attached page.

Are products and/or services being manufactured or performed at sites outside the
continental United States?

Yes ____

No ____

Describe and provide details:

Employee Bidding/Conflict of Interest

Offerors who are employees of the State of Missouri, a member of the General Assembly or a statewide elected official must comply with Sections 105.450 to 105.458 RSMo regarding conflict of interest. If the offeror and/or any of the owners of the offeror's organization are currently an employee of the State of Missouri, a member of the General Assembly or a statewide elected official, please provide the following information.

Name of State Employee, General Assembly Member, or Statewide Elected
Official:

In what office/agency are they employed?

Employment Title:

Percentage of ownership interest in offeror's organization:

_____ %

EXHIBIT B**Certification Regarding
Debarment, Suspension, Ineligibility and Voluntary Exclusion
Lower Tier Covered Transactions**

This certification is required by the regulations implementing Executive Order 12549, Debarment and Suspension, 29 CFR Part 98 Section 98.510, Participants' responsibilities. The regulations were published as Part VII of the May 26, 1988, Federal Register (pages 19160-19211).

(BEFORE COMPLETING CERTIFICATION, READ INSTRUCTIONS FOR CERTIFICATION)

- (1) The prospective recipient of Federal assistance funds certifies, by submission of this proposal, that neither it nor its principals are presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.
- (2) Where the prospective recipient of Federal assistance funds is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

Name and Title of Authorized Representative

Signature

Date

Instructions for Certification

1. By signing and submitting this proposal, the prospective recipient of Federal assistance funds is providing the certification as set out below.
 2. The certification in this clause is a material representation of fact upon which reliance was placed when this transaction was entered into. If it is later determined that the prospective recipient of Federal assistance funds knowingly rendered an erroneous certification, in addition to other remedies available to the Federal Government, the Department of Labor (DOL) may pursue available remedies, including suspension and/or debarment.
 3. The prospective recipient of Federal assistance funds shall provide immediate written notice to the person to which this proposal is submitted if at any time the prospective recipient of Federal assistance funds learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.
 4. The terms "covered transaction," "debarred," "suspended," "ineligible," "lower tier covered transaction," "participant," "person," "primary covered transaction," "principal," "proposal," and "voluntarily excluded," as used in this clause, have the meanings set out in the Definitions and Coverage sections of rules implementing Executive Order 12549. You may contact the person to which this proposal is submitted for assistance in obtaining a copy of those regulations.
 5. The prospective recipient of Federal assistance funds agrees by submitting this proposal that, should the proposed covered transaction be entered into, it shall not knowingly enter into any lower tier covered transaction with a person who is debarred, suspended, declared ineligible, or voluntarily excluded from participation in this covered transaction, unless authorized by the DOL.
 6. The prospective recipient of Federal assistance funds further agrees by submitting this proposal that it will include the clause titled "Certification Regarding Debarment, Suspension, Ineligibility and Voluntary Exclusion — Lower Tier Covered Transactions," without modification, in all lower tier covered transactions and in all solicitations for lower tier covered transactions.
 7. A participant in a covered transaction may rely upon a certification of a prospective participant in a lower tier covered transaction that it is not debarred, suspended, ineligible, or voluntarily excluded from the covered transaction, unless it knows that the certification is erroneous. A participant may decide the method and frequency by which it determines the eligibility of its principals. Each participant may but is not required to check the List of Parties Excluded from Procurement or Nonprocurement Programs.
 8. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render in good faith the certification required by this clause. The knowledge and information of a participant is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.
 9. Except for transactions authorized under paragraph 5 of these instructions, if a participant in a covered transaction knowingly enters into a lower tier covered transaction with a person who is suspended, debarred, ineligible, or voluntary excluded from participation in this transaction, in addition to other remedies available to the Federal Government, the DOL may pursue available remedies, including suspension and/or debarment.
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**STATE OF MISSOURI
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT
TERMS AND CONDITIONS — REQUEST FOR PROPOSAL**

1. TERMINOLOGY/DEFINITIONS

Whenever the following words and expressions appear in a Request for Proposal (RFP) document or any amendment thereto, the definition or meaning described below shall apply.

- a. **Agency and/or State Agency** means the statutory unit of state government in the State of Missouri for which the equipment, supplies, and/or services are being purchased by the **Division of Purchasing and Materials Management (DPMM)**. The agency is also responsible for payment.
- b. **Amendment** means a written, official modification to an RFP or to a contract.
- c. **Attachment** applies to all forms which are included with an RFP to incorporate any informational data or requirements related to the performance requirements and/or specifications.
- d. **Proposal Opening Date and Time** and similar expressions mean the exact deadline required by the RFP for the receipt of sealed proposals.
- e. **Offeror** means the person or organization that responds to an RFP by submitting a proposal with prices to provide the equipment, supplies, and/or services as required in the RFP document.
- f. **Buyer** means the procurement staff member of the DPMM. The **Contact Person** as referenced herein is usually the Buyer.
- g. **Contract** means a legal and binding agreement between two or more competent parties, for a consideration for the procurement of equipment, supplies, and/or services.
- h. **Contractor** means a person or organization who is a successful offeror as a result of an RFP and who enters into a contract.
- i. **Exhibit** applies to forms which are included with an RFP for the offeror to complete and submit with the sealed proposal prior to the specified opening date and time.
- j. **Request for Proposal (RFP)** means the solicitation document issued by the DPMM to potential offerors for the purchase of equipment, supplies, and/or services as described in the document. The definition includes these Terms and Conditions as well as all Pricing Pages, Exhibits, Attachments, and Amendments thereto.
- k. **May** means that a certain feature, component, or action is permissible, but not required.
- l. **Must** means that a certain feature, component, or action is a mandatory condition.
- m. **Pricing Page(s)** applies to the form(s) on which the offeror must state the price(s) applicable for the equipment, supplies, and/or services required in the RFP. The pricing pages must be completed and submitted by the offeror with the sealed proposal prior to the specified proposal opening date and time.
- n. **RSMo (Revised Statutes of Missouri)** refers to the body of laws enacted by the Legislature which govern the operations of all agencies of the State of Missouri. Chapter 34 of the statutes is the primary chapter governing the operations of DPMM.
- o. **Shall** has the same meaning as the word **must**.
- p. **Should** means that a certain feature, component and/or action is desirable but not mandatory.

2. APPLICABLE LAWS AND REGULATIONS

- a. The contract shall be construed according to the laws of the State of Missouri. The contractor shall comply with all local, state, and federal laws and regulations related to the performance of the contract to the extent that the same may be applicable.
- b. To the extent that a provision of the contract is contrary to the Constitution or laws of the State of Missouri or of the United States, the provisions shall be void and unenforceable. However, the balance of the contract shall remain in force between the parties unless terminated by consent of both the contractor and the DPMM.
- c. The contractor must be registered and maintain good standing with the Secretary of State of the State of Missouri and other regulatory agencies, as may be required by law or regulations.
- d. The contractor must timely file and pay all Missouri sales, withholding, corporate and any other required Missouri tax returns and taxes, including interest and additions to tax.
- e. The exclusive venue for any legal proceeding relating to or arising out of the RFP or resulting contract shall be in the Circuit Court of Cole County, Missouri.

3. OPEN COMPETITION/REQUEST FOR PROPOSAL DOCUMENT

- a. It shall be the offeror's responsibility to ask questions, request changes or clarification, or otherwise advise the DPMM if any language, specifications or requirements of an RFP appear to be ambiguous, contradictory, and/or arbitrary, or appear to inadvertently restrict or limit the requirements stated in the RFP to a single source. Any and all communication from offerors regarding specifications, requirements, competitive proposal process, etc., must be directed to the buyer from the DPMM, unless the RFP specifically refers the offeror to another contact. Such communication should be received at least ten calendar days prior to the official proposal opening date.

- b. Every attempt shall be made to ensure that the offeror receives an adequate and prompt response. However, in order to maintain a fair and equitable procurement process, all offerors will be advised, via the issuance of an amendment to the RFP, of any relevant or pertinent information related to the procurement. Therefore, offerors are advised that unless specified elsewhere in the RFP, any questions received less than ten calendar days prior to the RFP opening date may not be answered.
- c. Offerors are cautioned that the only official position of the State of Missouri is that which is issued by the DPMM in the RFP or an amendment thereto. No other means of communication, whether oral or written, shall be construed as a formal or official response or statement.
- d. The DPMM monitors all procurement activities to detect any possibility of deliberate restraint of competition, collusion among offerors, price-fixing by offerors, or any other anticompetitive conduct by offerors which appears to violate state and federal antitrust laws. Any suspected violation shall be referred to the Missouri Attorney General's Office for appropriate action.
- e. The RFP is available for viewing and downloading on the state's On-Line Bidding/Vendor Registration System website. Premium registered offerors are electronically notified of the proposal opportunity based on the information maintained in the State of Missouri's vendor database. If a Premium registered offeror's e-mail address is incorrect, the offeror must update the e-mail address themselves on the state's On-Line Bidding/Vendor Registration System website.
- f. The DPMM reserves the right to officially amend or cancel an RFP after issuance. Premium registered offerors who received e-mail notification of the proposal opportunity when the RFP was established and Premium registered offerors who have responded to the RFP on-line prior to an amendment being issued will receive e-mail notification of the amendment(s). Premium registered offerors who received e-mail notification of the proposal opportunity when the RFP was established and Premium registered offerors who have responded to the proposal on-line prior to a cancellation being issued will receive e-mail notification of a cancellation issued prior to the exact closing time and date specified in the RFP.

4. PREPARATION OF PROPOSALS

- a. Offerors **must** examine the entire RFP carefully. Failure to do so shall be at offeror's risk.
 - b. Unless otherwise specifically stated in the RFP, all specifications and requirements constitute minimum requirements. All proposals must meet or exceed the stated specifications and requirements.
 - c. Unless otherwise specifically stated in the RFP, any manufacturer names, trade names, brand names, information and/or catalog numbers listed in a specification and/or requirement are for informational purposes only and are not intended to limit competition. The offeror may offer any brand which meets or exceeds the specification for any item, but must state the manufacturer's name and model number for any such brands in the proposal. In addition, the offeror shall explain, in
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detail, (1) the reasons why the proposed equivalent meets or exceeds the specifications and/or requirements and (2) why the proposed equivalent should not be considered an exception thereto. Proposals which do not comply with the requirements and specifications are subject to rejection without clarification.

- d. Proposals lacking any indication of intent to offer an alternate brand or to take an exception shall be received and considered in complete compliance with the specifications and requirements as listed in the RFP.
- e. In the event that the offeror is an agency of state government or other such political subdivision which is prohibited by law or court decision from complying with certain provisions of an RFP, such a offeror may submit a proposal which contains a list of statutory limitations and identification of those prohibitive clauses which will be modified via a clarification conference between the DPMM and the offeror, if such offeror is selected for contract award. The clarification conference will be conducted in order to agree to language that reflects the intent and compliance of such law and/or court order and the RFP. Any such offeror needs to include in the proposal, a complete list of statutory references and citations for each provision of the RFP which is affected by this paragraph.
- f. All equipment and supplies offered in a proposal must be new, of current production, and available for marketing by the manufacturer unless the RFP clearly specifies that used, reconditioned, or remanufactured equipment and supplies may be offered.
- g. Prices shall include all packing, handling and shipping charges FOB destination, freight prepaid and allowed unless otherwise specified in the RFP.
- h. Prices offered shall remain valid for 90 days from proposal opening unless otherwise indicated. If the proposal is accepted, prices shall be firm for the specified contract period.
- i. Any foreign offeror not having an Employer Identification Number assigned by the United States Internal Revenue Service (IRS) must submit a completed IRS Form W-8 prior to or with the submission of their proposal in order to be considered for award.

5. SUBMISSION OF PROPOSALS

- a. Proposals may be submitted by delivery of a hard copy to the DPMM office. Electronic submission of proposals by Premium registered offerors through the State of Missouri's On-Line Bidding/Vendor Registration System website is not available unless stipulated in the RFP. Delivered proposals must be sealed in an envelope or container, and received in the DPMM office located at 301 West High St, Rm 630 in Jefferson City, MO no later than the exact opening time and date specified in the RFP. All proposals must (1) be submitted by a duly authorized representative of the offeror's organization, (2) contain all information required by the RFP, and (3) be priced as required. Hard copy proposals may be mailed to the DPMM post office box address. However, it shall be the responsibility of the offeror to ensure their proposal is in the DPMM office (address listed above) no later than the exact opening time and date specified in the RFP.
- b. The sealed envelope or container containing a proposal should be clearly marked on the outside with (1) the official RFP number and (2) the official opening date and time. Different proposals should not be placed in the same envelope, although copies of the same proposal may be placed in the same envelope.
- c. A proposal submitted electronically by a Premium registered offeror may be modified on-line prior to the official opening date and time. A proposal which has been delivered to the DPMM office, may be modified by signed, written notice which has been received by the DPMM prior to the official opening date and time specified. A proposal may also be modified in person by the offeror or its authorized representative, provided proper identification is presented before the official opening date and time. Telephone or telegraphic requests to modify a proposal shall not be honored.
- d. A proposal submitted electronically by a Premium registered offeror may be canceled on-line prior to the official opening date and time. A proposal which has been delivered to the DPMM office, may only be withdrawn by a signed, written notice or facsimile which has been received by the DPMM prior to the official opening date and time specified. A proposal may also be withdrawn in person by the offeror or its authorized representative, provided proper identification is presented before the official opening date and time. Telephone, e-mail, or telegraphic requests to withdraw a proposal shall not be honored.
- e. When submitting a proposal electronically, the Premium registered offeror indicates acceptance of all RFP terms and conditions by clicking on the "Submit" button on the Electronic Bid Response Entry form. Offerors delivering a hard copy proposal to DPMM must sign and return the RFP cover page or, if applicable, the cover page of the last amendment thereto in order to constitute acceptance by the offeror of all RFP terms and conditions. Failure to do so may result in rejection of the proposal unless the offeror's full compliance with those documents is indicated elsewhere within the offeror's response.

6. PROPOSAL OPENING

- a. Proposal openings are public on the opening date and at the opening time specified on the RFP document. Only the names of the respondents shall be read at the proposal opening. Premium registered vendors may view the same proposal response information on the state's On-Line Bidding/Vendor Registration System website. The contents of the responses shall not be disclosed at this time.
- b. Proposals which are not received in the DPMM office prior to the official opening date and time shall be considered late, regardless of the degree of lateness, and normally will not be opened. Late proposals may only be opened under extraordinary circumstances in accordance with 1 CSR 40-1.050.

7. PREFERENCES

- a. In the evaluation of proposals, preferences shall be applied in accordance with Chapter 34 RSMo. Contractors should apply the same preferences in selecting subcontractors.
- b. By virtue of statutory authority, a preference will be given to materials, products, supplies, provisions and all other articles produced, manufactured, made or grown within the State of Missouri and to all firms, corporations or individuals doing business as Missouri firms, corporations or individuals. Such preference shall be given when quality is equal or better and delivered price is the same or less.

- c. In accordance with Executive Order 05-30, contractors are encouraged to utilize certified minority and women-owned businesses in selecting subcontractors.

8. EVALUATION/AWARD

- a. Any clerical error, apparent on its face, may be corrected by the buyer before contract award. Upon discovering an apparent clerical error, the buyer shall contact the offeror and request clarification of the intended proposal. The correction shall be incorporated in the notice of award. Examples of apparent clerical errors are: 1) misplacement of a decimal point; and 2) obvious mistake in designation of unit.
 - b. Any pricing information submitted by an offeror shall be subject to evaluation if deemed by the DPMM to be in the best interest of the State of Missouri.
 - c. The offeror is encouraged to propose price discounts for prompt payment or propose other price discounts that would benefit the State of Missouri. However, unless otherwise specified in the RFP, pricing shall be evaluated at the maximum potential financial liability to the State of Missouri.
 - d. Awards shall be made to the offeror whose proposal (1) complies with all mandatory specifications and requirements of the RFP and (2) is the lowest and best proposal, considering price, responsibility of the offeror, and all other evaluation criteria specified in the RFP and any subsequent negotiations and (3) complies with Sections 34.010 and 34.070 RSMo and Executive Order 04-09.
 - e. In the event all offerors fail to meet the same mandatory requirement in an RFP, DPMM reserves the right, at its sole discretion, to waive that requirement for all offerors and to proceed with the evaluation. In addition, the DPMM reserves the right to waive any minor irregularity or technicality found in any individual proposal.
 - f. The DPMM reserves the right to reject any and all proposals.
 - g. When evaluating a proposal, the State of Missouri reserves the right to consider relevant information and fact, whether gained from a proposal, from a offeror, from offeror's references, or from any other source.
 - h. Any information submitted with the proposal, regardless of the format or placement of such information, may be considered in making decisions related to the responsiveness and merit of a proposal and the award of a contract.
 - i. Negotiations may be conducted with those offerors who submit potentially acceptable proposals. Proposal revisions may be permitted for the purpose of obtaining best and final offers. In conducting negotiations, there shall be no disclosure of any information submitted by competing offerors.
-

- j. Any award of a contract shall be made by notification from the DPMM to the successful offeror. The DPMM reserves the right to make awards by item, group of items, or an all or none basis. The grouping of items awarded shall be determined by DPMM based upon factors such as item similarity, location, administrative efficiency, or other considerations in the best interest of the State of Missouri.
- k. Pursuant to Section 610.021 RSMo, proposals and related documents shall not be available for public review until after a contract is executed or all proposals are rejected.
- l. The DPMM posts all proposal results on the On-line Bidding/Vendor Registration System website for Premium registered offerors to view for a reasonable period after proposal award and maintains images of all proposal file material for review. Offerors who include an e-mail address with their proposal will be notified of the award results via e-mail.
- m. The DPMM reserves the right to request clarification of any portion of the offeror's response in order to verify the intent of the offeror. The offeror is cautioned, however, that its response may be subject to acceptance or rejection without further clarification.
- n. Any proposal award protest must be received within ten (10) calendar days after the date of award in accordance with the requirements of 1 CSR 40-1.050 (10).
- o. The final determination of contract(s) award shall be made by DPMM.

9. CONTRACT/PURCHASE ORDER

- a. By submitting a proposal, the offeror agrees to furnish any and all equipment, supplies and/or services specified in the RFP, at the prices quoted, pursuant to all requirements and specifications contained therein.
- b. A binding contract shall consist of: (1) the RFP, amendments thereto, and/or Best and Final Offer (BAFO) request(s) with RFP changes/additions, (2) the contractor's proposal including the contractor's BAFO, and (3) DPMM's acceptance of the proposal by "notice of award" or by "purchase order."
- c. A notice of award issued by the State of Missouri does not constitute an authorization for shipment of equipment or supplies or a directive to proceed with services. Before providing equipment, supplies and/or services for the State of Missouri, the contractor must receive a properly authorized purchase order unless the purchase is equal to or less than \$3,000. State purchases equal to or less than \$3,000 may be processed with a purchase order or other form of authorization given to the contractor at the discretion of the state agency.
- d. The contract expresses the complete agreement of the parties and performance shall be governed solely by the specifications and requirements contained therein. Any change, whether by modification and/or supplementation, must be accomplished by a formal contract amendment signed and approved by and between the duly authorized representative of the contractor and the DPMM or by a modified purchase order prior to the effective date of such modification. The contractor expressly and explicitly understands and agrees that no other method and/or no other document, including correspondence, acts, and oral communications by or from any person, shall be used or construed as an amendment or modification.

10. INVOICING AND PAYMENT

- a. The State of Missouri does not pay state or federal taxes unless otherwise required under law or regulation.
- b. The statewide financial management system has been designed to capture certain receipt and payment information. For each purchase order received, an invoice must be submitted that references the purchase order number and must be itemized in accordance with items listed on the purchase order. Failure to comply with this requirement may delay processing of invoices for payment.
- c. The contractor shall not transfer any interest in the contract, whether by assignment or otherwise, without the prior written consent of the DPMM.
- d. Payment for all equipment, supplies, and/or services required herein shall be made in arrears unless otherwise indicated in the RFP.
- e. The State of Missouri assumes no obligation for equipment, supplies, and/or services shipped or provided in excess of the quantity ordered. Any unauthorized quantity is subject to the state's rejection and shall be returned at the contractor's expense.
- f. All invoices for equipment, supplies, and/or services purchased by the State of Missouri shall be subject to late payment charges as provided in Section 34.055 RSMo.
- g. The State of Missouri reserves the right to purchase goods and services using the state purchasing card.

11. DELIVERY

Time is of the essence. Deliveries of equipment, supplies, and/or services must be made no later than the time stated in the contract or within a reasonable period of time, if a specific time is not stated.

12. INSPECTION AND ACCEPTANCE

- a. No equipment, supplies, and/or services received by an agency of the state pursuant to a contract shall be deemed accepted until the agency has had reasonable opportunity to inspect said equipment, supplies, and/or services.
- b. All equipment, supplies, and/or services which do not comply with the specifications and/or requirements or which are otherwise unacceptable or defective may be rejected. In addition, all equipment, supplies, and/or services which are discovered to be defective or which do not conform to any warranty of the contractor upon inspection (or at any later time if the defects contained were not reasonably ascertainable upon the initial inspection) may be rejected.
- c. The State of Missouri reserves the right to return any such rejected shipment at the contractor's expense for full credit or replacement and to specify a reasonable date by which replacements must be received.

- d. The State of Missouri's right to reject any unacceptable equipment, supplies, and/or services shall not exclude any other legal, equitable or contractual remedies the state may have.

13. WARRANTY

- a. The contractor expressly warrants that all equipment, supplies, and/or services provided shall: (1) conform to each and every specification, drawing, sample or other description which was furnished to or adopted by the DPMM, (2) be fit and sufficient for the purpose expressed in the RFP, (3) be merchantable, (4) be of good materials and workmanship, and (5) be free from defect.
- b. Such warranty shall survive delivery and shall not be deemed waived either by reason of the state's acceptance of or payment for said equipment, supplies, and/or services.

14. CONFLICT OF INTEREST

- a. Officials and employees of the state agency, its governing body, or any other public officials of the State of Missouri must comply with Sections 105.452 and 105.454 RSMo regarding conflict of interest.
- b. The contractor hereby covenants that at the time of the submission of the proposal the contractor has no other contractual relationships which would create any actual or perceived conflict of interest. The contractor further agrees that during the term of the contract neither the contractor nor any of its employees shall acquire any other contractual relationships which create such a conflict.

15. REMEDIES AND RIGHTS

- a. No provision in the contract shall be construed, expressly or implied, as a waiver by the State of Missouri of any existing or future right and/or remedy available by law in the event of any claim by the State of Missouri of the contractor's default or breach of contract.
- b. The contractor agrees and understands that the contract shall constitute an assignment by the contractor to the State of Missouri of all rights, title and interest in and to all causes of action that the contractor may have under the antitrust laws of the United States or the State of Missouri for which causes of action have accrued or will accrue as the result of or in relation to the particular equipment, supplies, and/or services purchased or procured by the contractor in the fulfillment of the contract with the State of Missouri.

16. CANCELLATION OF CONTRACT

- a. In the event of material breach of the contractual obligations by the contractor, the DPMM may cancel the contract. At its sole discretion, the DPMM may give the contractor an opportunity to cure the breach or to explain how the breach will be cured. The actual cure must be completed within no more than 10 working days from notification, or at a minimum the contractor must provide DPMM within 10 working days from notification a written plan detailing how the contractor intends to cure the breach.
- b. If the contractor fails to cure the breach or if circumstances demand immediate action, the DPMM will issue a notice of cancellation terminating the contract immediately.
- c. If the DPMM cancels the contract for breach, the DPMM reserves the right to obtain the equipment, supplies, and/or services to be provided pursuant to the contract from other sources and upon such terms and in such manner as the DPMM deems appropriate and charge the contractor for any additional costs incurred thereby.
- d. The contractor understands and agrees that funds required to fund the contract must be appropriated by the General Assembly of the State of Missouri for each fiscal year included within the contract period. The contract shall not be binding upon the state for any period in which funds have not been appropriated, and the state shall not be liable for any costs associated with termination caused by lack of appropriations.

17. COMMUNICATIONS AND NOTICES

Any notice to the contractor shall be deemed sufficient when deposited in the United States mail postage prepaid, transmitted by facsimile, transmitted by e-mail or hand-carried and presented to an authorized employee of the contractor.

18. BANKRUPTCY OR INSOLVENCY

- a. Upon filing for any bankruptcy or insolvency proceeding by or against the contractor, whether voluntary or involuntary, or upon the appointment of a receiver, trustee, or assignee for the benefit of creditors, the contractor must notify the DPMM immediately.
- b. Upon learning of any such actions, the DPMM reserves the right, at its sole discretion, to either cancel the contract or affirm the contract and hold the contractor responsible for damages.

19. INVENTIONS, PATENTS AND COPYRIGHTS

The contractor shall defend, protect, and hold harmless the State of Missouri, its officers, agents, and employees against all suits of law or in equity resulting from patent and copyright infringement concerning the contractor's performance or products produced under the terms of the contract.

20. NON-DISCRIMINATION AND AFFIRMATIVE ACTION

In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall agree not to discriminate against recipients of services or employees or applicants for employment on the basis of race, color, religion, national origin, sex, age, disability, or veteran status. If the contractor or subcontractor employs at least 50 persons, they shall have and maintain an affirmative action program which shall include:

- a. A written policy statement committing the organization to affirmative action and assigning management responsibilities and procedures for evaluation and dissemination;
- b. The identification of a person designated to handle affirmative action;
- c. The establishment of non-discriminatory selection standards, objective measures to analyze recruitment, an upward mobility system, a wage and salary structure, and standards applicable to layoff, recall, discharge, demotion, and discipline;
- d. The exclusion of discrimination from all collective bargaining agreements; and
- e. Performance of an internal audit of the reporting system to monitor execution and to provide for future planning.

If discrimination by a contractor is found to exist, the DPMM shall take appropriate enforcement action which may include, but not necessarily be limited to, cancellation of the contract, suspension, or debarment by the DPMM until corrective action by the contractor is made and ensured, and referral to the Attorney General's Office, whichever enforcement action may be deemed most appropriate.

21. AMERICANS WITH DISABILITIES ACT

In connection with the furnishing of equipment, supplies, and/or services under the contract, the contractor and all subcontractors shall comply with all applicable requirements and provisions of the Americans with Disabilities Act (ADA).

22. FILING AND PAYMENT OF TAXES

The commissioner of administration and other agencies to which the state purchasing law applies shall not contract for goods or services with a vendor if the vendor or an affiliate of the vendor makes sales at retail of tangible personal property or for the purpose of storage, use, or consumption in this state but fails to collect and properly pay the tax as provided in chapter 144, RSMo. For the purposes of this section, “affiliate of the vendor” shall mean any person or entity that is controlled by or is under common control with the vendor, whether through stock ownership or otherwise. Therefore offeror’s failure to maintain compliance with chapter 144, RSMo may eliminate their proposal from consideration for award.

23. TITLES

Titles of paragraphs used herein are for the purpose of facilitating reference only and shall not be construed to infer a contractual construction of language.

Revised 01/03/06



RECEIVED
AUG 18 2006
Mercy CarePlus

NOTICE OF AWARD

State Of Missouri
Office Of Administration
Division Of Purchasing And Materials Management
PO Box 809
Jefferson City, MO 65102
<http://www.oa.mo.gov/purch>

CONTRACT NUMBER

C306118003

CONTRACT TITLE

Medicaid Managed Care – Central, Eastern, and
Western Regions

AMENDMENT NUMBER

Amendment #001

CONTRACT PERIOD

July 1, 2006 through June 30, 2007

REQUISITION NUMBER

NR 886 25757001820

VENDOR NUMBER

4317439020 2

CONTRACTOR NAME AND ADDRESS

Mercy CarePlus
10123 Corporate Square Drive
St. Louis MO 63132

STATE AGENCY'S NAME AND ADDRESS

Department of Social Services
Division of Medical Services
PO Box 6500
Jefferson City MO 65102-6500

ACCEPTED BY THE STATE OF MISSOURI AS FOLLOWS:

Contract C306118003 is hereby amended pursuant to the attached Amendment #001 dated 07/31/06.

BUYER

Laura Ortmeyer

BUYER CONTACT INFORMATION

E-Mail: laura.ortmeyer@oa.mo.gov
Phone: (573) 751-4579 Fax: (573) 526-9817

SIGNATURE OF BUYER

/s/ Laura Ortmeyer

DATE

8/10/06

**DIRECTOR OF PURCHASING AND MATERIALS
MANAGEMENT**

/s/ James Miluski



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
CONTRACT AMENDMENT

AMENDMENT NO.: 001
CONTRACT NO.: C306118003
TITLE: Medicaid Managed Care — Central, Eastern, & Western Regions
ISSUE DATE: 07/24/06

REQ NO.: NR 886 25757001820
BUYER: Laura Ortmeier
PHONE NO.: (573) 751-4579
E-MAIL: Laura.Ortmeier@oa.mo.gov

TO: Alliance for Community Health

RETURN AMENDMENT NO LATER THAN: August 4, 2006 AT 5:00 PM CENTRAL TIME

RETURN AMENDMENT TO:

(U.S. Mail)

Div of Purchasing & Matls Mgt (DPMM)
PO BOX 809
JEFFERSON CITY MO 65102-0809

OR

(Courier Service)

Div of Purchasing & Matls Mgt (DPMM)
301 WEST HIGH STREET, ROOM 630
JEFFERSON CITY MO 65101

OR FAX TO: (573) 526-9817 (*either mail or fax, not both*)

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Service
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

RCVD AUG 1'06 AM 9:44 OA-DPMM

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME

Mercy CarePlus

MAILING ADDRESS

10123 Corporate Square DR.

CITY, STATE, ZIP CODE

St. Louis, MO 63132

CONTACT PERSON

Jerry Linder/Marcia Albridge

PHONE NUMBER

314- 432-9300

TAXPAYER ID NUMBER (TIN)

43-1743902

TAXPAYER ID (TIN) TYPE (CHECK ONE)

☒ FEIN ☐ SSN

VENDOR NUMBER (IF KNOWN)

43-17439020 2

VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)

☒ Corporation ☐ Individual ☐ State/Local Government

☐ Partnership

☐ Sole Proprietor

☐ Other_____

(NOTE: LLC IS NOT A VALID TAX FILING TYPE.)

AUTHORIZED SIGNATURE

/s/ Jerry Linder

DATE

7/31/06

PRINTED NAME

Jerry Linder

TITLE

CEO



AMENDMENT #001 TO CONTRACT C306118003

CONTRACT TITLE: Medicaid Managed Care — Central, Eastern, & Western Regions

CONTRACT PERIOD: July 1, 2006 through June 30, 2007

In accordance with the attached Agreement and Consent document and effective July 1, 2006, the State of Missouri hereby assigns the above-referenced contract from Alliance for Community Health LLC d/b/a Community CarePlus (4317439020 1) to Mercy CarePlus. All references to Community CarePlus or CCP shall be replaced with Mercy CarePlus.

As a result of such assignment, the response to section 4.4.2 a. is replaced with the following:

The name and address of each person with an ownership or controlling interest of 5% or more in Mercy CarePlus is as follows:

- CCP Acquisition Limited, a MO Corporation (“CAL”) has a 40.050 % direct ownership interest. CCP Acquisition Limited is located at 101 S. Hanley, Suite 1250, Clayton, MO 63105
- Mercy Health Plans, Inc. (MHP), a Delaware corporation, has a 50% direct ownership interest. MHP is located at 14528 South Outer 40 Drive, Chesterfield MO 63017.

The above documents those entities with ownership of 5% or greater.

Missouri Physicians Associates, a MO Domestic Insurance Company (“MPA”) owns all of the capital stock of CAL; therefore, for purposes of this response, MPA is deemed to own an indirect interest of ownership or control in Mercy CarePlus. The address for MPA is 101 S. Hanley, Suite 1250, Clayton, MO 63105.

Also, the attached documentation from the Missouri Department of Insurance dated June 23, 2006 is included as an addition to Attachment 1 (reference the response to 4.5.1).

Additionally, the response to section 4.4.2 e and the originally submitted Attachment 10 is replaced with the Revised Attachment 10 attached hereto.

All other terms, conditions and provisions of the contract, including all prices, shall remain the same and apply hereto.

The contractor shall sign and return this document, on or before the date indicated, signifying acceptance of the amendment.

AGREEMENT AND CONSENT
TO ASSIGNMENT OF CONTRACT

ALLIANCE FOR COMMUNITY HEALTH
dba COMMUNITY CAREPLUS
10123 CORPORATE SQUARE DRIVE
ST LOUIS, MO 63132

(Assignor)

Alliance for community Health
dba : Mercy CarePlus

(Assignee)

RE: Contract C306118003

The Assignor, as named above, assigns the contract in its entirety to the Assignee, as named above.

The Assignee shall honor and comply with all terms and conditions, requirements and specifications of the contract, and hereby entitles the State of Missouri to performance by Assignee of all obligations under the contract. This assignment does not entitle the Assignee to receive payment in any amount above that which the Assignor would otherwise receive. In addition, the Assignee releases the State of Missouri from all responsibilities for payment made previously to the Assignor pursuant to the contract.

The Assignee agrees that any payments made by the State of Missouri pursuant to the contract, including all payments assigned to the Assignee, shall be contingent upon the performance of the Assignee in accordance with all terms and conditions, requirements and specifications of the contract, and the approval and acceptance of such performance by the State of Missouri.

This Agreement and Consent shall not be final until it is incorporated into the subject contract by formal amendment subject to approval and acceptance by the State of Missouri, Division of Purchasing and Materials Management.

IN WITNESS THEREOF, the parties hereto have executed this Agreement and Consent on the date as stated below.

(ASSIGNOR)

(ASSIGNEE)

BY: _____
NAME: _____
TITLE: _____
DATE: _____

BY: /s/ Jerry Linder
NAME: Jerry Linder
TITLE: CEO
DATE: 7/31/06
FEIN: 43-1743902



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS
MANAGEMENT (DPMM)
CONTRACT AMENDMENT

RECEIVED
JUL 31 2006
Mercy CarePlus

AMENDMENT NO.: 002
CONTRACT NO.: C306118003
TITLE: Medicaid Managed Care — Central, Eastern, and Western Regions
ISSUE DATE: 07/27/06

REQ NO.: NR 886 25757002046
BUYER: Laura Ortmeier
PHONE NO.: (573)751-4579
E-MAIL: Laura.Ortmeier@oa.mo.gov

TO: MERCY CARE PLUS

RETURN AMENDMENT NO LATER THAN: August 14, 2006 AT 5:00 PM CENTRAL TIME

RETURN AMENDMENT TO:

(U.S. Mail)

Div of Purchasing & Matls Mgt (DPMM)
PO BOX 809
JEFFERSON CITY MO 65102-0809

(Courier Service)

OR Div of Purchasing & Matls Mgt (DPMM)
301 WEST HIGH STREET, ROOM 630
JEFFERSON CITY MO 65101

OR FAX TO: (573) 526-9817 (*either mail or fax, not both*)

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Service
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME

LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID
NO.

MAILING ADDRESS

IRS FORM 1099 MAILING ADDRESS

CITY, STATE, ZIP CODE

CITY, STATE, ZIP CODE

CONTACT PERSON

EMAIL ADDRESS

PHONE NUMBER

FAX NUMBER

TAXPAYER ID NUMBER (TIN)

TAXPAYER ID(TIN) TYPE (CHECK ONE)

VENDOR NUMBER (IF KNOWN)

☐ FEIN ☐ SSN

(VENDOR TAX FILING TYPE WITH IRS (CHECK ONE))

(NOTE: LLC IS NOT A VALID TAX FILING TYPE.)

☐ Corporation ☐ Individual ☐ State/Local Government ☐ Partnership ☐ Sole Proprietor ☐ Other_____

AUTHORIZED SIGNATURE

DATE

PRINTED NAME

TITLE

AMENDMENT #002 TO CONTRACT C306118003**CONTRACT TITLE:** Medicaid Managed Care — Central, Eastern, and Western Regions**CONTRACT PERIOD:** July 1, 2006 through June 30, 2007

The State of Missouri hereby desires to amend the above-referenced contract, as follows, effective July 1, 2006:

1. Paragraph 2.4.9 is hereby amended as follows:
 - 2.4.9 The health plan shall maintain the fee schedule for office visit services and dental services located in Attachment 14 at no lower than the Medicaid fee-for-service fee schedule in effect at the time of service.
 2. Paragraph 2.7.1 l. is hereby amended as follows:
 - 2.7.1 l. Optical services include one comprehensive or one limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), and one pair eyeglasses following cataract surgery.
 3. Paragraphs 2.7.1 r. is hereby amended as follows:
 - 2.7.1 r. Durable medical equipment limited to: prosthetic devices (with the exception of artificial larynx), respiratory equipment and oxygen (with the exception of CPAP, BiPAP, and nebulizers), wheelchairs (including accessories and batteries), diabetic supplies and equipment, and ostomy supplies. Members with Home Health Plan of Care receive all medically necessary durable medical equipment services during the plan of care coverage period.
 4. Paragraph 2.7.2 is hereby amended as follows:
 - 2.7.2 The health plan shall include all the services specified in the comprehensive benefit package with the exception of non-emergency medical transportation (NEMT) for uninsured children in ME Codes 71-75 (Refer to Attachment 1, COA 5) and children in state custody with the following ME Codes 08, 52, 57, and 64 (Refer to Attachment 1, COA 4).
 5. Paragraph 2.7.3 c is hereby amended as follows:
 - 2.7.3 c. Optical services for children under age 21 include one comprehensive or one limited eye examination per year for refractive error, eyeglasses, and HCY/EPSTD optical screens and services. Optical services for pregnant women age 21 and over with ME codes 18, 43, 44, 45, or 61 include one comprehensive or one limited eye examination per year for refractive error. Eyeglasses (except the one pair following cataract surgery covered by the health plan) for these pregnant women are covered through the Fee for Service program.
 6. Paragraph 2.7.3 e. is hereby amended as follows:
 - 2.7.3 e. Durable medical equipment (including but not limited to: orthotic devices, artificial larynx, enteral and parenteral nutrition, walkers, CPAP, BiPAP, and nebulizers);
 7. Paragraph 2.12.7 is hereby amended as follows:
-

2.12.7 **Pharmacy Services:** Pharmacy services (including physician injections) not included in the health plan's awarded proposal shall be reimbursed by the state agency on a fee-for-service basis according to the terms and conditions of the Medicaid program.

8. Attachment 3 is hereby revised.
9. Attachment 6 is hereby revised.
10. Attachment 12 is hereby revised.
11. Attachment 14 is hereby revised.

The contractor shall indicate in Column 2 on the attached Pricing page, any changes to the firm fixed prices of the contract for performing the required services in accordance with the terms, conditions, and provisions of the contract, including the above stated changes. The contractor's firm, fixed PMPM Net Capitation Rate for Each Category of Aid (COA) Rate subgroup must not exceed the State's Maximum Net Capitation Rate Listed in Column 1.

All other terms, conditions and provisions of the contract shall remain the same and apply hereto.

The contractor shall sign and return this document, on or before the date indicated, signifying acceptance of the amendment.

REVISED ATTACHMENT 3

MANAGED CARE POLICIES GOVERNING MC+ SERVICES

The following are brief descriptions of the services included in the standard benefit package and the various programs and policies governing the delivery of services for the MC+ Managed Care Program. These policies follow the amount, duration, and scope of services covered under the Missouri Medicaid State Plan. For those services included in the MC+ Managed Care benefit package, the MC+ Managed Care health plan must offer, at a minimum, the amount, duration, and scope of that service included in the Medicaid State Plan. The state agency produces and updates MC+ Managed Care policy statements governing the delivery of services under MC+ managed care. The MC+ Managed Care health plan shall comply with such policies governing the delivery of services and as amended by the state agency. Detailed information regarding MC+ fee-for-service services is contained in the fee-for-service provider manuals and bulletins, and the deluxe pricing file.

ADULT DAY HEALTH CARE

Adult Day Health Care is a covered benefit for members.

Adult Day Health Care is a program of organized therapeutic, medical, rehabilitative, and social activities provided outside of the home. MC+ fee-for-service eligible persons are assessed to be eligible for the program by the Missouri Department of Health and Senior Services (DHSS). They must have functional impairments requiring nursing home level of care, but with the provision of this service and perhaps other supports, they may safely remain in their home. Adult Day Health Care must be provided in a DHSS licensed facility or be exempt from licensure by way of regulation.

AMBULATORY SURGICAL CENTERS (INCLUDING BIRTHING CENTERS)

Ambulatory Surgical Center services are a covered benefit. MC+ Managed Care health plans may utilize Ambulatory Surgical Centers as an alternative to outpatient hospital services. The Ambulatory Surgical Center provides a place for operative procedures to be accomplished that can be safely performed in an outpatient setting and be able to be completed within 90 minutes. This is the maximum length of time that a person may be placed under anesthetic in an Ambulatory Surgical Center.

Birthing Centers are also licensed as Ambulatory Surgical Centers and are appropriate settings for the delivery of services provided by a physician, advanced practice nurse, or certified nurse midwife. MC+ Managed Care health plans are responsible for Birthing Center services.

ANESTHESIA SERVICES

Anesthesia services are a covered benefit. Anesthesia services are covered when performed by an Anesthesiologist or Certified Registered Nurse Anesthetist (CRNA). Medical direction of anesthetists by an anesthesiologist is also a covered service.

CASE MANAGEMENT

Case management is a clinical system that focuses on the accountability of an identified individual or group for coordinating a patient's care (or group of patients) across an episode or continuum of care; negotiating, procuring, and coordinating services and resources needed by patients/families with complex issues; insuring and facilitating the achievement of quality, clinical, and cost outcomes; intervening at key points for individual patients; addressing and resolving patterns of issues that have a negative quality cost impact; and creating opportunities and systems to enhance outcomes. (Definition used with permission of The Center for Case Management, 6 Pleasant Street, South Natick, MA 01760.) Case management is understood as including, but not limited to the development of individualized treatment plans and ongoing communication and coordination with other systems of care. The treatment plans must be:

- Developed by the member's primary care provider with member participation, and in consultation with any specialists caring for the member;
 - Approved by the MC+ Managed Care health plan in a timely manner, if this approval is required; and
 - In accord with any applicable State quality assurance and utilization review standards.
-

MC+ Managed Care health plans shall provide case management to members with special health care needs and maintain a detailed case management record on each member. Members with special health care needs are those members who have ongoing special conditions that require a course of treatment or regular care monitoring. The Case Management MC+ Managed Care Policy Statement shall include a list of diagnoses for children and adults that, at a minimum, the MC+ Managed Care health plan shall use for identification of members with special health care needs requiring case management and criteria for maintaining a detailed case management record. The following groups of individuals are at high risk of having a special health care need:

- Individuals eligible for Supplemental Security Income (SSI);
- Individuals in foster care or other out-of-home placement;
- Individuals receiving foster care or adoption subsidy; and
- Individuals receiving services through a family-centered community-based coordinated care system that receives grant funds under Section 501(a)(1)(D) of Title V, as defined by the state agency in terms of either program participant or special health care needs.

At the time of enrollment, the MC+ Managed Care health plan shall perform an initial health assessment of members with special health care needs and members who are at high risk of having a special health care need and implement appropriate case management based upon that assessment appropriate to the member's needs.

The MC+ Managed Care health plan shall be responsible for providing members with special health care needs all services covered under the contract beginning with the effective date of enrollment. All services authorized prior to enrollment in an MC+ Managed Care health plan shall be terminated only after a case-specific, clinical decision has been made by an MC+ Managed Care health plan provider. The MC+ Managed Care health plan shall have a mechanism in place to allow members direct access to a specialist as appropriate for the member's condition and identified needs.

HCY CASE MANAGEMENT: MC+ Managed Care health plans are required to provide medically necessary HCY case management services for members under the age of 21. Healthy Children and Youth (HCY) Case Management is an activity under which responsibility for locating, coordinating, and monitoring necessary and appropriate services for members under age 21, rests with an MC+ Managed Care Health Plan or an organization or individual that the MC+ Managed Care Health Plan has contracted with. HCY Case Management is the process of collecting information on the health needs of the child, making (and following up on) referrals as needed, maintaining a health history, activating the Early Periodic Screening and Diagnostic Treatment (EPSDT) program and ensuring collaboration between providers.

LEAD CASE MANAGEMENT: The MC+ Managed Care health plan is responsible for the provision of lead case management for those children with elevated blood lead levels. The MC+ Managed Care health plan must screen children for elevated blood lead levels as part of the requirement for the EPSDT/HCY program. When a child is identified with an elevated blood lead level, the MC+ Managed Care health plan is responsible for providing medically necessary services including case management for the child.

CASE MANAGEMENT — PREGNANT WOMEN

MC+ Managed Care health plans are required to provide prenatal case management services for at risk pregnant women enrolled in their MC+ Managed Care health plan. Based on the prenatal risk assessment, the case manager will formulate an individualized plan of management designed to accomplish the intended objectives.

CHILDREN WITH SPECIAL HEALTH CARE NEEDS

Children with special health care needs are likely to require the services of the MC+ Managed Care health plan's special programs coordinator. These children may also be served by the Departments of Health and Senior Services, Mental Health, or Elementary and Secondary Education in early intervention programs (Individuals with Disabilities Education Act — Part C), school-based services, etc.

Without services such as private duty nursing, personal care, home health, durable medical equipment/supplies, and case management these children may require hospitalization or institutionalization. Nursing homes are not usually an option for children due to their intense needs as well as their age. Some examples of children with

special health care needs include: children with special needs due to physical and/or mental illnesses, foster care children, homeless children, children with serious and persistent mental illness and/or substance abuse, and children who are disabled or chronically ill with developmental or physical disabilities. The following information identifies some of the special health care needs of this population.

- X Requires vital functions to be sustained through unusual support such as oxygen, respirator support, total parenteral nutrition, inhalation therapy, and postural drainage.
- X Requires continuous nursing attention as the result of a surgical or medical procedure such as tracheostomy, ileostomy, colostomy, gastrostomy, nephrotomy, cast, or shunt.
- X Requires continuous maintenance because of gavage feedings, frequent oral suctioning, elimination care, and positioning needs.
- X Requires therapy such as physical, occupational, and/or speech therapy to reach their greatest potential and to minimize progression of disability as in children with cerebral palsy, rheumatoid arthritis, and spina bifida.
- X Require continuous medical monitoring of underlying disease and its therapy.
- X Requires monitoring of indicators of vital functions such as heart rate, respiration, blood sugar, oxygen levels, blood pressure, and urine output.
- X Requires assistance in bathing, toileting, eating, or other activities of daily living because of a medical condition.

COMPREHENSIVE DAY REHABILITATION

Comprehensive Day Rehabilitation services are a covered benefit for children under the age of 21 and pregnant women with ME codes 18, 43, 44, 45, and 61. Coverage for comprehensive day rehabilitation services is required for certain persons with disabling impairments as the result of a traumatic head injury. Comprehensive day rehabilitation services are services beginning early post trauma as part of a coordinated system of care. Rehabilitation services must be based on an individualized, goal-oriented, comprehensive and coordinated treatment plan. The treatment plan must be developed, implemented, and monitored through an interdisciplinary assessment designed to restore an individual to optimal level of physical, cognitive, and behavioral function (See RSMo 208.152). MC+ Managed Care health plans are responsible for providing rehabilitation services to survivors of a Traumatic Brain Injury (TBI).

DENTAL

All MC+ Managed Care members receive dental care related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Adults age 21 and over receive treatment of a disease/medical condition without which the health of the recipient would be adversely affected through the fee for service program. Medically necessary covered dental services provided by a dentist, doctor of medicine, osteopathy or dentistry are the responsibility of the MC+ Managed Care health plan. Medications prescribed by a dentist for MC+ Managed Care health plan members are the responsibility of the MC+ Managed Care health plan. The MC+ Managed Care health plan is not responsible for dental services which are exclusively for cosmetic reasons.

DENTAL — CHILDREN UNDER AGE 21

Dental screens, dental services, and orthodontic services are covered for members under age 21.

It is recommended that preventive dental services and oral treatment for children begin at age 6-12 months and be repeated every six months or as medically indicated.

DENTAL — PREGNANT WOMEN AGE 21 AND OVER WITH ME CODES 18, 43, 44, 45, AND 61: Dental services for pregnant women age 21 and over with ME codes 18, 43, 44, 45, and 61 shall be limited to dentures and services related to trauma to the mouth, jaw, teeth or other contiguous sites as a result of injury. Services to prepare the mouth for dentures, such as examinations, X-rays, or extractions will not be covered by the health plan. Ancillary denture services such as relining, rebasing, and repairs will not be covered by the health plan. All other Medicaid State Plan dental services for this population is covered through the fee for service program and is not the responsibility of the MC+ Managed Care health plan.

DIABETES SELF-MANAGEMENT TRAINING

Coverage of self management training must be provided to all children under age 21 and pregnant women in ME Codes 18, 43, 44, 45, and 61 used in the management and treatment of gestational, Type I, and Type II diabetes as prescribed by a health care provider licensed by law to prescribe such services.

DURABLE MEDICAL EQUIPMENT (DME)

MC+ Managed Care health plans are required to provide medically necessary DME items to children under the age of 21, pregnant women with ME codes 18, 43, 44, 45, and 61, and members with a Home Health Plan of Care. MC+ Managed Care health plans are required to provide limited medically necessary DME items to all other MC+ Managed Care members.

CHILDREN UNDER THE AGE OF 21 AND PREGNANT WOMEN WITH ME CODES 18, 43, 44, 45, AND 61 AND THOSE WITH A HOME HEALTH PLAN OF CARE REGARDLESS OF AGE: Medically necessary equipment such as hospital beds, walkers, commodes, decubitus care equipment, hoist lifts, augmentative communication devices when prior authorized by the MC+ Managed Care health plan, trapeze equipment, canes, and crutches, etc. will be provided to children under the age of 21 and pregnant women with ME codes 18, 43, 44, 45, and 61 and those with a home health plan of care regardless of age. The recipient must be MC+ eligible on the date the equipment is delivered or dispensed. Equipment that is purchased becomes the property of the recipient. Those with a home health plan of care receive covered DME items during the plan of care coverage period.

In addition to the above-mentioned DME items, the MC+ Managed Care health plans are required to provide the following:

- X HCY DME items and services to members under the age of 21. This includes medically necessary items such as diapers, medical supplies, enteral nutrition, PKU nutrition, and positioning equipment. MC+ Managed Care health plans must arrange for continuation of coverage of HCY equipment and supplies presently being reimbursed under the HCY program.
- X All medically necessary Total Parenteral Nutrition (TPN) items and services. This includes TPN pumps, nutritional solutions, and supplies.
- X All medically necessary non-sterile ostomy supplies.
- X All medically necessary orthotic and prosthetic devices.
- X All medically necessary diabetic supplies and equipment.
- X All medically necessary oxygen and respiratory equipment. This includes oxygen and oxygen delivery systems, ventilators, nebulizers, Apnea monitors, suction pumps, etc. A summary of oxygen and respiratory equipment benefits and limitations may be found in the MC+ Durable Medical Equipment Policy Statement.
- X Augmentative communication evaluations, devices, and training. Medically necessary communication devices prescribed as a result of the augmentative evaluation are covered as a Durable Medical Equipment (DME) benefit when the augmentative communication device is prior authorized by the MC+ Managed Care health plan.

LIMITED DURABLE MEDICAL EQUIPMENT FOR MC+ MANAGED CARE ELIGIBLE INDIVIDUALS WHO ARE NOT CHILDREN UNDER THE AGE OF 21, PREGNANT WOMEN WITH ME CODES 18, 43, 44, 45, AND 61, OR THOSE WITH A HOME HEALTH PLAN OF CARE INCLUDES:

- Diabetic supplies and equipment (insulin and needles are considered Pharmaceuticals),
 - Manual and power wheelchairs including wheelchair accessories and batteries,
 - Prosthetic devices (artificial larynx is not covered),
 - Respiratory equipment and oxygen. (Nebulizers, CPAP and BiPAP are not covered services unless medical necessity is determined through the MC+ Managed Care health plan's exception process. If services are currently authorized, the MC+ Managed Care health plan may only discontinue or reduce these services after a determination of medical necessity is made through the MC+ Managed Care health plan's exception process.)
 - Ostomy supplies.
-

EPSDT/HCY

The Omnibus Budget Reconciliation Act of 1989 (OBRA-89) mandated that MC+ fee-for-service provide medically necessary services to children from birth through age 20 which are necessary to treat or ameliorate defects, physical or mental illness, or conditions identified by an Early Periodic Screening, Diagnosis, and Treatment (EPSDT) well child visit (screen) regardless of whether or not the services are covered under the MC+ fee-for-service state plan. This program is referred to nationally as the EPSDT Program. In Missouri this program is referred to as the Healthy Children and Youth (HCY) Program. Services must be sufficient in amount, duration, and scope to reasonably achieve their purpose and may only be limited by medical necessity. The MG+ Managed Care health plans are responsible for providing EPSDT/HCY services for all members. If a problem is detected during a well child visit (screening examination), the child must be evaluated as necessary for further diagnosis and treatment services. The MC+ Managed Care health plan is responsible for the treatment services.

EPSDT/HCY WELL CHILD (SCREENING) SERVICES: MC+ Managed Care health plans are responsible for ensuring that HCY well child visits (screens) are performed on all members under the age of 21. Missouri has adopted the American Academy of Pediatrics' (AAP) Schedule for Preventive Pediatric Health Care as a minimum standard for frequency of providing full HCY well child visits. Immunizations are recommended in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines. MC+ Managed Care health plans are required to keep immunizations and well child visits current according to schedules as specified by the state agency. The current schedules are as follows:

Children should receive HCY/EPSDT well child visits regularly, at the ages listed below.

- | | | |
|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> Newborn | <input type="checkbox"/> 15-17 months | <input type="checkbox"/> 8-9 years |
| <input type="checkbox"/> By age one month | <input type="checkbox"/> 18-23 months | <input type="checkbox"/> 10-11 years |
| <input type="checkbox"/> 2-3 months | <input type="checkbox"/> 24 months | <input type="checkbox"/> 12-13 years |
| <input type="checkbox"/> 4-5 months | <input type="checkbox"/> 3 years | <input type="checkbox"/> 14-15 years |
| <input type="checkbox"/> 6-8 months | <input type="checkbox"/> 4 years | <input type="checkbox"/> 16-17 years |
| <input type="checkbox"/> 9-11 months | <input type="checkbox"/> 5 years | <input type="checkbox"/> 18-19 years |
| <input type="checkbox"/> 12- 14 months | <input type="checkbox"/> 6-7 years | <input type="checkbox"/> 20 years |

EPSDT/HCY LEAD SCREENING SERVICES: All children from 6 to 72 months of age are considered at risk and must be assessed for lead poisoning. A verbal risk assessment must be completed at each HCY visit and if at high risk, the child must have a blood lead test. A blood lead test is required at 12 and 24 months, regardless of risk or annually if residing in a high-risk area of Missouri as defined by Department of Health and Senior Services regulation 19 CSR 20-8.030. The Division of Medical Services requires the use of the Lead Screening Guide (MO 886-2998) when providing services to MC+ eligible children.

Childhood Immunization Schedule: Children should receive childhood immunizations regularly, at the ages listed on the Recommended Childhood Immunization Schedule, as amended. The current schedule appears in the Missouri Medicaid Provider Manuals that may be found on the Internet at the Division of Medical Services website, <http://www.medicaid.state.iriio.us/index1.html> (Look under Missouri Medicaid Provider Manuals, List of Forms, Recommended Childhood Immunization Schedule.)

FAMILY PLANNING/STERILIZATIONS

Family planning services are a covered benefit. MC+ Managed Care health plans are required to provide freedom of choice for family planning and reproductive health services which may be accessed out-of-network. Examples of reproductive health services are: contraception management, insertion of Norplant, intrauterine devices, Depo-Provera injections, pap test, pelvic exams, sexually transmitted disease testing, and family planning counseling/education on various methods of birth control. For family planning purposes, sterilizations shall only be those elective sterilization procedures performed for the purpose of rendering an individual permanently incapable of reproducing and must always be reported as family planning services in accordance with mandated federal regulations 42 CFR 441.250-441.259.

HEARING AID - Limited to Children under the age of 21 and Pregnant Women with ME codes 18, 43, 44, 45, and 61

MC+ Managed Care health plans are required to provide medically necessary hearing aids and related services. This includes medically necessary audiometric and hearing aid services for all MC+ Managed Care members under the age of 21 including but not limited to hearing aid batteries, FM system, diagnostic testing, post cochlear implant training, aural habilitation, auditory trainers, etc.

HOME HEALTH

MC+ Managed Care health plans are responsible for covering medically necessary, physician ordered home health benefits. MC+ Managed Care health plans shall not terminate such services without a case-specific, clinical decision made by a provider. Home health services provide primarily medically oriented treatment or supervision to members with an acute illness, or an exacerbation of a chronic or long term illness which can be therapeutically managed at home. The delivered care should follow a written plan of treatment established and periodically reviewed by a physician.

The home health program is divided into two distinct segments based on the age of the member. Members who are 21 years of age and older are defined as adults within the home health program. Members 20 and under are classified as children and are eligible to receive expanded home health services as part of the EPSDT federal mandate. Services include skilled nursing, aide visits, psychiatric nursing, physical, occupational, and speech therapy and supplies.

HOSPICE

MC+ Managed Care health plans are required to provide hospice services when a terminally ill member elects those services. The hospice benefit is designed to meet the needs of members with life-limiting illnesses and to help their families cope with related problems and feelings. To be eligible to elect hospice care, members must be certified by a physician as being terminally ill with a life expectancy of six months or less. Hospice care cannot be prescribed or ordered by a physician. The member must elect hospice care and agree to seek only palliative care for the duration of the hospice election.

HYSTERECTOMY SERVICES

In order to be in compliance with 42 CFR 441.256, the MC+ Managed Care health plan must require a completed copy of the "Acknowledgement of Receipt of Hysterectomy Information" form from the performing provider. The MC+ Managed Care health plan must assure that the "Acknowledgement of Receipt of Hysterectomy Information" form meets all of the criteria required by HCFA in 42 CFR 441.250 through 441.259.

INPATIENT/OUTPATIENT HOSPITAL including MENTAL HEALTH

Inpatient hospitalization and outpatient services for physical health needs are the responsibility of the MC+ Managed Care health plan for all members, based on medical necessity. This includes charges for the pretransplant and post discharge follow-up for transplant recipients (see Transplants).

MATERNITY PRE-NATAL CARE AND DELIVERY

MC+ Managed Care health plans are required to cover maternity pre-natal care and delivery.

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

MC+ Managed Care health plans are responsible for all medically necessary mental health and substance abuse services available in the fee-for-service program for members. Mental health and substance abuse services shall include court ordered, 96 hour detentions and involuntary commitments. Mental health and substance abuse services may be provided by an acute care hospital (for a psychiatric stay), private or state psychiatric hospital, community mental health or substance abuse treatment program certified or licensed by the joint commission, Commission for Accreditation of Rehabilitation Facilities (CARF), or the Missouri Department of Mental Health including qualified mental health professionals, licensed and provisionally licensed psychologists, licensed and provisionally licensed clinical social workers, licensed and provisionally licensed professional counselors, psychiatrist, psychiatric advance practice nurse or home health psychiatric nurse.

Mental health and substance abuse services (including inpatient and outpatient) for children in Category of Aid 4 (primarily children in state custody) are not the financial responsibility of the MC+ Managed Care health plan and

will be reimbursed to MC+ fee-for-service enrolled providers on a fee-for-service basis. For inpatients with dual diagnoses (physical and mental) identified at admission or during the stay, the MC+ Managed Care health plans will be financially responsible for all inpatient hospital days if the primary, secondary, or tertiary diagnosis is a combination of physical and mental health.

OPTICAL

MC+ Managed Care health plans are required to provide medically necessary optical services for members as described herein.

Optical services include one comprehensive or one limited eye examination every two years for refractive error, services related to trauma or treatment of disease/medical condition (including eye prosthetics), and one pair eyeglasses following cataract surgery. Additionally:

- Children under age 21 services include one comprehensive or one limited eye examination per year for refractive error, eyeglasses, HCY/EPSTDT optical screens and services.
- Pregnant women age 21 and over with ME codes 18, 43, 44, 45, and 61 services include one comprehensive or one limited eye examination per year for refractive error. Eyeglasses (except the one pair following cataract surgery covered by the health plan) for these pregnant women are covered through the Fee for Service program.

When it is medically necessary for an optical procedure to be performed in an inpatient or outpatient hospital facility, emergency room, or ambulatory surgical center, the facility charges and ancillary services associated with the optical procedure are the responsibility of the MC+ Managed Care health plan.

If the MC+ Managed Care health plan approves optical items which are delivered or placed after enrollment in the MC+ Managed Care health plan ends, the MC+ Managed Care health plan that approves the optical item(s) is responsible for payment.

PERSONAL CARE

Personal care services are covered benefits for all members. Personal care services are medically oriented tasks that may be reviewed by a physician. Personal care services are not physician driven. Personal care services are tasks which assist an individual in activities of daily living due to a stable, chronic condition. Personal care services are provided as a cost effective alternative to nursing home placement.

Basic personal care services are services related to an MC+ enrollee's physical requirements, such as assistance with eating, bathing, dressing, personal hygiene, and activities of daily living. They also include services essential to the health and welfare of the MC+ enrollee, such as housekeeping chores like preparing meals, bedmaking, dusting, and vacuuming.

Advanced personal care tasks are maintenance services provided to assist MC+ enrollees with stable, chronic conditions when such assistance requires devices and procedures related to altered body functions.

Nurse visits provided by an RN or LPN in the personal care program are authorized to provide increased supervision of the aid, assessment of the MC+ enrollee's health and the suitability of the care plan to meet the patient's needs as well as referral and/or follow-up action. In addition, nurse visits may be authorized for skilled tasks that must be performed by a nurse, such as filling insulin syringes, setting up oral medications, monitoring skin conditions, providing nail care for diabetic patients, etc.

If personal care services have been authorized prior to a member enrolling in an MC+ Managed Care health plan, the MC+ Managed Care health plan may only discontinue or reduce these services based on an assessment performed by the Department of Health and Senior Services.

PERSONAL CARE (HCY): Children, ages 0 through 20, are determined to be in need of personal care by medical necessity. Personal care needs (including advanced personal care needs) for children are demonstrated by

their need for extra assistance in bathing, toileting, eating, or other activities of daily living because of a medical condition. The fact that a child has a caretaker does not make him or her ineligible for personal care services. The primary caretaker may not be present to deliver the required services or may lack the time or ability to deliver the essential care. A family member may not be reimbursed for the delivery of personal care services.

PHARMACY

MC+ Managed Care health plans are required to provide pharmacy services if the health plan included pharmacy benefits in its proposal. Under the current Missouri MC+ Fee-For-Service Pharmacy Program, nearly all products of manufacturers participating in the national rebate program are reimbursable, including many over-the-counter preparations. Insulin syringes are also reimbursable under this program.

Some products have been excluded from coverage under the current Missouri MC+ Fee-For-Service Pharmacy Program. MC+ Managed Care health plans may elect to exclude these, but may not exclude from coverage any product not excluded from the current Fee-For-Service Pharmacy Program (see the MC+ Pharmacy Policy Statement for a list of products excluded from coverage). Protease inhibitors will be reimbursed by the state agency on a fee-for-service basis.

It is not essential that MC+ Managed Care health plans cover pharmaceutical products without restriction to the same extent that current fee-for-service policy dictates. However, any product that is reimbursable by the current Fee-For-Service Pharmacy Program must be made available to members, regardless of whether or not the prescriber is in the MC+ Managed Care health plan's network. MC+ Managed Care health plans may elect to have a restricted formulary; however, products not included on that formulary that are covered or allowed through prior authorization by the current Fee-For-Service Pharmacy Program must be made available to members when medically necessary. MC+ Managed Care health plans may also require that prior authorization be obtained for prescriptions generated by an out-of-network prescriber. MC+ Managed Care health plans may have a more extensive list of products requiring prior authorization, but MC+ Managed Care health plans may not exclude from coverage any products not excluded under the current Fee-For-Service Pharmacy Program.

It is acceptable for MC+ Managed Care health plans to implement a drug authorization program in order to provide this access. Any drug prior authorization program implemented by an MC+ Managed Care health plan must meet the following criteria:

- X MC+ Managed Care health plans must provide response by telephone or other telecommunication device within 24 hours of a request for prior authorization.
- X MC+ Managed Care health plans must provide for the dispensing of at least a 72-hour supply of a drug product that requires prior authorization in an emergency situation.
- X Approvals must be granted for any medically accepted use. Medically accepted use is defined as any use for an FDA approved drug product which appears in peer-reviewed literature or which is accepted by one or more of the following compendia: the American Hospital Formulary Service — Drug Information and the United States Pharmacopeia — Drug Information and DRUGDEX.

In addition, MC+ Managed Care health plans must have a mechanism whereby drugs can be prior-authorized if a member is out of the MC+ Managed Care health plans' service area and during the time lag between the date of a members' effective enrollment and that members' assignment to a primary care provider.

PHARMACY DISPENSING FEES: The recipient portion of the pharmacy dispensing fee is to be collected according to current fee-for-service policy. Unlike traditional copayment requirements, the current Fee-For-Service Pharmacy fee requirement is considered a portion of the professional dispensing fee and is not deducted from reimbursement to providers. Therefore, the recipient portion of the dispensing fees is required to be collected for pharmacy services provided by MC+ Managed Care health plans. Providers of service may not deny or reduce services to MC+ members solely on the basis of the member's inability to pay the fee when charged. A member's inability to pay a required amount as due and charged when a service is delivered, shall in no way extinguish the member's liability to pay the amount due. Fee responsibility and amounts collectible shall be as follows:

MC+ Fee-For-Service Maximum Allowable Ingredient Cost for Each Prescription	Beneficiary Participation in Professional Dispensing Fee
\$10.00 or less	\$0.50
\$10.01 to \$25.00	\$1.00
\$25.01 or greater	\$2.00

Under the current pharmacy dispensing fee policy all Missouri eligible beneficiaries are subject to the fee requirement when provided covered pharmacy services, with the exception of the following which are excluded:

- X Beneficiaries under age 19;
- X Services related to Early Periodic Screening, Diagnosis and Treatment (EPSDT);
- X Institutionalized beneficiaries who are residing in a skilled nursing facility, a psychiatric hospital, a residential care facility, or an adult boarding home;
- X Foster Care children up to 21 years of age;
- X All Medicare/MC+ Fee-For-Service crossover claims as primary coverage is afforded by the Medicare Program;
- X Those services specifically identified as relating to Family Planning services;
- X Emergency services; and
- X Services provided to pregnant women which are directly related to the pregnancy or a complication of the pregnancy.

Participation in each MC+ Managed Care health plan's pharmacy network shall be limited to providers who accept, as payment in full, the amounts paid by the MC+ Managed Care health plan plus any fee amount required of the member and collected by the provider.

PHARMACY — GENERIC DRUG REIMBURSEMENT OVERRIDE POLICY: The current MC+ Fee-For-Service Pharmacy Program reimbursement methodology limits payment at a generic level for many drugs that are available generically from multiple sources. The majority of these reimbursement limitations are established as federal upper limits by the Centers for Medicare and Medicaid Services (CMS). Other such limitations have been established by the state agency (Missouri Maximum Allowable Cost or MAC).

Both CMS and the Missouri Division of Medical Services recognize that there are situations in which trade name products are necessary for patient's treatment. There is currently a generic reimbursement override procedure. If the MC+ Managed Care health plan intends to implement similar generic reimbursement limitations on multiple source products, a mechanism must exist so that trade name reimbursement is available when it is medically necessary. This mechanism may not be more restrictive than current fee-for-service policy.

PHYSICIAN INJECTIONS: Under the current Fee-For-Service Pharmacy Program, all FDA approved injectable products are reimbursable when billed by National Drug Code (NDC) on a pharmacy claim form by a private physician for administration in his/her office. MC+ Managed Care health plans are required to provide pharmacy services (including physician injections) if the health plan included pharmacy benefits in its proposal. In addition, certain non-injectable products are also reimbursable when billed by a private physician. These products include Norplant and irrigation solutions. Every product that is reimbursable by the current Fee-For-Service Pharmacy Program either without restriction or through prior authorization, must be covered by the MC+ Managed Care health plans either without restriction or through prior authorization except for protease inhibitors which are excluded from MC+ Managed Care. However, it is not essential that health plans cover injectable pharmaceutical products without restriction to the same extent that current policy dictates. Coverage must be granted for any medically accepted use.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY FOR ADULT PREGNANT WOMEN WITH ME CODES 18, 43, 44, 45, AND 61

MC+ Managed Care health plans are required to provide physical therapy (PT), occupational therapy (OT), and speech therapy (ST) services for adult pregnant women with ME codes 18, 43, 44, 45, and 61 as follows.

Medically necessary physical therapy (PT) benefits are covered in the outpatient hospital setting and as part of home health when the patient is medically homebound. PT is covered in a rehabilitation center if the services are for adaptive training for a prosthetic or orthotic device.

Occupational therapy (OT) is covered in a rehabilitation center for adaptive training for a prosthetic or orthotic device. Medically necessary OT is covered as part of home health if the patient is medically homebound.

Speech therapy (ST) is covered in a rehabilitation center for adaptive training for an artificial larynx. Medically necessary ST is covered in as part of home health if the patient is medically homebound.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY (HCY)

MC+ Managed Care health plans are required to provide medically necessary physical (PT), occupational (OT), and speech (ST) therapy and supplies used for casting and splinting to children age 20 and under. Physical, occupational, and speech therapy services identified in a child's Individual Education Plan (IEP) or Individualized Family Service Plan (IFSP) will not be the responsibility of the MC+ Managed Care health plan. These services will be paid fee-for-service by the state agency. Medically necessary PT, OT, and ST services beyond the scope identified in a child's IEP or IFSP are the responsibility of the MC+ Managed Care health plan. This includes developmental as well as maintenance therapy.

Medically necessary equipment and supplies used in connection with PT, OT, and ST services are the responsibility of the MC+ Managed Care health plan.

PHYSICIAN/ADVANCED PRACTICE NURSE SERVICES

MC+ Managed Care health plans are required to provide medically necessary physician/advanced practice nurse services within their scope of practice.

FEDERALLY QUALIFIED HEALTH CENTER (FQHC): Federally Qualified Health Center (FQHC) services are the responsibility of the MC+ Managed Care health plans. FQHC core services that must be performed in an FQHC setting are listed in Attachment 2. To receive FQHC provider status, a health center must be certified by the Public Health Services, be certified for participation in MC+ Fee-For-Service and enrolled with Missouri MC+ Fee-For-Service as an FQHC. FQHCs are entitled to cost-based reimbursement from the state agency for FQHC services provided to MC+ enrollees. The cost settlement will be performed by the state agency through an FQHC MC+ Fee-For-Service cost report.

PODIATRY SERVICES

MC+ Managed Care health plans are required to provide medically necessary podiatry services that are within the scope of practice of the podiatrist for children under the age of 21 or pregnant women with ME codes 18, 43, 44, 45, and 61. All other MC+ Managed Care enrollees are eligible for podiatry services with the exception of trimming of nondystrophic nails, any number; debridement of nail(s) by any method(s), one to five; debridement of nail(s) by any method(s), six or more; excision of nail and nail matrix, partial or complete; and strapping of ankle and/or foot.

PRIVATE DUTY NURSING (HCY)

Private Duty Nursing services are covered under the Healthy Children and Youth (HCY) program. The HCY program serves children age 20 and under. Private duty nursing is shift care delivered either by an R.N. or an L.P.N acting within the scope of the Missouri Nurse Practice Act according to an individualized plan of care approved by a physician. The duration of care can extend up to twenty-four (24) hours per day. The duration and frequency of care is dependent upon the child's need and physician orders. Children receiving private duty nursing care are high risk children that are medically fragile. The MC+ Managed Care health plans shall only terminate such services after a case-specific, clinical decision has been reached by a provider.

RADIOLOGY AND LABORATORY SERVICES

MC+ Managed Care health plans are required to provide medically necessary radiology and laboratory services. The MC+ Managed Care health plan must assure that the criteria required by CMS defined under the CLIA Act of 1988 as defined in 42 CFR 493.2 and Section 2303 of the Deficit Reduction Act of 1984 (P.L. 98-369) for Clinical Diagnostic Laboratory Procedures are met.

TRANSPLANTS

MC+ Managed Care health plans are responsible for the pre-surgery assessment/evaluation, care (excluding the solid organ procurement or bone marrow/stem cell harvest), post-transplant discharge follow-up care, and immuno-suppressive pharmacy products prescribed after the inpatient transplant discharge.

The transplant must be prior authorized by the Division of Medical Services (DMS) and must be performed at a DMS approved transplant facility. DMS will continue to cover the solid organ/stem cell/bone marrow procurement costs, the inpatient stay for the transplant from the date of the transplant through the date of discharge and the transplant surgeon's fee, all physician, lab etc. charges incurred during the transplant stay (date of transplant through the date of discharge).

TRANSPORTATION

The MC+ Managed Care health plan must provide emergency (ground or air) medical transportation.

The MC+ Managed Care health plan must provide necessary non-emergency medical transportation (NEMT) for members accessing health care services included in the comprehensive benefit package as well as health care services that are carved out of the MC+ Managed Care contract. The MC+ Managed Care health plan must arrange the least expensive and most appropriate mode of transportation based on the MC+ Managed Care member's medical needs.

MC+ Managed Care health plans are not required to provide transportation to MC+ Managed Care members with access to free transportation at no cost to them, however, such members may be eligible for ancillary services. Also, MC+ Managed Care health plans are not required to provide NEMT services to Durable Medical Equipment providers that provide free delivery or mail order services nor to a pharmacy.

An offer of transportation assistance must be made to all children prior to periodic screenings required under EPSDT/HCY. Parents/guardians must be informed of this transportation benefit.

NEMT services are not covered for those MC+ enrollees with ME Codes 71 through 75.

VACCINE FOR CHILDREN (VFC)

VFC services are a covered benefit. Under the provision of the Omnibus Budget Reconciliation Act (OBRA) of 1993, vaccines are available free to providers who enroll with the VFC Program. MC+ Managed Care health plans and their subcontractors must enroll in the VFC Program administered by the Missouri Department of Health and Senior Services and must use the free vaccines when administering vaccines to members. A separate administration fee will not be paid to the MC+ Managed Care health plans as the reimbursement is included in the capitation payment. If a vaccine is medically necessary and not covered through the VFC program, the MC+ Managed Care health plan is responsible for the vaccine and the administration costs.

Revised Attachment 6

The following is the state agency's Quality Improvement (QI) Strategy. The state agency produces and updates the MC+ Managed Care Quality Improvement (QI) Strategy, MC+ Managed Care contract and the MC+ Managed Care policy statements. The MC+ Managed Care health plan shall comply with the Quality Improvement (QI) Strategy, MC+ Managed Care policy statements and the MC+ Managed Care contract.

MISSOURI DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL SERVICES

QUALITY IMPROVEMENT (Q I) STRATEGY

1. DEPARTMENT OF SOCIAL SERVICES MISSION STATEMENT

To maintain or improve the quality of life for people in the state of Missouri by providing the best possible services to the public, with respect, responsiveness and accountability which will enable individuals and families to better fulfill their potential.

Purpose

The Department of Social Services (DSS), Division of Medical Services (DMS) seeks to assure access and availability of quality health care services for MC+ Managed Care members through a Managed Care delivery system, standards setting and enforcement, and education of providers and members. This QI strategy supports the following DMS objectives:

- o Assessment of the quality and appropriateness of care and services furnished to members, including those with special health care needs, centered on evidenced based practice;
 - o Use of care management with emphasis on the individual member to ensure that members have a medical home which focuses attention on the wellness of the member and includes personal responsibility and investment on the part of the member;
 - o Use of data regarding the race, ethnicity, and primary language spoken of each member to improve care delivery;
 - o Use of national performance measures and levels when identified and developed by CMS in consultation with states and other relevant stakeholders;
 - o An effective information system that supports initial and ongoing operation and review of the quality strategy;
 - o A process for public input that provides for the integration of various perspectives and priorities and will facilitate improvements in member health status;
 - o Appropriate use of sanctions, including intermediate sanctions, to assure appropriate delivery of care to members; and
 - o Compliance with regulatory and contractual requirements.
-

Goal

The goal is to ensure that:

- o Quality health care services are provided to MO Managed Care members;
- o MC+ Managed Care health plans are in compliance with Federal, State, and contract requirements; and
- o A collaborative process is maintained to collegially work with the MC+ Managed Care health plans to improve care.

Overview

This strategy will be annually evaluated for effectiveness. This process includes obtaining input from stakeholders, the State Quality Assessment & Improvement Advisory Group, Consumer Advisory Committee, and approval from CMS prior to implementation. In the instance there is significant change in outcome or indicator status that is not self-limiting and impacts on more than one area of the population's health status, modifications will be made to the strategy reporting process. These modifications may include changes to the monthly, quarterly and annual MC+ Managed Care health plan reports, on-site review topics, and MC+ Managed Care performance measures.

Each MC+ Managed Care health plan must meet program standards for monitoring and evaluation of systems as outlined in the MC+Managed Care contract to meet Federal and State regulations. Each MC+ Managed Care health plan must implement a QI strategy that addresses the standards as noted but is not limited to the requirements within the MC+ Managed Care Quality Improvement (QI) Strategy or the MC+ Managed Care contract. The MC+ Managed Care health plan's strategy shall include components to monitor, evaluate, and implement the contract standards and processes to improve:

- o Quality management;
- o Utilization management;
- o Records management;
- o Information management;
- o Care management;
- o Member services;
- o Provider services;
- o Organizational structure;
- o Credentialing;
- o Network Performance;
- o Fraud and abuse detection and prevention;
- o Access and availability; and
- o Data collection, analysis and reporting.

1.1 Program Components

I. MC+ Managed Care Health Plans Reports of Quality Assessment and Improvement

The MC+ Managed Care health plans will provide the DMS with regular reports of utilization and quality assessment. These reports will be provided in accordance with the:

- o MC+ Managed Care Policy Statements;
- o MC+ Managed Care contract;
- o MC+ Managed Care Performance Measures (Exhibit 1); and
- o MC+ Managed Care QA & I Program, Reporting Period Schedule, (Exhibit 2).

The frequency and types of reports include:

- A. Monthly Reports: Monthly reports regarding special needs and lead poisoning prevention will be submitted to DMS in a format specified by the state agency. Monthly reports will be due the last working day of each month.
 - B. Quarterly Reports: Quarterly reports of member grievances and appeals, provider complaints, grievances, and appeals, and fraud and abuse detection will be submitted to DMS in a format specified by the state agency.
 - C. Annual Evaluation: An annual evaluation of the MC+ Managed Care health plan's quality assessment and improvement program specific to the Missouri MC+ Managed Care Program is to be submitted in the format specified by the state agency (Exhibit 4). The evaluation shall contain information concerning the effectiveness and impact of the health plan's MC+ Managed Care quality assessment and improvement strategy. The annual evaluation report must provide information that indicates that data is collected, analyzed and reported, and health operations are in compliance with State, federal and MC+ Managed Care contractual requirements. The annual evaluation of the health plan's QA & I program must incorporate multiple year outcomes and trends. The evaluation must show the health plan's QA & I program is ongoing, continuous and based upon evaluation of past outcomes. The evaluation will, at a minimum, contain information from subcontractors and internal processes including:
 - a. An analysis and evaluation of member grievances and appeals and provider complaints, grievances and appeals;
 - b. An analysis and evaluation of how the health plan incorporates race, ethnicity, and primary language into the health plan's quality strategy. The DSS asks each potential enrollee their race, ethnicity and primary language at the time of application in accordance with Medicaid eligibility rules. DSS uses the federally recognized categories for race, ethnicity and language. The state agency shall electronically provide race, ethnicity and language to the health plan upon member enrollment.
 - c. An analysis and evaluation of utilization and clinical performance data that supports use of evidenced based practice;
 - d. An analysis and evaluation of 24 access/after hours availability, appointment availability and open/closed panels;
 - e. An analysis and evaluation of the MC+ Managed Care health plan's provider network including provider/enrollee ratios;
 - f. An analysis and evaluation of all MC+ Managed Care quality indicators:
 - 1. Trends in Missouri Medicaid Quality Indicators provided by the Department of Health and Senior Services (DHSS) (Exhibit 3);
 - 2. HEDIS Indicators by Missouri MC+ Managed Care Health Plans Within Regions, Live Births provided by the Department of Health and Senior Services (DHSS) (Exhibit 3); and
 - 3. MC+ Managed Care Performance Measures (Exhibit 1).
 - h. An analysis and evaluation of quality issues and actions identified through the quality strategy and how these efforts were used to improve systems of care and health outcomes;
 - i. An analysis and evaluation of action items documented in the meeting minutes of the MC+ Managed Care health plan's quality and compliance committee(s) including:
 - 1. Trends identified for focused study; results of focused studies; corrective action taken; evaluation of the effectiveness of the actions and outcomes.
 - j. An analysis and evaluation of Performance Improvement Projects (PIP) that addresses clinical and non-clinical PIPs and the requirement for on-going interventions and improvement;
 - k. An analysis and evaluation of subcontractor relationships that addresses integration with the health plan's QA&I program. This analysis and evaluation is not a replication of the Subcontractor Oversight Annual Evaluation report;
 - l. An analysis and evaluation of the health plan's fraud and abuse program;
-

- m. An analysis and evaluation of care management that includes case management, disease management and care coordination for both medical and mental health services; and
 - n. An analysis and evaluation of the health plan's claims processing and Management Information System.
- D. Periodic Reports of Quality and Utilization: The MC+ Managed Care health plan will provide periodic reports regarding case management, quality initiatives, and other quality analysis reports per DMS request.
- E. An annual report regarding multilingual services for members who speak a language other than English and the MC+ Managed Care health plan's methods for communicating with members with visual and hearing impairments and accommodating for the physically disabled. The health plan's report shall include but not be limited to the following:
- 1. A count by language of how many members declared a language other than English as their primary language.
 - 2. A summary by language of translation services provided to members (oral and in-person).
 - 3. A count of members identified as needing communication accommodations due to visual or hearing impairments or a physical disability.
 - 4. A summary of services provided to members with visual or hearing impairments or members who are physically disabled (Braille, large print, cassette, sign interpreters-, etc.).
 - 5. An inventory by language of member material translated.
 - 6. An inventory of member materials available in alternative formats.
 - 7. A summarization of grievances regarding multilingual issues and dispositions.
- F. Annual subcontractor oversight reports that reflect the health plan's monitoring activities in the previous year for each health care service subcontractor and any corrective actions implemented as a result of its monitoring activities. The annual subcontractor oversight reports shall be submitted in the format specified by the state agency (Exhibit 5).

II. DMS Analysis and Evaluation

DMS will analyze and evaluate data from a variety of sources including the state agency's Medicaid Management Information System (MMIS) to assess the quality and appropriateness of care delivery to the MC+ Managed Care population. The DMS will analyze and evaluate the following:

- Monthly reports, quarterly reports, periodic reports, annual reports, and the annual evaluations submitted by MC+ Managed Care health plans.
- Encounter data.
- Performance measures.
- Performance improvement projects.
- Compliance with the MC+ Managed Care contract.
- Enrollment, transfer and disenrollment activity.

Results from the analysis and evaluation activities will be compiled and presented through regularly scheduled meetings of the State Quality Assessment & Improvement Advisory Group. The QA & I Advisory Group will review these results to identify opportunities for improvement.

III. External Quality Review

An external quality review of the MC+ Managed Care health plans will be conducted annually in accordance with the “Medicaid Program; External Quality Review of Medicaid Managed Care Organizations; Final Rule, 42 CFR Part 438, Subpart E”. External quality review means the analysis and evaluation by an External Quality Review Organization (EQRO) of aggregated information on quality, timeliness, and access to health care services. The EQRO will provide an annual evaluation report to the QA & I Advisory Group regarding, but not limited to, the following:

1. Validation of two (2) performance improvement projects that were underway during the preceding 12 months for each MC+ Managed Care health plan.
2. Validation of three (3) performance measures reported during the preceding 12 months.
3. A review every three years to determine the MC+ Managed Care health plan’s compliance with standards as listed within the MC+ Managed Care contract.
4. Validation of encounter data.

IV. Compliance

A. **Intermediate Sanctions.** The DMS may establish and specify intermediate sanctions that may be imposed when a MC+ Managed Care health plan acts or fails to act as specified below. The DMS may require a corrective action plan, as referenced in section 2.28.5, to be developed and approved by the DMS in situations where intermediate sanctions may be imposed. The DMS shall approve and monitor implementation of such a plan and set appropriate timelines to bring activities of the MC+ Managed Care health plan into compliance with state and federal regulations. The DMS may monitor via required reporting on a specified basis and/or through on-site evaluations, the effectiveness of the plan. Before imposing intermediate sanctions, the DMS shall give the MC+ Managed Care health plan timely written notice that explains the basis and nature of the sanction and any other due process protections that the DMS elects to provide.

1. Fails substantially to provide medically necessary services that the MC+ Managed Care health plan is required to provide, under law or under this contract, to a member covered under the contract.
2. Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
3. Acts to discriminate among members on the basis of their health status or need for health care services.
4. Misrepresents or falsifies information that it furnishes to CMS or to the DMS.
5. Misrepresents or falsifies information that it furnishes to a member, potential member, or a health care provider.
6. Fails to comply with the requirements for physician incentive plans, as set forth (for Medicare) in 42 CFR 422.208 and 422.210.
7. Distributes directly, or indirectly through any agent or independent contractor, marketing materials that have not been approved by the DMS or that contain false or materially misleading information.
8. Violates any of the other applicable requirements of sections 1903(m) or 1932 of the Act and any implementing regulations.
9. Violates any of the other applicable requirements of sections 1932 or 1905(t)(3) of the Act and any implementing regulations.

B. **Intermediate Sanctions: Types.** The types of intermediate sanctions that the DMS may impose include:

1. Civil monetary penalties in the following specified amounts:
 - a. A maximum of \$25,000 for each determination of failure to provide services; misrepresentation or falsification of statements to members, potential members or health care providers; failure to comply with physician incentive plan requirements; or marketing violations.
 - b. A maximum of \$100,000 for each determination of discrimination among members on the basis of their health status or need for services; or misrepresentation or falsification to CMS or the DMS.
 - c. A maximum of \$15,000 for each member the DMS determines was discriminated against based on the member's health status or need for services (subject to the \$100,000 limit above).
 - d. A maximum of \$25,000 or double the amount of the excess charges (whichever is greater), for charging premiums or charges in excess of the amounts permitted under the Medicaid program. The DMS shall return the amount of overcharge to the affected member(s).
 2. Appointment of temporary management for a health plan as provided in 42 CFR 438.706.
 3. Granting members the right to terminate enrollment without cause and notifying the affected members of their right to disenroll.
 4. Suspension of all new enrollment, including default enrollment, after the effective date of the sanction.
 5. Suspension of payment for members enrolled after the effective date of the sanction and until CMS or the DMS is satisfied that the reason for imposition of the sanction no longer exists and is not likely to recur.
 6. Additional sanctions allowed under state statutes or regulations that address areas of noncompliance described above.
-

MC+ MANAGED CARE PERFORMANCE MEASURES

a. EFFECTIVENESS OF CARE

1. (H) Childhood Immunization Status (CIS)*
2. (H) Adolescent Immunization Status (AIS)*
3. (H) Cervical Cancer Screening (CCS)*
4. (H) Chlamydia Screening in Women (CHL)*
5. (H) Follow-up After Hospitalization For Mental Health Disorders (FUH)
6. (H) Use of Appropriate Medications for People with Asthma (ASM)*

1) ACCESS/AVAILABILITY OF CARE

7. (H) Prenatal and Postpartum Care (PPC)
8. (H) Annual dental visit (ADV)*

2) SATISFACTION WITH THE EXPERIENCE OF CARE

9. (H) CAHPS 3.OH Child/Adult Survey*

3) USE OF SERVICES

10. (H) Well child Visits in the First 15 Months of Life (W15)
11. (H) Well Child Visits in the Third, Fourth, Fifth, and Sixth Year of Life (W34)
12. (H) Adolescent Well-Care Visits (AWC)*
13. (H) Ambulatory Care (AMB)
14. (H) Mental Health Utilization — Percentage of Members Receiving Inpatient, Intermediate Care and Ambulatory Services (MPT)
15. (H) Identification of Alcohol and Other Drug Services (IAD)

(H) = HEDIS Measure

* DHSS required measure. Follow the instructions provided within 19 CSR 10-5.010.

Note: The measures shall be collected and reported in accordance with HEDIS specifications. In the event that NCQA retires a DMS required measure, the Division will inform the health plan whether the DMS will require the health plan to collect and report using HEDIS specifications in effect prior to the measurement's retirement or whether the Division will follow NCQA's retirement of the measure. NCQA rotates certain measures every year. As approved by DMS, rotated measures shall be reported in accordance with current HEDIS technical specifications for reporting rotated measures. DMS shall not approve rotation of CAHPS. DHSS measures shall be reported according to DHSS specifications as provided in 19 CSR 100-5.010. MC+ Managed Care health plans contracted for more than one region shall submit region specific data. All MC+ Managed Care health plans shall submit the measures in an electronic format utilizing tables provided by the DMS and DHSS.

**MC+ Managed Care Quality Assessment and Improvement
Reporting Periods**

The following reporting periods have been defined for reporting of monthly, quarterly and annual reports by MC+ Managed Care health plans participating in the MC+ Managed Care Program.

MONTHLY REPORTING

<u>Time Period</u>	<u>Due Date</u>
Calendar month	Last working day of the month

QUARTERLY REPORTING

<u>Time Period</u>	<u>Due Date</u>
1 st Quarter (July thru September)	December 1st of each year
2 nd Quarter (October thru December)	March 1st of each year
3 rd Quarter (January thru March)	June 1st of each year
4 th Quarter (April thru June)	September 1st of each year

**ANNUAL REPORTS — ANNUAL EVALUATION, MULTILINGUAL SERVICES,
SUBCONTRACTOR OVERSIGHT**

<u>Time Period</u>	<u>Due Date</u>
July 1 thru June 30	November 30, 2007 and on November 30 of each subsequent year

PERFORMANCE MEASURES

<u>Time Period</u>	<u>Due Date</u>
January 1 thru December 31	June 30 of each year

**Trends in Missouri Medicaid Quality Indicators
(Secondary-Source Reporting)**

1. Trimester Prenatal Care Began:
 - a. First
 - b. Second
 - c. Third
 - d. None
 - e. Total
2. Inadequate Prenatal Care
3. Birth weight (grams) — total number of births by weight category For each live birth.
 - a. <500Gms.
 - b. 500-1499 Gms.
 - c. 1500-1999 Gms.
 - d. 2000-2499 Gms.
 - e. .2500 Gms.
 - f. Stillborn fetuses
4. Low Birth Weight (<2500 grams)
5. Method of Delivery
 - a. C-Section
 - b. VBAC
 - c. Repeat C-Section
6. Smoking During Pregnancy
7. Spacing <18 months since last birth
8. Births to mothers <18 years of age
9. Repeat teen births
10. Fetal Deaths (20+weeks)*
11. Total live birth or stillbirth fetuses 500 grams or more**
12. Percent of pregnant women on Women's Infants and Children Program (WIC)
13. Percent of prenatals on WIC
14. VLBW not delivered in level 111 hospitals
15. Average maternal length of stay (days), Inpatient admissions
16. Average behavioral health length of stay (days), Inpatient admissions
17. Asthma inpatient admissions ages 4-17**
18. Asthma emergency room visits ages 4-17**
19. Asthma admissions under age 16, Inpatient admissions**
20. Asthma admissions ages 18 — 64, Inpatient admissions**
21. Emergency room visits under age 18**
22. Emergency room visits ages 18 — 64**
23. Hysterectomies**
24. Vaginal hysterectomies
25. Preventable hospitalization under age 18**

* Rate per 1000 live births

** Rate per 1000 population

**HEDIS Indicators by Missouri MC+ Managed Care Health Plans Within Regions, Live Births
(Secondary-Source Reporting)**

1. C-Sections
 2. VBACs
 3. Adequacy of Prenatal Care
 4. Early Prenatal Care
 5. Low Birth Weight
 6. Low Birth Weight Delivered in Level II/III Hospitals
 7. Very Low Birth Weight Delivered in Level II/III Hospitals
 8. Smoking During Pregnancy
 9. Spacing Less Than 18 Months
 10. Births to Mothers Less Than 18
 11. Repeat Births to Teen Mothers
 12. Prenatal WIC Participants
-

MC+ MANAGED CARE ANNUAL EVALUATION REPORT FORMAT**TABLE OF CONTENTS****EXECUTIVE SUMMARY**

- Overview of the Quality Improvement Program
- Overview of the Effectiveness of the Quality Improvement Program

DEVELOPMENT, APPROVAL AND MONITORING OF THE QI PROGRAM

- Quality and Compliance Committee
- Analysis of Quality Improvement Process
- Overall Effectiveness of the Quality Improvement Program
 - Strengths and Accomplishments
 - Opportunities for Improvement

POPULATION CHARACTERISTICS

- Race/Ethnicity
- Special Needs
- Languages Identified
- Opt Outs

QUALITY INDICATORS

- Performance Measures
- Trends in Missouri Medicaid Quality Indicators
- HEDIS Indicators by Missouri MC+ Managed Care Health Plans Within Regions, Live Births

ACCESSIBILITY OF SERVICES

- Average Speed of Answer
- Call Abandonment Rate
- Non-Routine Needs Appointments
- Routine Needs Appointments
- Access to Emergent and Urgent Care
- Network Adequacy — Provider/Enrollee Ratios
- 24 Hour Access/After Hours Availability
- Open/Closed Panels
- Cultural Competency
- Requests to Change Practitioners

FRAUD AND ABUSE

- Prevention, Detection, Investigation
- Training and Education

INFORMATION MANAGEMENT

- Claims Processing — Timeliness of Claims Payment
- Membership
- Providers

QUALITY MANAGEMENT

- Provider Satisfaction
- Care Coordination
- Case Management
- Disease Management Program
- Mental Health Care Management including Case Management
- Clinical Practice Guidelines
- Credentialing and Re-Credentialing
- Medical Record Review
- Subcontractor Monitoring

RIGHTS AND RESPONSIBILITIES

Provider Complaint, Grievance and Appeal Management
Member Grievance and Appeal Management
Confidentiality

UTILIZATION MANAGEMENT

Utilization Improvement Program Scope
Discharges Per Year*
Inpatient Visits*
Average Length of Stay
Re-Admissions*
Emergency Department Utilization*
Outpatient Visits* .
Over/Under Utilization
Inter-Rater Reliability
Timeliness of Care Delivery
Timeliness of Prior Authorization/Certification Decision Making

*Per 1000 members

PERFORMANCE IMPROVEMENT PROJECTS (PIP)

Clinical
Non- Clinical
On-going Interventions and Improvements
Effect on Health Outcomes and Member Satisfaction

WORKPLAN FOR NEXT YEAR

APPENDICES

SUBCONTRACTOR OVERSIGHT ANNUAL EVALUATION REPORT TEMPLATE

(Complete for each subcontractor- 2-5pages)

Subcontractor Name

- A. Overview of subcontractor including contract effective dates**
 - B. Description of delegated services/products/activities**
 - C. Description of MC+ Managed Care health plan's oversight process** (must include, but shall not be limited to, the following:)
 - 1) Review of subcontractor contract documents compliance with requirements included in the MC+ Managed Care contract with state**
(Refer to Section 3.8.3 of MC+ Managed Care contract)
 - 2) Subcontractor policies and procedures comply with subcontractor/MC+ Managed Care health plan's/state contract requirements**
 - 3) Implementation of policies/procedures/contract requirements**
 - D. Oversight outcomes/findings** (must include, but shall not be limited to, the following:)
 - 1) Access/availability**
 - 2) Fraud and abuse**
 - 3) Grievances and appeals**
 - 4) Performance projects and measures**
 - 5) Encounter data**
 - 6) Prior authorization denials**
 - 7) Timely payment**
 - E. Work plan for next year**
-

OFFICE VISIT SERVICES

Procedure Code	Program Type	Allowable Fee for Dates of Service July 1, 2006 and after
99201	Medical Services	\$21.52
99201 GE	Medical Services	\$21.52
99201 GT	Medical Services	\$21.52
99201	Nurse Midwife	\$21.52
99201	Podiatry	\$21.52
99201 GE	Podiatry	\$21.52
99201 W2	Podiatry	\$21.52
99201	Other Medical	\$21.52
99201 GE	Other Medical	\$21.52
99202	Medical Services	\$38.23
99202 EP	Medical Services	\$38.23
99202 GT	Medical Services	\$38.23
99202 GT EP	Medical Services	\$38.23
99202 GE	Medical Services	\$38.23
99202 GE EP	Medical Services	\$38.23
99202	Nurse Midwife	\$38.23
99202 EP	Nurse Midwife	\$38.23
99202	Podiatry	\$38.23
99202 W2	Podiatry	\$38.23
99202 GE	Podiatry	\$38.23
99202	Other Medical	\$38.23
99202 EP	Other Medical	\$38.23
99202 GE	Other Medical	\$38.23
99202 GE EP	Other Medical	\$38.23
99203	Medical Services	\$56.93
99203 EP	Medical Services	\$56.93
99203 GE	Medical Services	\$56.93
99203 GE EP	Medical Services	\$56.93
99203 GT	Medical Services	\$56.93
99203 GT EP	Medical Services	\$56.93
99203	Nurse Midwife	\$56.93
99203 EP	Medical Services	\$56.93
99203	Podiatry	\$56.93
99203 W2	Podiatry	\$56.93
99203	Other Medical	\$56.93
99203 EP	Other Medical	\$56.93
99203 GE	Other Medical	\$56.93

OFFICE VISIT SERVICES

Procedure Code	Program Type	Allowable Fee for Dates of Service July 1, 2006 and after
99203 GE EP	Other Medical	\$56.93
99204	Medical Services	\$80.62
99204 EP	Medical Services	\$80.62
99204 GT	Medical Services	\$80.62
99204 GT EP	Medical Services	\$80.62
99204	Nurse Midwife	\$80.62
99204 EP	Nurse Midwife	\$80.62
99204	Podiatry	\$80.62
99204 W2	Podiatry	\$80.62
99204	Other Medical	\$80.62
99204 EP	Other Medical	\$80.62
99205	Medical Services	\$102.58
99205 EP	Medical Services	\$102.58
99205 GT	Medical Services	\$102.58
99205 GT EP	Medical Services	\$102.58
99205	Nurse Midwife	\$102.58
99205 EP	Nurse Midwife	\$102.58
99205	Podiatry	\$102.58
99205 W2	Podiatry	\$102.58
99205	Other Medical	\$102.58
99205 EP	Other Medical	\$102.58
99211	Medical Services	\$12.55
99211 GE	Medical Services	\$12.55
99211 GT	Medical Services	\$12.55
99211	Nurse Midwife	\$12.55
99211	Podiatry	\$12.55
99211 W2	Podiatry	\$12.55
99211 GE	Podiatry	\$12.55
99211	Other Medical	\$12.55
99211 GE	Other Medical	\$12.55
99212	Medical Services	\$22.60
99212 GT	Medical Services	\$22.60
99212 GE	Medical Services	\$22.60
99212	Nurse Midwife	\$22.60
99212	Podiatry	\$22.60
99212 W2	Podiatry	\$22.60
99212 GE	Podiatry	\$22.60

OFFICE VISIT SERVICES

Procedure Code	Program Type	Allowable Fee for Dates of Service July 1, 2006 and after
99212	Other Medical	\$22.60
99212 GE	Other Medical	\$22.60
99213	Medical Services	\$30.86
99213 GE	Medical Services	\$30.86
99213 GT	Medical Services	\$30.86
99213	Nurse Midwife	\$30.86
99213	Podiatry	\$30.86
99213 W2	Podiatry	\$30.86
99213 GE	Podiatry	\$30.86
99213	Other Medical .	\$30.86
99213 GE	Other Medical	\$30.86
99214	Medical Services	\$48.45
99214 EP	Medical Services	\$48.45
99214 GT	Medical Services	\$48.45
99214 GT EP	Medical Services	\$48.45
99214	Nurse Midwife	\$48.45
99214 EP	Nurse Midwife	\$48.45
99214	Podiatry	\$48.45
99214 W2	Podiatry	\$48.45
99214	Other Medical	\$48.45
99214 EP	Other Medical	\$48.45
99215	Medical Services	\$70.63
99215 EP	Medical Services	\$70.63
99215 GT	Medical Services	\$70.63
99215 GT EP	Medical Services	\$70.63
99215	Nurse Midwife	\$70.63
99215 EP	Nurse Midwife	\$70.63
99215	Podiatry	\$70.63
99215 W2	Podiatry	\$70.63
99215	Other Medical	\$70.63
99215 EP	Other Medical	\$70.63

DENTAL SERVICES

Procedure Code	Age
D0210	0-125
D0270	0-125
D0272	0-125
D0330	0-125
D0340	0-20
D0350	0-20
D1110	13-125
D1203	0-20
D1204	21-125
D1351	0-20
D2140	0-125
D2150	0-125
D2160	0-125
D2161	0-125
D2330	0-125
D2331	0-125
D2332	0-125
D2335	0-125
D2910	0-125
D2920	0-125
D2930	0-125
D2931	0-125
D2932	0-125
D2940	0-125
D3220	0-125
D3310	0-125
D3320	0-125
D3330	0-125
D3346	0-125
D3347	0-125
D3348	0-125
D3410	0-125
D3421	0-125
D3425	0-125
D4210	0-125
D5510	0-125
D5520	0-125
D5610	0-125
D5630	0-125
D5640	0-125

DENTAL SERVICES

Procedure Code	Age
D5650	0-125
D5660	0-125
D5710	0-125
D5711	0-125
D5721	0-125
D5730	0-125
D5731	0-125
D5740	0-125
D5741	0-125
D5750	0-125
D5751	0-125
D5760	0-125
D5761	0-125
D5820	0-125
D5821	0-125
D6930	0-125
D7220	0-125
D7230	0-125
D7240	0-125
D7241	0-125
D7960	0-125
D7970	0-125
D9110	0-125
D9241	0-125
D9910	0-125
D9951	0-125

NOTE: The health plan shall review provider bulletins posted on the DMS website for future code changes due to HCPCS and HIPAA.

5.2 West Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$677.81	\$
1	01 - 06	Male and Female	\$125.63	\$
1	07 - 13	Male and Female	\$107.39	\$
1	14 - 20	Female	\$265.58	\$
1	14 - 20	Male	\$121.43	\$
1	21 - 44	Female	\$353.42	\$
1	21 - 44	Male	\$196.90	\$
1	45 - 99	Male and Female	\$402.91	\$
4	00 - 20 JC	Male and Female	\$206.11	\$
4	00 - 20 OSJC	Male and Female	\$249.74	\$
5	00 - 06	Male and Female	\$159.62	\$
5	07 - 13	Male and Female	\$128.99	\$
5	14 - 18	Male and Female	\$172.28	\$

5.3 East Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$777.07	\$
1	01 - 06	Male and Female	\$113.59	\$
1	07 - 13	Male and Female	\$90.07	\$
1	14 - 20	Female	\$240.17	\$
1	14 - 20	Male	\$114.66	\$
1	21 - 44	Female	\$333.06	\$
1	21 - 44	Male	\$172.85	\$
1	45 - 99	Male and Female	\$399.40	\$
4	00 - 20	Male and Female	\$207.76	\$
5	00 - 06	Male and Female	\$ 140.03	\$
5	07 - 13	Male and Female	\$ 108.12	\$
5	14 - 18	Male and Female	\$158.18	\$

5.4 Central Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$581.95	\$
1	01 - 06	Male and Female	\$126.99	\$
1	07 - 13	Male and Female	\$103.08	\$
1	14 - 20	Female	\$301.80	\$
1	14 - 20	Male	\$123.65	\$
1	21 - 44	Female	\$405.35	\$
1	21 - 44	Male	\$ 194.98	\$
1	45 - 99	Male and Female	\$416.76	\$
4	00 - 20	Male and Female	\$207.15	\$
5	00 - 06	Male and Female	\$162.54	\$
5	07 - 13	Male and Female	\$124.27	\$
5	14 - 18	Male and Female	\$178.45	\$

Policies and Procedures Requiring Prior Approval

Required Policy	Contract Reference	Required Policy	Contract Reference	Required Policy	Contract Reference
Non-Discrimination in Hiring and Provisions of Services	2.2.6	24-Hour Coverage	2.14.1	Provider C, G & A	2.16
Linking Members to PCPs	2.3.2	Prior Authorization	2.14.2	QA&I	2.17.1
Marketing Guidelines	2.6.1 a.18)	Appointment Standards Edu.	2.14.4 d.1)	Utilization Management	2.17.5 b
Member Rights	2.6.2 j.2)	Referral to non-network provider	2.14.5	Provider Credentialing	2. 17.5 c
Assignment of PCP	2.6.2 k.	Standing Referral to Specialist	2.14.6	Monitoring Providers	2.17.5 c.
Assignment of PCP	2.6.2 k.4)	Referral to Specialty Care Cntr.	2.14.7	Records Retention	2.26.4
Transfers Between Health Plans	2.6.2 r.	Transitioning of Care	2.14.10	Medical Records	2.26.5
Disenrollment Effective Dates	2.6.2 u.	Care Management	2.14.11 c.	Fraud & Abuse	2.31
Provider Listing Updates	2.9.1 g.	Certification Review	2.14.12	Subcontractor Oversight	3.8.3
Second Opinion	2.13	Member Grievance System	2.15		



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
CONTRACT AMENDMENT

AMENDMENT NO.: 003
CONTRACT NO.: C306118003
TITLE: Medicaid Managed Care — Central, Eastern, and Western Regions
ISSUE DATE: 02/23/07

REQ NO.: NR 886 25757007159
BUYER: Laura Ortmeyer
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeyer@oa.mo.gov

TO: MERCY CAREPLUS
10123 CORPORATE SQUARE DR
ST LOUIS, MO 63132

RETURN AMENDMENT NO LATER THAN: March 7, 2007 AT 5:00 PM CENTRAL TIME

RETURN AMENDMENT TO:

(U.S. Mail)

Div of Purchasing & Matls Mgt (DPMM)
PO BOX 809
JEFFERSON CITY MO 65102-0809

OR

(Courier Service)

Div of Purchasing & Matls Mgt (DPMM)
301 WEST HIGH STREET, ROOM 630
JEFFERSON CITY MO 65101

OR FAX TO: (573) 526-9817 (either mail or fax, not both)

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Missouri Department of Social Service
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME

Mercy CarePlus
MAILING ADDRESS

10123 Corporate Square Drive
CITY, STATE, ZIP CODE

St. Louis, MO 63132

CONTACT PERSON

Jerry Linder
PHONE NUMBER

(314) 432-9300 Ext. 202

LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS
TAX ID NO.

Alliance for Community Health, LLC
IRS FORM 1099 MAILING ADDRESS

10123 Corporate Square Drive
CITY, STATE, ZIP CODE

St. Louis, MO 63132

EMAIL ADDRESS

jlinder@mercyplus.com
FAX NUMBER

(314) 432-9203 or (314) 994-9398

TAXPAYER ID NUMBER (TIN)

43-1743902

TAXPAYER ID (TIN) TYPE (CHECK ONE)

☒ FEIN ☐ SSN

VENDOR NUMBER (IF KNOWN)

4317439020 2

VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)

(NOTE: LLC IS NOT A VALID TAXFILING TYPE.)

☒ Corporation ☐ Individual ☐ State/Local Government ☐ Partnership ☐ Sole Proprietor ☐ Other _____

AUTHORIZED SIGNATURE

/s/ Jerry Linder
PRINTED NAME

Jerry Linder

DATE

February 27, 2007
Chief Executive Officer - President

AMENDMENT #003 TO CONTRACT C306118003

CONTRACT TITLE: Medicaid Managed Care - Central, Eastern, and Western Regions

CONTRACT PERIOD: July 1, 2006 through June 30, 2007

The State of Missouri hereby desires to amend the above-referenced contract, as follows, effective July 1, 2006:

In order to determine the impact of the eligibility changes implemented effective with fiscal year 2007 on the overall birth rate, the state agency's actuary consultant conducted an analysis specific to the female child bearing rate cells in order to ensure the actuarially soundness of the rates. The attached Pricing Page reflects the actuarially sound rates determined as a result of the analysis.

The contractor shall indicate in Column 2 on the attached Pricing Page, any changes to the firm fixed prices of the contract for performing the required services in accordance with the terms, conditions, and provisions of the contract. The contractor's firm, fixed PMPM Net Capitation Rate for Each Category of Aid (COA) Rate subgroup must not exceed the State's Maximum Net Capitation Rate Listed in Column 1.

All other terms, conditions and provisions of the contract, including all prices, shall remain the same and apply hereto.

The contractor shall sign and return this document, on or before the date indicated, signifying acceptance of the amendment.

5.2 West Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$ 677.81	\$ 677.81
1	01 - 06	Male and Female	\$ 125.63	\$ 125.63
1	07 - 13	Male and Female	\$ 107.39	\$ 107.39
1	14 - 20	Female	\$ 270.37	\$ 270.37
1	14 - 20	Male	\$ 121.43	\$ 121.43
1	21 - 44	Female	\$ 368.58	\$ 368.58
1	21 - 44	Male	\$ 196.90	\$ 196.90
1	45 - 99	Male and Female	\$ 402.91	\$ 402.91
4	00 - 20 JC	Male and Female	\$ 249.74	\$ 249.74
4	00 - 20 OSJC	Male and Female	\$ 206.11	\$ 206.11
5	00 - 06	Male and Female	\$ 159.62	\$ 159.62
5	07 - 13	Male and Female	\$ 128.99	\$ 128.99
5	14 - 18	Male and Female	\$ 172.28	\$ 172.28

5.3 East Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$ 777.07	\$ 777.07
1	01 - 06	Male and Female	\$ 113.59	\$ 113.59
1	07 - 13	Male and Female	\$ 90.07	\$ 90.07
1	14 - 20	Female	\$ 269.72	\$ 269.72
1	14 - 20	Male	\$ 114.66	\$ 114.66
1	21 - 44	Female	\$ 368.27	\$ 368.27
1	21 - 44	Male	\$ 172.85	\$ 172.85
1	45 - 99	Male and Female	\$ 399.40	\$ 399.40
4	00 - 20	Male and Female	\$ 207.76	\$ 207.76
5	00 - 06	Male and Female	\$ 140.03	\$ 140.03
5	07 - 13	Male and Female	\$ 108.12	\$ 108.12
5	14 - 18	Male and Female	\$ 158.18	\$ 158.18

5.4 Central Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$ 581.95	\$ 581.95
1	01 - 06	Male and Female	\$ 126.99	\$ 126.99
1	07 - 13	Male and Female	\$ 103.08	\$ 103.08
1	14 - 20	Female	\$ 314.36	\$ 314.36
1	14 - 20	Male	\$ 123.65	\$ 123.65
1	21 - 44	Female	\$ 427.42	\$ 427.42
1	21 - 44	Male	\$ 194.98	\$ 194.98
1	45 - 99	Male and Female	\$ 416.76	\$ 416.76
4	00 - 20	Male and Female	\$ 207.15	\$ 207.15
5	00 - 06	Male and Female	\$ 162.54	\$ 162.54
5	07 - 13	Male and Female	\$ 124.27	\$ 124.27
5	14 - 18	Male and Female	\$ 178.45	\$ 178.45



STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
CONTRACT AMENDMENT

AMENDMENT NO.: 004
CONTRACT NO.: C306118003
TITLE: Medicaid Managed Care — Central, Eastern, and Western Regions
ISSUE DATE: 02/23/07

REQ NO.: NR 886 25757006928
BUYER: Laura Ortmeier
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeier@oa.mo.gov

TO: MERCY CAREPLUS
10123 CORPORATE SQUARE DR
ST LOUIS, MO 63132

RETURN AMENDMENT NO LATER THAN: March 7, 2007 AT 5:00 PM CENTRAL TIME

RETURN AMENDMENT TO:

(U.S. Mail)
Div of Purchasing & Matls Mgt (DPMM)
PO BOX 809
JEFFERSON CITY MO 65102-0809

OR

(Courier Service)
Div of Purchasing & Matls Mgt (DPMM)
301 WEST HIGH STREET, ROOM 630
JEFFERSON CITY MO 65101

OR FAX TO: (573) 526-9817 (either mail or fax, not both)

DELIVER SUPPLIES/SERVICES FOB (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Missouri Department of Social Service
Division of Medical Services
P.O. Box 6500
Jefferson City, MO 65102-6500

SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME

Mercy CarePlus
MAILING ADDRESS

10123 Corporate Square Drive
CITY, STATE, ZIP CODE

St. Louis, MO 63132

CONTACT PERSON

Jerry Linder
PHONE NUMBER

(314) 432-9300 Ext. 202

LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID NO.

Alliance for Community Health, LLC
IRS FORM 1099 MAILING ADDRESS

10123 Corporate Square Drive
CITY, STATE, ZIP CODE

St. Louis, MO 63132

EMAIL ADDRESS

jlinder@mercyplus.com
FAX NUMBER

(314)432-9203 or (314) 994-9398

TAXPAYER ID NUMBER (TIN)

43-1743902

TAXPAYER ID (TIN) TYPE (CHECK ONE)

☒ FEIN ☐ SSN

VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)

☒ Corporation ☐ Individual ☐ State/Local Government ☐ Partnership

VENDOR NUMBER(IF- KNOWN)

4317439020 2

(NOTE: LLC IS NOT A VALID TAX FILING TYPE.)

☐ Sole Proprietor ☐ Other_____

AUTHORIZED SIGNATURE

/s/ Jerry Linder
PRINTED NAME

Jerry Linder

DATE

February 27, 2007
TITLE

Chief Executive Officer — President

AMENDMENT #004 TO CONTRACT C306118003

CONTRACT TITLE: Medicaid Managed Care — Central, Eastern, and Western Regions

CONTRACT PERIOD: July 1, 2006 through June 30, 2007

The State of Missouri hereby desires to amend the above-referenced contract in accordance with the following:

1. Paragraph 2.4.8 a. 2) is hereby amended effective January 1, 2007:

- 2) The health plan shall pay out-of-network providers for emergency services at the current Missouri Medicaid program rates in effect at the time of service.

2. Paragraph 2.28.1 b. is hereby amended effective July 1, 2006:

- b. If the health plan is new to a MC+ managed care region, the health plan shall agree that its capitation rate shall reflect the average participant ratio of the MC+ managed care health plans that are not new to the region by rate cell and category of assistance for the applicable measurement period reflected in Attachment 11. Beginning January 2008, the new health plan shall agree that their future capitation rates shall be adjusted by the health plan's actual 12-month HCY/EPSTD participant ratio.

All other terms, conditions and provisions of the contract, including all prices, shall remain the same and apply hereto.

The contractor shall sign and return this document, on or before the date indicated, signifying acceptance of the amendment.

(SEAL)

NOTICE OF AWARD

**State Of Missouri
Office Of Administration
Division Of Purchasing And Materials Management
PO Box 809
Jefferson City, MO 65102
<http://www.oa.mo.gov/purch>**

CONTRACT NUMBER

C306118003

AMENDMENT NUMBER

005

REQUISITION NUMBER

MR 886 25757008216

CONTRACTOR NAME AND ADDRESS

Mercy Careplus
10123 Corporate Square Dr
St. Louis, MO 63132

CONTRACT TITLE

Medicaid Managed Care-Central, Eastern, and Western Regions

CONTRACT PERIOD

July 1, 2007 through June 30, 2008

VENDOR NUMBER

4317439020 2

STATE AGENCY'S NAME AND ADDRESS

Department of Social Services
Division of Medical Services
Jefferson City, MO 65102-6500 PO Box 6500

ACCEPTED BY THE STATE OF MISSOURI AS FOLLOWS:

Contract C306118003 is hereby amended pursuant to the attached Amendment #005 dated April 16, 1007.

BUYER

Laura Ortmeyer

SIGNATURE OF BUYER

/s/ Laura Ortmeyer

BUYER CONTACT INFORMATION

Email: laura.ortmeyer@oa.mo.gov

Phone: (573) 751-4579

Fax: (573)526-9817

DATE

April 24, 2007

DIRECTOR OF PURCHASING AND MATERIALS MANAGEMENT

/s/ James Milvsk

(SEAL) STATE OF MISSOURI
OFFICE OF ADMINISTRATION
DIVISION OF PURCHASING AND MATERIALS MANAGEMENT (DPMM)
CONTRACT RENEWAL

AMENDMENT NO.: 005
CONTRACT NO.: C306118003
TITLE: Medicaid Managed Care — Central, Eastern, and Western Regions
ISSUE DATE: 04/10/07
REQ NO.: NR 886 25757008216
BUYER: Laura Ortmeier
PHONE NO.: (573) 751-4579
E-MAIL: laura.ortmeyer@oa.mo.gov

TO: MERCY CAREPLUS
10123 CORPORATE SQUARE DR
ST LOUIS MO 63132

RETURN AMENDMENT NO LATER THAN: 04/24/07 AT 5:00 PM CENTRAL TIME

RETURN AMENDMENT TO:

(U.S. Mail)		(Courier Service)
Div of Purchasing & Matls Mgt (DPMM)	<u>OR</u>	Div of Purchasing & Matls Mgt (DPMM)
PO BOX 809		301 WEST HIGH STREET, ROOM 630
JEFFERSON CITY MO 65102-0809		JEFFERSON CITY MO 65101

OR FAX TO: (573) 526-9817 (either mail or fax, not both)

DELIVER SUPPLIES/SERVICES FOR (Free On Board) DESTINATION TO THE FOLLOWING ADDRESS:

Department of Social Services
Division of Medical Services
PO Box 6500
Jefferson City MO 65102-6500
SIGNATURE REQUIRED

DOING BUSINESS AS (DBA) NAME	LEGAL NAME OF ENTITY/INDIVIDUAL FILED WITH IRS FOR THIS TAX ID NO.
------------------------------	--

Mercy CarePlus	Alliance for Community Health, LLC dba Mercy CarePlus
----------------	---

MAILING ADDRESS	IRS FORM 1099 MAILING ADDRESS
-----------------	-------------------------------

10123 Corporate Square Drive CITY, STATE, ZIP CODE	10123 Corporate Square Drive CITY, STATE, ZIP CODE
---	---

St. Louis, MO 63132 CONTACT PERSON	St. Louis, MO 63132 EMAIL ADDRESS
---------------------------------------	--------------------------------------

Jerry Linder PHONE NUMBER	jlinder@mercyplus.com FAX NUMBER
------------------------------	-------------------------------------

(314) 432-9300 ext. 202	(314) 994-9389
-------------------------	----------------

TAXPAYER ID NUMBER (TIN)	TAXPAYERID (TIN) TYPE (CHECK ONE)	VENDOR NUMBER (IF KNOWN)
--------------------------	-----------------------------------	--------------------------

43-1743902	<input checked="" type="checkbox"/> FEIN <input type="checkbox"/> SSN	4317439020 2
VENDOR TAX FILING TYPE WITH IRS (CHECK ONE)		(NOTE: LLC IS NOT A VALID TAX FILING TYPE.)

☒ Corporation ☐ Individual ☐ State/Local Government ☐ Partnership ☐ Sole Proprietor ☐ Other _____

AUTHORIZED SIGNATURE	DATE
----------------------	------

/s/ Jerry Linder PRINTED NAME	4-16-07 TITLE
----------------------------------	------------------

Jerry Linder	CEO
--------------	-----

AMENDMENT #005 TO CONTRACT C306118003

CONTRACT TITLE: Medicaid Managed Care — Central, Eastern, and Western Regions

CONTRACT PERIOD: July 1, 2007 through June 30, 2008

The State of Missouri hereby exercises its option to renew the above-referenced contract.

The contractor shall indicate in Column 2 on the attached Pricing page, any changes to the firm, fixed prices of the contract for performing the required services in accordance with the terms, conditions, and provisions of the contract. The contractor's firm, fixed PMPM Net Capitation Rate for Each Category of Aid (COA) Rate subgroup must not exceed the State's Maximum Net Capitation Rate listed in Column 1.

The contractor must furnish a **performance security deposit** in accordance with the terms and conditions stated in the original contract in the amount of \$1,000,000.00 for each region. The **performance security deposit** must specify the contract number and contract period.

All other terms, conditions and provisions of the previous contract period shall remain and apply hereto. The contractor shall sign and return this document, along with completed pricing and the applicable bond, on or before the date indicated.

NOTE: The contractor's failure to complete and return this document shall not stop the action specified herein. If the contractor fails to complete and return this document prior to the return date specified or the effective date of the contract period stated above, whichever is later, the state may renew the contract at the same price(s) as the previous contract period or at the price(s) allowed by the contract, whichever is lower.

5.3 East Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	Column 1	Column 2
			State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$ 863.53	\$ 863.53
1	01 - 06	Male and Female	\$ 125.55	\$ 125.55
1	07 - 13	Male and Female	\$ 98.44	\$ 98.44
1	14 - 20	Female	\$ 306.93	\$ 306.93
1	14 - 20	Male	\$ 126.73	\$ 126.73
1	21 - 44	Female	\$ 418.80	\$ 418.80
1	21 - 44	Male	\$ 191.64	\$ 191.64
1	45 - 99	Male and Female	\$ 436.77	\$ 436.77
4	00 - 20	Male and Female	\$ 233.97	\$ 233.97
5	00 - 06	Male and Female	\$ 152.68	\$ 152.68
5	07 - 13	Male and Female	\$ 117.88	\$ 117.88
5	14 - 18	Male and Female	\$ 175.38	\$ 175.38

5.2 West Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	Column 1	Column 2
			State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$ 758.67	\$ 758.67
1	01 - 06	Male and Female	\$ 147.55	\$ 147.55
1	07 - 13	Male and Female	\$ 119.08	\$ 119.08
1	14 - 20	Female	\$ 312.64	\$ 312.64
1	14 - 20	Male	\$ 149.02	\$ 149.02
1	21 - 44	Female	\$ 469.35	\$ 469.35
1	21 - 44	Male	\$ 229.66	\$ 229.66
1	45 - 99	Male and Female	\$ 447.06	\$ 447.06
4	00 - 20 JC		\$ 284.16	\$ 284.16
4	00 - 20 OSJC	Male and Female	\$ 230.99	\$ 230.99
5	00 - 06	Male and Female	\$ 177.17	\$ 177.17
5	07 - 13	Male and Female	\$ 142.71	\$ 142.71
5	14 - 18	Male and Female	\$ 191.75	\$ 191.75

5.4 Central Region — Firm Fixed Net Capitation Pricing Page

Category of Aid	Age	Sex	Column 1	Column 2
			State's Maximum Net Capitation Rate (Per Member Per Month)	Firm Fixed Net Capitation Rate (Per Member Per Month)
1	Newborn < 01	Male and Female	\$ 687.17	\$ 687.17
1	01 - 06	Male and Female	\$ 143.61	\$ 143.61
1	07 - 13	Male and Female	\$ 116.00	\$ 116.00
1	14 - 20	Female	\$ 340.24	\$ 340.24
1	14 - 20	Male	\$ 144.98	\$ 144.98
1	21 - 44	Female	\$ 483.82	\$ 483.82
1	21 - 44	Male	\$ 230.15	\$ 230.15
1	45 - 99	Male and Female	\$ 470.57	\$ 470.57
4	00 - 20	Male and Female	\$ 227.94	\$ 227.94
5	00 - 06	Male and Female	\$ 175.25	\$ 175.25
5	07 - 13	Male and Female	\$ 134.72	\$ 134.72
5	14 - 18	Male and Female	\$ 193.45	\$ 193.45

Contract with Eligible Medicare Advantage (MA) Organization Pursuant to
Sections 1851 through 1859 of the Social Security Act for the Operation
of a Medicare Advantage Coordinated Care Plan(s)

CONTRACT (# _____)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

(hereinafter referred to as the MA Organization)

CMS and the MA Organization, an entity which has been determined to be an eligible Medicare Advantage Organization by the Administrator of the Centers for Medicare & Medicaid Services under 42 CFR 422.503, agree to the following for the purposes of sections 1851 through 1859 of the Social Security Act (hereinafter referred to as the Act):

(NOTE: Citations indicated in brackets are placed in the text of this contract to note the regulatory authority for certain contract provisions. All references to Part 422 are to 42 CFR Part 422.)

You must check off AND initial each required Addendum type to reflect the coverage offered under the H (or R) number associated with this contract

Addendum Type	Initials
<input type="checkbox"/> Part D Addendum	_____
<input type="checkbox"/> Employer-Only MA-PD Addendum (800 Series)	_____
<input type="checkbox"/> Employer-Only MA Only Addendum (800 Series)	_____
<input type="checkbox"/> Variances/Waivers (Provided directly to Demonstration Organizations by CMS)	_____
<input type="checkbox"/> Regional Preferred Provider Organization Addendum (Provided directly to RPPOs by CMS)	_____

Article I

Term of Contract

The term of this contract shall be from the date of signature by CMS' authorized representative through December 31, 2007, after which this contract may be renewed for successive one-year periods in accordance with 42 CFR 422.505(c) and as discussed in Paragraph A in Article VII below. **[422.505]**

This contract governs the respective rights and obligations of the parties as of the effective date set forth above, and supersedes any prior agreements between the MA Organization and CMS as of such date. MA organizations offering Part D also must execute an Addendum to the Medicare Managed Care Contract Pursuant to Sections 1860D-1 through 1860D-42 of the Social Security Act for the Operation of a Voluntary Medicare Prescription Drug Plan (hereafter the "Part D Addendum"). For MA Organizations offering MA-PD plans, the Part D Addendum governs the rights and obligations of the parties relating to the provision of Part D benefits, in accordance with its terms, as of its effective date.

Article II

Coordinated Care Plan

A. The Medicare Advantage Organization agrees to operate one or more coordinated care plans as defined in 42 CFR 422.4(a)(1)(iii)), including at least one MA-PD plan as required under 42 CFR 422.4(c), as described in its final Plan Benefit Package (PBP) bid submission (benefit and price bid) proposal as approved by CMS and as attested to in the Medicare Advantage Attestation of Benefit Plan and Price, and in compliance with the requirements of this contract and applicable Federal statutes, regulations, and policies.

B. Except as provided in paragraph (C) of this Article, this contract is deemed to incorporate any changes that are required by statute to be implemented during the term of the contract and any regulations or policies implementing or interpreting such statutory provisions.

C. CMS will not implement, other than at the beginning of a calendar year, requirements under 42 CFR Part 422 that impose a new significant cost or burden on MA organizations or plans, unless a different effective date is required by statute. **[422.521]**

Article III

Functions To Be Performed By Medicare Advantage Organization

A. PROVISION OF BENEFITS

1. The MA Organization agrees to provide enrollees in each of its MA plans the basic benefits as required under §422.101 and, to the extent applicable, supplemental benefits under §422.102 and as established in the MA Organization's final benefit and price bid proposal as approved by CMS and listed in the MA Organization Plan Attestation of Benefit Plan and Price, which is attached to this contract. The MA Organization agrees to provide access to such benefits as

required under subpart C in a manner consistent with professionally recognized standards of health care and according to the access standards stated in §422.112.

2. The MA Organization agrees to provide post-hospital extended care services, should an MA enrollee elect such coverage, through a skilled nursing home facility according to the requirements of section 1852(1) of the Act and §422.133. A skilled nursing home facility is a facility in which an MA enrollee resided at the time of admission to the hospital, a facility that provides services through a continuing care retirement community, a facility in which the spouse of the enrollee is residing at the time of the enrollee's discharge from the hospital, or hospital, or wherever the enrollee resides immediately before admission for extended care services. **[422.133; 422.504(a)(3)]**

B. ENROLLMENT REQUIREMENTS

1. The MA Organization agrees to accept new enrollments, make enrollments effective, process voluntary disenrollments, and limit involuntary disenrollments, as provided in subpart B of part 422,

2. The MA Organization shall comply with the provisions of §422.110 concerning prohibitions against discrimination in beneficiary enrollment, other than in enrolling eligible beneficiaries in a CMA-approved special needs plan that exclusively enrolls special needs individuals as consistent with §§422.2,422.4(a)(1)(iv) and 422.52. **[422.504(a)(2)]**

C. BENEFICIARY PROTECTIONS

1. The MA Organization agrees to comply with all requirements in subpart M of part 422, governing coverage determinations, grievances, and appeals. **[422.504(a)(7)]**

2. The MA Organization agrees to comply with the confidentiality and enrollee record accuracy requirements in §422.118.

3. Beneficiary Financial Protections. The MA Organization agrees to comply with the following requirements:

(a) Each MA Organization must adopt and maintain arrangements satisfactory to CMS to protect its enrollees from incurring liability for payment of any fees that are the legal obligation of the MA Organization. To meet this requirement the MA Organization must—

(i) Ensure that all contractual or other written arrangements with providers prohibit the Organization's providers from holding any beneficiary enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(ii) Indemnify the beneficiary enrollee for payment of any fees that are the legal obligation of the MA Organization for services furnished by providers that do not contract, or that have not otherwise entered into an agreement with the MA Organization, to provide services to the organization's beneficiary enrollees. **[422.504(g)(1)]**

(b) The MA Organization must provide for continuation of enrollee health care benefits-

(i) For all enrollees, for the duration of the contract period for which CMS payments have been made; and

(ii) For enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of the MA Organization's insolvency, through the date of discharge. **[422.504(g)(2)]**

(c) In meeting the requirements of this section (C), other than the provider contract requirements specified in paragraph (C)(3)(a) of this Article, the MA Organization may use—

- (i) Contractual arrangements;
- (ii) Insurance acceptable to CMS;
- (iii) Financial reserves acceptable to CMS; or
- (iv) Any other arrangement acceptable to CMS. **[422.504(g)(3)]**

D. PROVIDER PROTECTIONS

1. The MA Organization agrees to comply with all applicable provider requirements in 42 CFR Part 422 Subpart E, including provider certification requirements, anti-discrimination requirements, provider participation and consultation requirements, the prohibition on interference with provider advice, limits on provider indemnification, rules governing payments to providers, and limits on physician incentive plans. **[422.504(a)(6)]**

2. Prompt Payment.

(a) The MA Organization must pay 95 percent of “clean claims” within 30 days of receipt if they are claims for covered services that are not furnished under a written agreement between the organization and the provider.

(i) The MA Organization must pay interest on clean claims that are not paid within 30 days in accordance with sections 1816(c)(2) and 1842(c)(2) of the Act.

(ii) All other claims from non-contracted providers must be paid or denied within 60 calendar days from the date of the request **[422.520(a)]**

(b) Contracts or other written agreements between the MA Organization and its providers must contain a prompt payment provision, the terms of which are developed and agreed to by both the MA Organization and the relevant provider. **[422.520(b)]**

(c) If CMS determines, after giving notice and opportunity for hearing, that the MA Organization has failed to make payments in accordance with subparagraph (2)(a) of this section, CMS may provide—

(i) For direct payment of the sums owed to providers; and

(ii) For appropriate reduction in the amounts that would otherwise be paid to the MA Organization, to reflect the amounts of the direct payments and the cost of making those payments. **[422.520(c)]**

E. QUALITY IMPROVEMENT PROGRAM

1. The MA Organization agrees to operate, for each plan that it offers, an ongoing quality improvement program as stated in accordance with Section 1852(e) of the Social Security Act and 42 CFR 422.152.

2. Chronic Care Improvement Program

(a) Each MA organization (other than MA private-fee-for-service plans) must have a chronic care improvement program and must establish criteria for participation in the program. The CCIP must have a method for identifying enrollees with multiple or sufficiently severe chronic conditions who meet the criteria for participation in the program and a mechanism for monitoring enrollees’ participation in the program.

(b) Plans have flexibility to choose the design of their program; however, in addition to meeting the requirements specified above, the CCIP selected must be relevant to the plan’s MA

population. MA organizations are required to submit annual reports on their CCIP program to CMS.

3. Performance Measurement and Reporting: The MA Organization shall measure performance under its MA plans using standard measures required by CMS, and report (at the organization level) its performance to CMS. The standard measures required by CMS during the term of this contract will be uniform data collection and reporting instruments, to include the Health Plan and Employer Data Information Set (HEDIS), Consumer Assessment of Health Plan Satisfaction (CAHPS) survey, and Health Outcomes Survey (HOS). These measures will address clinical areas, including effectiveness of care, enrollee perception of care and use of services; and non-clinical areas including access to and availability of services, appeals and grievances, and organizational characteristics. **[422.152(b)(1), (e)]**

4. Utilization Review:

(a) An MA Organization for an MA coordinated care plan must use written protocols for utilization review and policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and have in effect mechanisms to detect both underutilization and over utilization of services. **[422.152(b)]**

(b) For MA regional preferred provider organizations (RPPOs) and MA local preferred provider organizations (PPOs) that are offered by an organization that is not licensed or organized under State law as an HMOs, if the MA Organization uses written protocols for utilization review, those policies and procedures must reflect current standards of medical practice in processing requests for initial or continued authorization of services and include mechanisms to evaluate utilization of services and to inform enrollees and providers of services of the results of the evaluation. **[422.152(e)]**

5. Information Systems:

(a) The MA Organization must:

- (i) Maintain a health information system that collects, analyzes and integrates the data necessary to implement its quality improvement program;
- (ii) Ensure that the information entered into the system (particularly that received from providers) is reliable and complete;
- (iii) Make all collected information available to CMS. **[422.152(f)(1)]**

6. External Review

The MA Organization will comply with any requests by Quality Improvement Organizations to review the MA Organization's medical records in connection with appeals of discharges from hospitals, skilled nursing facilities, and home health agencies.

F. COMPLIANCE PLAN

The MA Organization agrees to implement a compliance plan in accordance with the requirements of §422.503(b)(4)(vi). **[422.503(b)(4)(vi)]**

G. COMPLIANCE DEEMED ON THE BASIS OF ACCREDITATION

CMS may deem the MA Organization to have met the quality improvement requirements of §1852(e) of the Act and §422.152, the confidentiality and accuracy of enrollee records requirements of §1852(h) of the Act and §422.118, the anti-discrimination requirements of §1852(b) of the Act and §422.110, the access to services requirements of §1852(d) of the Act and §422.112, and the advance directives requirements of §1852(i) of the Act and §422.128, the

provider participation requirements of § 1852(j) of the Act and 42 CFR Part 422, Subpart F, and the applicable requirements described in §423.165, if the MA Organization is fully accredited (and periodically reaccredited) by a private, national accreditation organization approved by CMS and the accreditation organization used the standards approved by CMS for the purposes of assessing the MA Organization's compliance with Medicare requirements. The provisions of §422.156 shall govern the MA Organization's use of deemed status to meet MA program requirements.

H. PROGRAM INTEGRITY

1. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS of any integrity items related to payments from governmental entities, both federal and state, for healthcare or prescription drug services. These items include any investigations, legal actions or matters subject to arbitration brought involving the MA Organization (or MA Organization's firm if applicable) and its subcontractors (excluding contracted network providers), including any key management or executive staff, or any major shareholders (5% or more), by a government agency (state or federal) on matters relating to payments from governmental entities, both federal and state, for healthcare and/or prescription drug services. In providing the notice, the sponsor shall keep the government informed of when the integrity item is initiated and when it is closed. Notice should be provided of the details concerning any resolution and monetary payments as well as any settlement agreements or corporate integrity agreements.

2. The MA Organization agrees to provide notice based on best knowledge, information, and belief to CMS in the event the MA Organization or any of its subcontractors is criminally convicted or has a civil judgment entered against it for fraudulent activities or is sanctioned under any Federal program involving the provision of health care or prescription drug services.

I. MARKETING

1. The MA Organization may not distribute any marketing materials, as defined in 42 CFR 422.80(b) and in the Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans and Prescription Drug Plans (Medicare Marketing Guidelines), unless they have been filed with and not disapproved by CMS in accordance with §422.80. The file and use process set out at §422.80(a)(2) must be used, unless the MA organization notifies CMS that it will not use this process.

2. CMS and the MA Organization shall agree upon language setting forth the benefits, exclusions and other language of the Plan. The MA Organization bears full responsibility for the accuracy of its marketing materials. CMS, in its sole discretion, may order the MA Organization to print and distribute the agreed upon marketing materials, in a format approved by CMS. The MA Organization must disclose the information to each enrollee electing a plan as outlined in 42 CFR 422.111.

3. The MA Organization agrees that any advertising material, including that labeled promotional material, marketing materials, or supplemental literature, shall be truthful and not misleading. All marketing materials must include the Contract number. All membership identification cards must include the Contract number on the front of the card.

4. The MA Organization must comply with the Medicare Marketing Guidelines, as well as all applicable statutes and regulations, including and without limitation Section 1851(h) of the Act

and 42 CFR §§422.80, 422.111 and 423.50. Failure to comply may result in sanctions as provided in 42 CFR Part 422 Subpart O.

Article IV

CMS Payment to MA Organization

A. The MA Organization agrees to develop its annual benefit and price bid proposal and submit to CMS all required information on premiums, benefits, and cost sharing, as required under 42 CFR Part 422 Subpart F. **[422.504(a)(10)]**

B. Methodology. CMS agrees to pay the MA Organization under this contract in accordance with the provisions of section 1853 of the Act and 42 CFR Part 422 Subpart G. **[422.504(a)(9)]**

C. Attestation of payment data (Attachments A, B, and C).

As a condition for receiving a monthly payment under paragraph B of this article, and 42 CFR Part 422 Subpart G, the MA Organization agrees that its chief executive officer (CEO), chief financial officer (CFO), or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must request payment under the contract on the forms attached hereto as Attachment A (enrollment attestation) and Attachment B (risk adjustment data) which attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data identified on these attachments. The Medicare Advantage Plan Attestation of Benefit Plan and Price must be signed and attached to the executed version of this contract.

1. Attachment A requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest based on best knowledge, information, and belief that each enrollee for whom the MA Organization is requesting payment is validly enrolled, or was validly enrolled during the period for which payment is requested, in an MA plan offered by the MA Organization. The MA Organization shall submit completed enrollment attestation forms to CMS, or its contractor, on a monthly basis. (NOTE: The forms included as attachments to this contract are for reference only. CMS will provide instructions for the completion and submission of the forms in separate documents. MA Organizations should not take any action on the forms until appropriate CMS instructions become available.)

2. Attachment B requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest to *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the risk adjustment data it submits to CMS under §422.310 are accurate, complete, and truthful. The MA Organization shall make annual attestations to this effect for risk adjustment data on Attachment B and according to a schedule to be published by CMS. If such risk adjustment data are generated by a related entity, contractor, or subcontractor of an MA Organization, such entity, contractor, or subcontractor must similarly attest to *(based on best knowledge, information, and belief, as of the date specified on the attestation form)* the accuracy, completeness, and truthfulness of the data. **[422.504(1)]**

3. The Medicare Advantage Plan Attestation of Benefit Plan and Price (which is attached hereto) requires that the CEO, CFO, or an individual delegated with the authority to sign on behalf of one of these officers, and who reports directly to such officer, must attest *(based on best knowledge, information and belief, as of the date specified on the attestation form)* that the information and documentation comprising the bid submission proposal is accurate, complete, and truthful and fully conforms to the Bid Form and Plan Benefit Package requirements; and that the benefits described in the CMS-approved proposal bid submission agree with the benefit package the MA Organization will offer during the period covered by the proposal bid submission. This document is being sent separately to the MA Organization and must be signed and attached to the executed version of this contract, and is incorporated herein by reference. **[422.502(1)]**

Article V

MA Organization Relationship with Related Entities, Contractors, and Subcontractors

A. Notwithstanding any relationship(s) that the MA Organization may have with related entities, contractors, or subcontractors, the MA Organization maintains full responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS. **[422.504(i)(1)]**

B. The MA Organization agrees to require all related entities, contractors, or subcontractors to agree that—

(1) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent contracts, books, documents, papers, and records of the related entity(s), contractor(s), or subcontractor(s) involving transactions related to this contract; and

(2) HHS, the Comptroller General, or their designees have the right to inspect, evaluate, and audit any pertinent information for any particular contract period for 10 years from the final date of the contract period or from the date of completion of any audit, whichever is later.

[422.504(i)(2)]

C. The MA Organization agrees that all contracts or written arrangements into which the MA Organization enters with providers, related entities, contractors, or subcontractors (first tier and downstream entities) shall contain the following elements:

(1) Enrollee protection provisions that provide—

(a) Consistent with Article III(C), arrangements that prohibit providers from holding an enrollee liable for payment of any fees that are the legal obligation of the MA Organization; and

(b) Consistent with Article III(C), provision for the continuation of benefits.

(2) Accountability provisions that indicate that the MA Organization may only delegate activities or functions to a provider, related entity, contractor, or subcontractor in a manner consistent with requirements set forth at paragraph D of this article.

(3) A provision requiring that any services or other activity performed by a related entity, contractor or subcontractor in accordance with a contract or written agreement between the related entity, contractor, or subcontractor and the MA Organization will be consistent and comply with the MA Organization's contractual obligations to CMS. **[422.504(i)(3)]**

D. If any of the MA Organization's activities or responsibilities under this contract with CMS is delegated to other parties, the following requirements apply to any related entity, contractor, subcontractor, or provider:

(1) Written arrangements must specify delegated activities and reporting responsibilities.

(2) Written arrangements must either provide for revocation of the delegation activities and reporting requirements or specify other remedies in instances where CMS or the MA Organization determine that such parties have not performed satisfactorily.

(3) Written arrangements must specify that the performance of the parties is monitored by the MA Organization on an ongoing basis.

(4) Written arrangements must specify that either—

(a) The credentials of medical professionals affiliated with the party or parties will be either reviewed by the MA Organization; or

(b) The credentialing process will be reviewed and approved by the MA Organization and the MA Organization must audit the credentialing process on an ongoing basis.

(5) All contracts or written arrangements must specify that the related entity, contractor, or subcontractor must comply with all applicable Medicare laws, regulations, and CMS instructions. **[422.504(i)(4)]**

E. If the MA Organization delegates selection of the providers, contractors, or subcontractors to another organization, the MA Organization's written arrangements with that organization must state that the MA Organization retains the right to approve, suspend, or terminate any such arrangement. **[422.504(i)(5)]**

F. As of the date of this contract and throughout its term, the MA Organization

(1) Agrees that any physician incentive plan it operates meets the requirements of §422.208, and

(2) Has assured that all physicians and physician groups that the MA Organization's physician incentive plan places at substantial financial risk have adequate stop-loss protection in accordance with §422.208(f). **[422.208]**

Article VI
Records Requirements

A. MAINTENANCE OF RECORDS

1. The MA Organization agrees to maintain for 10 years books, records, documents, and other evidence of accounting procedures and practices that—

(a) Are sufficient to do the following:

(i) Accommodate periodic auditing of the financial records (including data related to Medicare utilization, costs, and computation of the benefit and price bid) of the MA Organization.

(ii) Enable CMS to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, and the facilities of the MA Organization.

(iii) Enable CMS to audit and inspect any books and records of the MA Organization that pertain to the ability of the organization to bear the risk of potential financial losses, or to services performed or determinations of amounts payable under the contract.

(iv) Properly reflect all direct and indirect costs claimed to have been incurred and used in the preparation of the benefit and price bid proposal.

(v) Establish component rates of the benefit and price bid for determining additional and supplementary benefits.

(vi) Determine the rates utilized in setting premiums for State insurance agency purposes and for other government and private purchasers; and

(b) Include at least records of the following:

(i) Ownership and operation of the MA Organization's financial, medical, and other record keeping systems.

(ii) Financial statements for the current contract period and six prior periods.

(iii) Federal income tax or informational returns for the current contract period and six prior periods.

(iv) Asset acquisition, lease, sale, or other action.

(v) Agreements, contracts (including, but not limited to, with related or unrelated prescription drug benefit managers) and subcontracts.

(vi) Franchise, marketing, and management agreements.

(vii) Schedules of charges for the MA Organization's fee-for-service patients.

(viii) Matters pertaining to costs of operations.

(ix) Amounts of income received, by source and payment.

(x) Cash flow statements.

(xi) Any financial reports filed with other Federal programs or State authorities. **[422.504(d)]**

2. Access to facilities and records. The MA Organization agrees to the following:

(a) The Department of Health and Human Services (HHS), the Comptroller General, or their designee may evaluate, through inspection or other means—

(i) The quality, appropriateness, and timeliness of services furnished to Medicare enrollees under the contract;

(ii) The facilities of the MA Organization; and

(iii) The enrollment and disenrollment records for the current contract period and ten prior periods.

(b) HHS, the Comptroller General, or their designees may audit, evaluate, or inspect any books, contracts, medical records, documents, papers, patient care documentation, and other records of the MA Organization, related entity, contractor, subcontractor, or its transferee that pertain to any aspect of services performed, reconciliation of benefit liabilities, and determination of amounts payable under the contract, or as the Secretary may deem necessary to enforce the contract.

(c) The MA Organization agrees to make available, for the purposes specified in section (A) of this article, its premises, physical facilities and equipment, records relating to its Medicare enrollees, and any additional relevant information that CMS may require, in a manner that meets CMS record maintenance requirements.

(d) HHS, the Comptroller General, or their designee's right to inspect, evaluate, and audit extends through 10 years from the final date of the contract period or completion of audit, whichever is later unless-

(i) CMS determines there is a special need to retain a particular record or group of records for a longer period and notifies the MA Organization at least 30 days before the normal disposition date;

(ii) There has been a termination, dispute, or fraud or similar fault by the MA Organization, in which case the retention may be extended to 10 years from the date of any resulting final resolution of the termination, dispute, or fraud or similar fault; or

(iii) HHS, the Comptroller General, or their designee determines that there is a reasonable possibility of fraud, in which case they may inspect, evaluate, and audit the MA Organization at any time. **[422.504(e)]**

B. REPORTING REQUIREMENTS

1. The MA Organization shall have an effective procedure to develop, compile, evaluate, and report to CMS, to its enrollees, and to the general public, at the times and in the manner that CMS requires, and while safeguarding the confidentiality of the doctor-patient relationship, statistics and other information as described in the remainder of this section (B). **[422.516(a)]**

2. The MA Organization agrees to submit to CMS certified financial information that must include the following:

(a) Such information as CMS may require demonstrating that the organization has a fiscally sound operation, including:

(i) The cost of its operations;

(ii) A description, submitted to CMS annually and within 120 days of the end of the fiscal year, of significant business transactions (as defined in §422.500) between the MA Organization and a party in interest showing that the costs of the transactions listed in paragraph (2)(a)(v) of this section do not exceed the costs that would be incurred if these transactions were with someone who is not a party in interest; or

(iii) If they do exceed, a justification that the higher costs are consistent with prudent management and fiscal soundness requirements.

(iv) A combined financial statement for the MA Organization and a party in interest if either of the following conditions is met:

(aa) Thirty-five percent or more of the costs of operation of the MA Organization go to a party in interest.

(bb) Thirty-five percent or more of the revenue of a party in interest is from the MA Organization. **[422.516(b)]**

(v) Requirements for combined financial statements.

(aa) The combined financial statements required by paragraph (2)(a)(iv) must display in separate columns the financial information for the MA Organization and each of the parties in interest.

(bb) Inter-entity transactions must be eliminated in the consolidated column.

(cc) The statements must have been examined by an independent auditor in accordance with generally accepted accounting principles and must include appropriate opinions and notes.

(dd) Upon written request from the MA Organization showing good cause, CMS may waive the requirement that the organization's combined financial statement include the financial information required in paragraph (2)(a)(v) with respect to a particular entity. **[422.516(c)]**

(vi) A description of any loans or other special financial arrangements the MA Organization makes with contractors, subcontractors, and related entities.

(b) Such information as CMS may require pertaining to the disclosure of ownership and control of the MA Organization. **[422.504(f)(1)(ii)]**

(c) Patterns of utilization of the MA Organization's services.

3. The MA Organization agrees to participate in surveys required by CMS and to submit to CMS all information that is necessary for CMS to administer and evaluate the program and to simultaneously establish and facilitate a process for current and prospective beneficiaries to exercise choice in obtaining Medicare services. This information includes, but is not limited to:

(a) The benefits covered under the MA plan;

(b) The MA monthly basic beneficiary premium and MA monthly supplemental beneficiary premium, if any, for the plan.

(c) The service area and continuation area, if any, of each plan and the enrollment capacity of each plan;

(d) Plan quality and performance indicators for the benefits under the plan including —

(i) Disenrollment rates for Medicare enrollees electing to receive benefits through the plan for the previous 2 years;

(ii) Information on Medicare enrollee satisfaction;

(iii) The patterns of utilization of plan services;

(iv) The availability, accessibility, and acceptability of the plan's services;

(v) Information on health outcomes and other performance measures required by CMS;

(vi) The recent record regarding compliance of the plan with requirements of this part, as determined by CMS; and

(vii) Other information determined by CMS to be necessary to assist beneficiaries in making an informed choice among MA plans and traditional Medicare;

(e) Information about beneficiary appeals and their disposition;

(f) Information regarding all formal actions, reviews, findings, or other similar actions by States, other regulatory bodies, or any other certifying or accrediting organization;

(g) Any other information deemed necessary by CMS for the administration or evaluation of the Medicare program. **[422.504(f)(2)]**

4. The MA Organization agrees to provide to its enrollees and upon request, to any individual eligible to elect an MA plan, all informational requirements under §422.64 and, upon an enrollee's request, the financial disclosure information required under §422.516. **[422.504(f)(3)]**

5. Reporting and disclosure under ERISA.

(a) For any employees' health benefits plan that includes an MA Organization in its offerings, the MA Organization must furnish, upon request, the information the plan needs to fulfill its reporting and disclosure obligations (with respect to the MA Organization) under the Employee Retirement Income Security Act of 1974 (ERISA).

(b) The MA Organization must furnish the information to the employer or the employer's designee, or to the plan administrator, as the term "administrator" is defined in ERISA. **[422.516(d)]**

6. Electronic communication. The MA Organization must have the capacity to communicate with CMS electronically. **[422.504(b)]**

7. Risk Adjustment data. The MA Organization agrees to comply with the requirements in §422.310 for submitting risk adjustment data to CMS. **[422.504(a)(8)]**

Article VII

Renewal of the MA Contract

A. Renewal of contract: In accordance with §422.505, following the initial contract period, this contract is renewable annually only if-

- (1) The MA Organization has not provided CMS with a notice of intention not to renew; **[422.506(a)]**
- (2) CMS and the MA Organization reach agreement on the bid under 42 CFR Part 422, Subpart F; and **[422.505(d)]**
- (3) CMS informs the MA Organization that it authorizes a renewal.

B. Nonrenewal of contract

(1) Nonrenewal by the Organization.

(a) In accordance with §422.506, the MA Organization may elect not to renew its contract with CMS as of the end of the term of the contract for any reason, provided it meets the time frames for doing so set forth in subparagraphs (b) and (c) of this paragraph.

(b) If the MA Organization does not intend to renew its contract, it must notify—

- (i) CMS, in writing, by the first Monday in June of the year in which the contract would end, pursuant to §422.506
- (ii) Each Medicare enrollee, at least 90 days before the date on which the nonrenewal is effective. This notice must include a written description of all alternatives available for obtaining Medicare services within the service area including alternative MA plans, Medigap options, and original Medicare and prescription drug plans and must receive CMS approval prior to issuance.
- (iii) The general public, at least 90 days before the end of the current calendar year, by publishing a CMS-approved notice in one or more newspapers of general circulation in each community located in the MA Organization's service area.

- (c) CMS may accept a nonrenewal notice submitted after the applicable annual non-renewal notice deadline if —
- (i) The MA Organization notifies its Medicare enrollees and the public in accordance with subparagraph (1)(b)(ii) and (1)(b)(iii) of this section; and
 - (ii) Acceptance is not inconsistent with the effective and efficient administration of the Medicare program.
- (d) If the MA Organization does not renew a contract under subparagraph (1), CMS will not enter into a contract with the Organization for 2 years from the date of contract separation unless there are special circumstances that warrant special consideration, as determined by CMS. **[422.506(a)]**
- (2) CMS decision not to renew.
- (a) CMS may elect not to authorize renewal of a contract for any of the following reasons:
 - (i) The MA Organization's level of enrollment, growth in enrollment, or insufficient number of contracted providers is determined by CMS to threaten the viability of the organization under the MA program and or be an indicator of beneficiary dissatisfaction with the MA plan(s) offered by the organization.
 - (ii) For any of the reasons listed in §422.510(a) [Article VIII, section (B)(1)(a) of this contract], which would also permit CMS to terminate the contract.
 - (iii) The MA Organization has committed any of the acts in §422.752(a) that would support the imposition of intermediate sanctions or civil money penalties under 42 CFR Part 422 Subpart O.
 - (iv) The MA Organization did not submit a benefit and price bid or the benefit and price bid was not acceptable **[422.505(d)]**
 - (b) Notice. CMS shall provide notice of its decision whether to authorize renewal of the contract as follows:
 - (i) To the MA Organization by May 1 of the contract year, except in the event of (2)(a)(iv) above, for which notice will be sent by September 1.
 - (ii) To the MA Organization's Medicare enrollees by mail at least 90 days before the end of the current calendar year.
 - (iii) To the general public at least 90 days before the end of the current calendar year, by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.
 - (c) Notice of appeal rights. CMS shall give the MA Organization written notice of its right to reconsideration of the decision not to renew in accordance with § 422.644. **[422.506(b)]**
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Article VIII

Modification or Termination of the Contract

A. Modification or Termination of Contract by Mutual Consent

1. This contract may be modified or terminated at any time by written mutual consent.

(a) If the contract is modified by written mutual consent, the MA Organization must notify its Medicare enrollees of any changes that CMS determines are appropriate for notification within time frames specified by CMS. **[422.508(a)(2)]**

(b) If the contract is terminated by written mutual consent, except as provided in section (A)(2) of this Article, the MA Organization must provide notice to its Medicare enrollees and the general public as provided in section B(2)(b)(ii) and B(2)(b)(iii) of this Article. **[422.508(a)(1)]**

2. If this contract is terminated by written mutual consent and replaced the day following such termination by a new MA contract, the MA Organization is not required to provide the notice specified in section B of this article. **[422.508(b)]**

B. Termination of the Contract by CMS or the MA Organization

1. Termination by CMS.

(a) CMS may terminate a contract for any of the following reasons:

(i) The MA Organization has failed substantially to carry out the terms of its contract with CMS.

(ii) The MA Organization is carrying out its contract with CMS in a manner that is inconsistent with the effective and efficient implementation of 42 CFR Part 422.

(iii) CMS determines that the MA Organization no longer meets the requirements of 42 CFR Part 422 for being a contracting organization.

(iv) There is credible evidence that the MA Organization committed or participated in false, fraudulent or abusive activities affecting the Medicare program, including submission of false or fraudulent data.

(v) The MA Organization experiences financial difficulties so severe that its ability to make necessary health services available is impaired to the point of posing an imminent and serious risk to the health of its enrollees, or otherwise fails to make services available to the extent that such a risk to health exists.

(vi) The MA Organization substantially fails to comply with the requirements in 42 CFR Part 422 Subpart M relating to grievances and appeals.

(vii) The MA Organization fails to provide CMS with valid risk adjustment data as required under §422.310 and 423.329(b)(3).

(viii) The MA Organization fails to implement an acceptable quality improvement program as required under 42 CFR Part 422 Subpart D.

(ix) The MA Organization substantially fails to comply with the prompt payment requirements in §422.520.

(x) The MA Organization substantially fails to comply with the service access requirements in §422.112.

(xi) The MA Organization fails to comply with the requirements of §422.208 regarding physician incentive plans.

(xii) The MA Organization substantially fails to comply with the marketing requirements in 422.80.

(b) Notice. If CMS decides to terminate a contract for reasons other than the grounds specified in section (B)(l)(a) above, it will give notice of the termination as follows:

(i) CMS will notify the MA Organization in writing 90 days before the intended date of the termination.

(ii) The MA Organization will notify its Medicare enrollees of the termination by mail at least 30 days before the effective date of the termination.

(iii) The MA Organization will notify the general public of the termination at least 30 days before the effective date of the termination by publishing a notice in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(c) Immediate termination of contract by CMS.

(i) For terminations based on violations prescribed in paragraph (B)(l)(a)(v) of this article, CMS will notify the MA Organization in writing that its contract has been terminated effective the date of the termination decision by CMS. If termination is effective in the middle of a month, CMS has the right to recover the prorated share of the capitation payments made to the MA Organization covering the period of the month following the contract termination.

(ii) CMS will notify the MA Organization's Medicare enrollees in writing of CMS' decision to terminate the MA Organization's contract. This notice will occur no later than 30 days after CMS notifies the plan of its decision to terminate this contract. CMS will simultaneously inform the Medicare enrollees of alternative options for obtaining Medicare services, including alternative MA Organizations in a similar geographic area and original Medicare.

(iii) CMS will notify the general public of the termination no later than 30 days after notifying the MA Organization of CMS' decision to terminate this contract. This notice will be published in one or more newspapers of general circulation in each community or county located in the MA Organization's service area.

(d) Corrective action plan

(i) General. Before terminating a contract for reasons other than the grounds specified in section (B)(l)(a)(v) of this article, CMS will provide the MA Organization with reasonable opportunity, not to exceed time frames specified at 42 CFR Part 422 Subpart N, to develop and receive CMS approval of a corrective action plan to correct the deficiencies that are the basis of the proposed termination.

(ii) Exception. If a contract is terminated under section (B)(l)(a)(v) of this article, the MA Organization will not have the opportunity to submit a corrective action plan.

(e) Appeal rights. If CMS decides to terminate this contract, it will send written notice to the MA Organization informing it of its termination appeal rights in accordance with 42 CFR Part 422 Subpart N. **[422.510]**

2. Termination by the MA Organization

(a) Cause for termination. The MA Organization may terminate this contract if CMS fails to substantially carry out the terms of the contract.

(b) Notice. The MA Organization must give advance notice as follows:

(i) To CMS, at least 90 days before the intended date of termination. This notice must specify the reasons why the MA Organization is requesting contract termination.

(ii) To its Medicare enrollees, at least 60 days before the termination effective date. This notice must include a written description of alternatives available for obtaining Medicare services within the service area, including alternative MA and MA-PD plans, PDP plans, Medigap options, and original Medicare and must receive CMS approval.

(iii) To the general public at least 60 days before the termination effective date by publishing a CMS-approved notice in one or more newspapers of general circulation in each community or county located in the MA Organization's geographic area.

(c) Effective date of termination. The effective date of the termination will be determined by CMS and will be at least 90 days after the date CMS receives the MA Organization's notice of intent to terminate.

(d) CMS' liability. CMS' liability for payment to the MA Organization ends as of the first day of the month after the last month for which the contract is in effect, but CMS shall make payments for amounts owed prior to termination but not yet paid.

(e) Effect of termination by the organization. CMS will not enter into an agreement with the MA Organization for a period of two years from the date the Organization has terminated this contract, unless there are circumstances that warrant special consideration, as determined by CMS. **[422.512]**

Article IX

Requirements of Other Laws and Regulations

A. The MA Organization agrees to comply with—

(1) Federal laws and regulations designed to prevent or ameliorate fraud, waste, and abuse, including, but not limited to, applicable provisions of Federal criminal law, the False Claims Act (31 USC 3729 et seq.), and the anti-kickback statute (section 1128B(b) of the Act); and

(2) HIPAA administrative simplification rules at 45 CFR parts 160, 162, and 164. **[422.504(h)]**

B. The MA Organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS, notwithstanding any relationship(s) that the MA organization may have with related entities, contractors, or subcontractors. **[422.504(i)]**

C. In the event that any provision of this contract conflicts with the provisions of any statute or regulation applicable to an MA Organization, the provisions of the statute or regulation shall have full force and effect.

Article X

Severability

The MA Organization agrees that, upon CMS' request, this contract will be amended to exclude any MA plan or State-licensed entity specified by CMS, and a separate contract for any such excluded plan or entity will be deemed to be in place when such a request is made. **[422.504(k)]**

Article XI

Miscellaneous

A. Definitions. Terms not otherwise defined in this contract shall have the meaning given to such terms in 42 CFR Part 422.

B. Alteration to Original Contract Terms. The MA Organization agrees that it has not altered in any way the terms of this contract presented for signature by CMS. The MA Organization agrees that any alterations to the original text the MA Organization may make to this contract shall not be binding on the parties.

C. Approval to Begin Marketing and Enrollment. The MA Organization agrees that it must complete CMS operational requirements prior to receiving CMS approval to begin Part C marketing and enrollment activities. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform such functions on the MA Organization's Sponsor's behalf) and successfully demonstrating capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the MA Organization must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

D. Incorporation of Applicable Addenda. All addenda checked off and initialed on the cover sheet of this contract by the MA Organization are hereby incorporated by reference.

In witness whereof, the parties hereby execute this contract.

FOR THE MA ORGANIZATION

Printed Name

Title

Signature

Date

Organization

Address

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

David A. Lewis
Acting Director
Medicare Advantage Group
Center for Beneficiary Choices

Date

**ADDENDUM TO MEDICARE MANAGED CARE CONTRACT PURSUANT TO
SECTIONS 1860D-1 THROUGH 1860D-42 OF THE SOCIAL SECURITY ACT
FOR THE OPERATION OF A VOLUNTARY MEDICARE PRESCRIPTION
DRUG PLAN**

The Centers for Medicare & Medicaid Services (hereinafter referred to as “CMS”) and _____, a Medicare managed care organization (hereinafter referred to as the MA-PD Sponsor) agree to amend the contract *(INSERT “H” OR “R” NUMBER)* governing the MA-PD Sponsor’s operation of a Part C plan described in Section 1851(a)(2)(A) of the Social Security Act (hereinafter referred to as “the Act”) or a Medicare cost plan to include this addendum under which the MA-PD Sponsor shall operate a Voluntary Medicare Prescription Drug Plan pursuant to sections 1860D-1 through 1860D-42 (with the exception of section 1860D-22 and 1860D-31) of the Act.

This addendum is made pursuant to Subpart L of 42 CFR Part 417 (in the case of cost plan sponsors offering a Part D benefit) and Subpart K of 42 CFR Part 422 (in the case of an MA-PD Sponsor offering a Part C plan).

NOTE: For purposes of this addendum, unless otherwise noted, reference to an “MA-PD Sponsor” or “MA-PD Plan” is deemed to include a cost plan sponsor or a MA private fee-for-service contractor offering a Part D benefit.

Article I
Medicare Voluntary Prescription Drug Benefit

- A. The MA-PD Sponsor agrees to operate one or more Medicare Voluntary Prescription Drug Plans as described in its application and related materials, including but not limited to all the attestations contained therein and all supplemental guidance, for Medicare approval and in compliance with the provisions of this addendum, which incorporates in its entirety the Solicitation For Applications for New Medicare Advantage Prescription Drug Plan (MA-PD) Sponsors, released on January 24, 2006 [applicable to Medicare Part C contractors] or the Solicitation for Applications for New Cost Plan Sponsors, released on January 24, 2006 [applicable to Medicare cost plan contractors] (hereinafter collectively referred to as “the addendum”). The MA-PD Sponsor also agrees to operate in accordance with the regulations at 42 CFR §423.1 through 42 CFR §423.910 (with the exception of Subparts Q, R, and S), sections 1860D-1 through 1860D-42 (with the exception of sections 1860D-22(a) and 1860D-31) of the Social Security Act, and the applicable solicitation identified above, as well as all other applicable Federal statutes, regulations, and policies. This addendum is deemed to incorporate any changes that are required by statute to be implemented during the term of this addendum and any regulations or policies implementing or interpreting such statutory provisions.
- B. CMS agrees to perform its obligations to the MA-PD Sponsor consistent with the regulations at 42 CFR §423.1 through 42 CFR §423.910 (with the exception of Subparts Q, R, and S), sections 1860D-1 through 1860D-42 (with the exception of sections 1860D-22(a) and 1860D-31) of the Social Security Act, and the applicable solicitation, as well as all other applicable Federal statutes, regulations, and policies.
- C. CMS agrees that it will not implement, other than at the beginning of a calendar year, regulations under 42 CFR Part 423 that impose new, significant regulatory requirements on the MA-PD Sponsor. This provision does not apply to new requirements mandated by statute.
- D. This addendum is in no way intended to supersede or modify 42 CFR, Parts 417, 422 or 423. Failure to reference a regulatory requirement in this addendum does not affect the applicability of such requirements to the MA-PD Sponsor and CMS.

Article II
Functions to be Performed by the MA-PD Sponsor

A. ENROLLMENT

1. MA-PD Sponsor agrees to enroll in its MA-PD plan only Part D-eligible beneficiaries as they are defined in 42 CFR §423.30(a) and who have elected to enroll in MA-PD Sponsor’s Part C or Section 1876 benefit.

2. If the MA-PD Sponsor is a cost plan sponsor, the MA-PD Sponsor acknowledges that its Section 1876 plan enrollees are not required to elect enrollment in its Part D plan.

B. PRESCRIPTION DRUG BENEFIT

1. MA-PD Sponsor agrees to provide the required prescription drug coverage as defined under 42 CFR §423.100 and, to the extent applicable, supplemental benefits as defined in 42 CFR §423.100 and in accordance with Subpart C of 42 CFR Part 423. MA-PD Sponsor also agrees to provide Part D benefits as described in the MA-PD Sponsor's Part D bid(s) approved each year by CMS (and in the Attestation of Benefit Plan and Price, attached hereto).
2. MA-PD Sponsor agrees to calculate and collect beneficiary Part D premiums in accordance with 42 CFR §§423.286 and 423.293.
3. If the MA-PD Sponsors is a cost plans sponsor, it acknowledge that its Part D benefit is offered as an optional supplemental service in accordance with 42 CFR §417.440(b)(2)(ii).

C. DISSEMINATION OF PLAN INFORMATION

1. MA-PD Sponsor agrees to provide the information required in 42 CFR §423.48.
2. MA-PD Sponsor agrees to disclose information related to Part D benefits to beneficiaries in the manner and the form specified by CMS under 42 CFR §§423.128 and 423.50 and in the "Marketing Materials Guidelines for Medicare Advantage-Prescription Drug Plans (MA-PDs) and Prescription Drug Plans (PDPs)."
3. MA-PD Sponsor certifies that all materials it submits to CMS under the File and Use Certification authority described in the Marketing Materials Guidelines are accurate, truthful, not misleading, and consistent with CMS marketing guidelines.

D. QUALITY ASSURANCE/UTILIZATION MANAGEMENT

MA-PD Sponsor agrees to operate quality assurance, cost, and utilization management, medication therapy management programs, and support electronic prescribing in accordance with Subpart D of 42 CFR Part 423.

E. APPEALS AND GRIEVANCES

MA-PD Sponsor agrees to comply with all requirements in Subpart M of 42 CFR Part 423 governing coverage determinations, grievances and appeals, and formulary exceptions. MA-PD Sponsor acknowledges that these requirements are separate and distinct from the appeals and grievances requirements applicable to the MA-PD Sponsor through the operation of its Part C or cost plan benefits.

F. PAYMENT TO MA-PD SPONSOR

1. MA-PD Sponsor and CMS agree that payment paid for Part D services under the addendum will be governed by the rules in Subpart G of 42 CFR Part 423.
2. If the MA-PD Sponsor is participating in the Part D Reinsurance Payment Demonstration, described in 70 FR 9360 (Feb. 25, 2005), it affirms that it will not seek payment under the demonstration for services provided to employer group enrollees.

G. BID SUBMISSION AND REVIEW

If the MA-PD Sponsor intends to participate in the Part D program for the future year, MA-PD Sponsor agrees to submit a future year's Part D bid, including all required information on premiums, benefits, and cost-sharing, by the applicable due date, as provided in Subpart F of 42 CFR Part 423 so that CMS and the MA-PD Sponsor may conduct negotiations regarding the terms and conditions of the proposed bid and benefit plan renewal. MA-PD Sponsor acknowledges that failure to submit a timely bid under this section may affect the sponsor's ability to offer a Part C plan, pursuant to the provisions of 42 CFR §422.4(c).

H. COORDINATION WITH OTHER PRESCRIPTION DRUG COVERAGE

1. MA-PD Sponsor agrees to comply with the coordination requirements with State Pharmacy Assistance Programs (SPAPs) and plans that provide other prescription drug coverage as described in Subpart J of 42 CFR Part 423.
2. MA-PD Sponsor agrees to comply with Medicare Secondary Payer procedures as stated in 42 CFR §423.462.

I. SERVICE AREA AND PHARMACY ACCESS

1. The MA-PD Sponsor agrees to provide Part D benefits in the service area for which it has been approved by CMS to offer Part C or cost plan benefits utilizing a pharmacy network and formulary approved by CMS that meet the requirements of 42 CFR §423.120.
2. The MA-PD Sponsor agrees to ensure adequate access to Part D-covered drugs at out-of-network pharmacies according to 42 CFR §423.124.
3. MA-PD Sponsor agrees to provide benefits by means of point-of-service systems to adjudicate prescription drug claims in a timely and efficient manner in compliance with CMS standards, except when necessary to provide access in underserved areas, I/T/U pharmacies (as defined in 42 CFR §423.100), and long-term care pharmacies (as defined in 42 CFR §423.100).

4. MA-PD Sponsor agrees to contract with any pharmacy that meets the MA-PD Sponsor's reasonable and relevant standard terms and conditions. If MA-PD Sponsor has demonstrated that it historically fills 98% or more of its enrollees' prescriptions at pharmacies owned and operated by the MA-PD Sponsor (or presents compelling circumstances that prevent the sponsor from meeting the 98% standard or demonstrates that its Part D plan design will enable the sponsor to meet the 98% standard during the contract year), this provision does not apply to MA-PD Sponsor's plan.
5. The provisions of 42 CFR §423.120(a) concerning the TRICARE retail pharmacy access standard do not apply to MA-PD Sponsor if the Sponsor has demonstrated to CMS that it historically fills more than 50% of its enrollees' prescriptions at pharmacies owned and operated by the MA-PD Sponsor. MA-PD Sponsors excused from meeting the TRICARE standard are required to demonstrate retail pharmacy access that meets the requirements of 42 CFR §422.112 for a Part C contractor and 42 CFR §417.416(e) for a cost plan contractor.

J. COMPLIANCE PLAN/PROGRAM INTEGRITY

MA-PD Sponsor agrees that it will develop and implement a compliance plan that applies to its Part D-related operations, consistent with 42 CFR §423.504(b)(4)(vi).

K. LOW-INCOME SUBSIDY

MA-PD Sponsor agrees that it will participate in the administration of subsidies for low-income individuals according to Subpart P of 42 CFR Part 423.

L. BENEFICIARY FINANCIAL PROTECTIONS

The MA-PD Sponsor agrees to afford its enrollees protection from liability for payment of fees that are the obligation of the MA-PD Sponsor in accordance with 42 CFR §423.505(g).

M. RELATIONSHIP WITH RELATED ENTITIES, CONTRACTORS, AND SUBCONTRACTORS

1. The MA-PD Sponsor agrees that it maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of this addendum.
2. The MA-PD Sponsor shall ensure that any contracts or agreements with subcontractors or agents performing functions on the MA-PD Sponsor's behalf related to the operation of the Part D benefit are in compliance with 42 CFR §423.505(i).

N. CERTIFICATION OF DATA THAT DETERMINE PAYMENT

MA-PD Sponsor must provide certifications in accordance with 42 CFR §423.505(k).

Article III
Record Retention and Reporting Requirements

A. MAINTENANCE OF RECORDS

MA-PD Sponsor agrees to maintain records and provide access in accordance with 42 CFR §§423.504(d) and 505(d) and (e).

B. GENERAL REPORTING REQUIREMENTS

The MA-PD Sponsor agrees to submit to information to CMS according to 42 CFR §§423.505(f), 423.514, and the “Final Medicare Part D Reporting Requirements,” a document issued by CMS and subject to modification each program year.

C. CMS LICENSE FOR USE OF PLAN FORMULARY

PDP Sponsor agrees to submit to CMS each plan’s formulary information, including any changes to its formularies, and hereby grants to the Government[, and any person or entity who might receive the formulary from the Government,] a non-exclusive license to use all or any portion of the formulary for any purpose related to the administration of the Part D program, including without limitation publicly distributing, displaying, publishing or reconfiguration of the information in any medium, including www.medicare.gov, and by any electronic, print or other means of distribution.

Article IV
HIPAA Transactions/Privacy/Security

A. MA-PD Sponsor agrees to comply with the confidentiality and enrollee record accuracy requirements specified in 42 CFR §423.136.

B. MA-PD Sponsor agrees to enter into a business associate agreement with the entity with which CMS has contracted to track Medicare beneficiaries’ true out-of-pocket costs.

Article V
Addendum Term and Renewal

A. TERM OF ADDENDUM

This addendum is effective from the date of CMS' authorized representative's signature through December 31, 2007. This addendum shall be renewable for successive one-year periods thereafter according to 42 CFR §423.506. MA-PD Sponsor shall not conduct Part D-related marketing activities prior to October 1, 2006 and shall not process enrollment applications prior to November 15, 2006. MA-PD Sponsor shall begin delivering Part D benefit services on January 1, 2007.

B. QUALIFICATION TO RENEW ADDENDUM

1. In accordance with 42 CFR §423.507, the MA-PD Sponsor will be determined qualified to renew this addendum annually only if—
 - (a) CMS informs the MA-PD Sponsor that it is qualified to renew its addendum; and
 - (b) The MA-PD Sponsor has not provided CMS with a notice of intention not to renew in accordance with Article VII of this addendum.
2. Although MA-PD Sponsor may be determined qualified to renew its addendum under this Article, if the MA-PD Sponsor and CMS cannot reach agreement on the Part D bid under Subpart F of 42 CFR Part 423, no renewal takes place, and the failure to reach agreement is not subject to the appeals provisions in Subpart N of 42 CFR Parts 422 or 423. (Refer to Article XI for consequences of non renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VI
Nonrenewal of Addendum

A. NONRENEWAL BY THE MA-PD SPONSOR

1. MA-PD Sponsor may non-renew this addendum in accordance with 42 CFR 423.507(a).
2. If the MA-PD Sponsor non-renews this addendum under this Article, CMS cannot enter into a Part D addendum with the organization for 2 years unless there are special circumstances that warrant special consideration, as determined by CMS.

B. NONRENEWAL BY CMS

CMS may non-renew this addendum under the rules of 42 CFR 423.507(b). (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VII

Modification or Termination of Addendum by Mutual Consent

This addendum may be modified or terminated at any time by written mutual consent in accordance with 42 CFR 423.508. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article VIII

Termination of Addendum by CMS

CMS may terminate this addendum in accordance with 42 CFR 423.509. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article IX

Termination of Addendum by the MA-PD Sponsor

- A. The MA-PD Sponsor may terminate this addendum only in accordance with 42 CFR 423.510.
- B. CMS will not enter into a Part D addendum with an organization that has terminated its addendum within the preceding 2 years unless there are circumstances that warrant special consideration, as determined by CMS.
- C. If the addendum is terminated under section A of this Article, the MA-PD Sponsor must ensure the timely transfer of any data or files. (Refer to Article X for consequences of non-renewal on the Part C contract and the ability to enter into a Part C contract.)

Article X

Relationship Between Addendum and Part C Contract or 1876 Cost Contract

- A. MA-PD Sponsor acknowledges that, if it is a Medicare Part C contractor, the termination or nonrenewal of this addendum by either party may require CMS to terminate or non-renew the Sponsor's Part C contract in the event that such nonrenewal or termination prevents the MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c), in which case the Sponsor must provide the notices specified in this contract, as well as the notices specified under Subpart K of 42 CFR Part 422. MA-PD Sponsor also acknowledges that Article X.B. of this addendum may prevent the sponsor from entering into a Part C contract for two years following an addendum termination or non-renewal where such non-renewal or termination prevents the MA-PD Sponsor from meeting the requirements of 42 CFR §422.4(c).

- B. The termination of this addendum by either party shall not, by itself, relieve the parties from their obligations under the Part C or cost plan contracts to which this document is an addendum.
- C. In the event that the MA-PD Sponsor's Part C or cost plan contract (as applicable) is terminated or nonrenewed by either party, the provisions of this addendum shall also terminate. In such an event, the MA-PD Sponsor and CMS shall provide notice to enrollees and the public as described in this contract as well as 42 CFR Part 422, Subpart K or 42 CFR Part 417, Subpart K, as applicable.

Article XI
Intermediate Sanctions

The MA-PD Sponsor shall be subject to sanctions and civil monetary penalties, consistent with Subpart O of 42 CFR Part 423.

Article XII
Severability

Severability of the addendum shall be in accordance with 42 CFR §423.504(e).

Article XIII
Miscellaneous

- A. DEFINITIONS: Terms not otherwise defined in this addendum shall have the meaning given such terms at 42 CFR Part 423 or, as applicable, 42 CFR Part 422 or Part 417.
- B. ALTERATION TO ORIGINAL ADDENDUM TERMS: The MA-PD Sponsor agrees that it has not altered in any way the terms of the MA-PD addendum presented for signature by CMS. MA-PD Sponsor agrees that any alterations to the original text the MA-PD Sponsor may make to this addendum shall not be binding on the parties.
- C. ADDITIONAL CONTRACT TERMS: The MA-PD Sponsor agree to include in this addendum other terms and conditions in accordance with 42 CFR §423.505(j).
- D. CMS APPROVAL TO BEGIN MARKETING AND ENROLLMENT ACTIVITIES: The MA-PD Sponsor agrees that it must complete CMS operational requirements related to its Part D benefit prior to receiving CMS approval to begin MA-PD plan marketing activities relating to its Part D benefit. Such activities include, but are not limited to, establishing and successfully testing connectivity with CMS systems to process enrollment applications (or contracting with an entity qualified to perform

such functions on MA-PD Sponsor's behalf) and successfully demonstrating the capability to submit accurate and timely price comparison data. To establish and successfully test connectivity, the PDP Sponsor must, 1) establish and test physical connectivity to the CMS data center, 2) acquire user identifications and passwords, 3) receive, store, and maintain data necessary to perform enrollments and send and receive transactions to and from CMS, and 4) check and receive transaction status information.

**PART C/D BENEFIT PLAN(S) DESCRIPTION
TO BE ATTACHED TO MA CONTRACT**

**SECTION 1876/PART D OPTIONAL SUPPLEMENTAL BENEFIT PLAN
DESCRIPTION TO BE ATTACHED TO SECTION 1876 CONTRACT**

ATTACHMENT A

**ATTESTATION OF ENROLLMENT INFORMATION
RELATING TO CMS PAYMENT
TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution. This attestation shall not be considered a waiver of the MA Organization's right to seek payment adjustments from CMS based on information or data which does not become available until after the date the MA Organization submits this attestation.

1. The MA Organization has reported to CMS for the month of (INDICATE MONTH AND YEAR) all new enrollments, disenrollments, and changes in enrollees' institutional status with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

2. The MA Organization has reviewed the CMS monthly membership report and reply listing for the month of (INDICATE MONTH AND YEAR) for the above-stated MA plans and has reported to CMS any discrepancies between the report and the MA Organization's records. For those portions of the monthly membership report and the reply listing to which the MA Organization raises no objection, the MA Organization, through the certifying CEO/CFO, will be deemed to have attested, based on best knowledge, information, and belief as of the date indicated below, to their accuracy, completeness, and truthfulness.

(INDICATE TITLE [CEO, CFO, or delegate])

on behalf of

(INDICATE MA ORGANIZATION)

DATE

ATTACHMENT B

**ATTESTATION OF RISK ADJUSTMENT DATA INFORMATION RELATING TO
CMS PAYMENT TO A MEDICARE ADVANTAGE ORGANIZATION**

Pursuant to the contract(s) between the Centers for Medicare & Medicaid Services (CMS) and (INSERT NAME OF MA ORGANIZATION), hereafter referred to as the MA Organization, governing the operation of the following Medicare Advantage plans (INSERT PLAN IDENTIFICATION NUMBERS HERE), the MA Organization hereby requests payment under the contract, and in doing so, makes the following attestation concerning CMS payments to the MA Organization. The MA Organization acknowledges that the information described below directly affects the calculation of CMS payments to the MA Organization or additional benefit obligations of the MA Organization and that misrepresentations to CMS about the accuracy of such information may result in Federal civil action and/or criminal prosecution.

The MA Organization has reported to CMS during the period of (INDICATE DATES) all (INDICATE TYPE OF DATA —INPATIENT HOSPITAL, OUTPATIENT HOSPITAL, OR PHYSICIAN) risk adjustment data available to the MA Organization with respect to the above-stated MA plans. Based on best knowledge, information, and belief as of the date indicated below, all information submitted to CMS in this report is accurate, complete, and truthful.

(INDICATE TITLE [CEO, CFO, or delegate])

on behalf of

(INDICATE MA ORGANIZATION)

DATE

[SAMPLE — DO NOT USE - THIS DOCUMENT WILL BE SENT DIRECTLY TO THE MAO THROUGH HPMS]
ATTACHMENT C - Medicare Advantage Plan Attestation of Benefit Plan and Price

<Legal Entity Name>
<Contract#>

Date: <XX/XX/XXXX>

I attest that the following plan numbers as established in the final Plan Benefit Package (PBP) will be operated by the above-stated organization and made available to eligible Medicare beneficiaries in the approved service area during program year 2007.

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	PartD Premium	CMS Approval	Effective Date
<xxx>	<x>	<x>	<Plan Name>	<Plan Type>	<Transaction Type>	\$<Plan Premium>	\$<Plan D Premium>	<xx/xx/xx>	<xx/xx/xx>
<xxx>	<x>	<x>	<Plan Name>	<Plan Type>	<Transaction Type>	\$<Plan Premium>	\$<Plan D Premium>	<xx/xx/xx>	<xx/xx/xx>
<xxx>	<x>	<x>	<Plan Name>	<Plan Type>	<Transaction Type>	\$<Plan Premium>	\$<Plan D Premium>	<xx/xx/xx>	<xx/xx/xx>

CEO

<Name of CFO>
<Title>
<Address 1>
<Address 2>
<City, State Zip>
<Phone #>

Date

CFO

<Name of CFO>
<Title>
<Address 1>
<Address 2>
<City, State Zip>
<Phone #>

Date

**PACIFIC TOWERS ASSOCIATES
OFFICE LEASE
ARCO CENTER
LONG BEACH, CALIFORNIA**

LANDLORD: PACIFIC TOWERS ASSOCIATES,
a California Limited Partnership

TENANT: MOLINA HEALTHCARE, INC.,
a California corporation

Dated for reference purposes as of: July 10, 2002

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ARCO CENTER OFFICE LEASE
Basic Lease Information

Lease Date	July 10, 2002
Tenant	Molina Healthcare, Inc., a California corporation
Address	Attn: Mr. C. Joseph Heinz One Golden Shore, Long Beach, CA 90802
Telephone	(562) 435-3666 with a copy to: eRealty Commercial, Attn: Mr. Damian McKinney 12780 High Bluff Drive, Suite 100, San Diego, CA 92130
Telephone	(858) 350-5580
Landlord	Pacific Towers Associates, a California Limited Partnership
Address	200 Oceangate, Suite 310 Long Beach, California 90802
Contact Person	Building Manager
Telephone	(562) 435-8200
Building	Arco Center, Long Beach, California
Building Rentable Area	459,636 rentable square feet
Premises	
Tower Designation	200 Oceangate, Long Beach, California
Suite	200, 600 & 700
Floor(s)	2 nd , 6 th & 7 th
Rentable Square Footage	49,456 rentable square feet See Article 1 for expansion into 8 th Floor
Term	
Commencement Date	See Article 2
Expiration Date	See Article 2
Monthly Base Rental	See Article 3
Tenant's Share (of increased operating expenses and taxes)	Calculated in accordance with Article 4
Base Tax Amount	The greater of \$55,000,000 or the assessed value of the Building as finally determined by the County of Los Angeles for the 2002-2003 fiscal tax year, after all appeals and other challenges thereto have been exhausted.
Base Expense Year	Calendar year 2003

Use	General office use consistent with Class A office building
Security Deposit	See Article 28
Parking	See Paragraph 5 of Addendum
Broker	CB Richard Ellis and eRealty Commercial

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ARCO CENTER
OFFICE LEASE

This Lease is made and entered into this 10th day of July, 2002, by and between PACIFIC TOWERS ASSOCIATES, a California limited partnership (herein called "Landlord") and MOLINA HEALTHCARE, INC., a California corporation (herein called "Tenant").

WITNESSETH:

Landlord and Tenant hereby covenant and agree as follows:

1. PREMISES

1.1 Upon and subject to the terms, covenants and conditions hereinafter set forth, Landlord hereby leases to Tenant and Tenant hereby hires from Landlord those premises (herein called the "Premises") located in the building (herein called the "Building") and on the floors specified in the Basic Lease Information attached hereto and comprising the area substantially as shown on the floor plan or plans attached hereto as Exhibit A.

Commencing on the earlier of (i) one year after the Commencement Date or (ii) the date that Tenant commences its business operations therein, the Premises shall be expanded to include the entire 8th Floor of 200 Oceangate, containing 16,575 rentable square feet, and at which time the Premises shall contain a total of 66,031 rentable square feet. Landlord shall deliver possession of the entire 8th Floor Premises to Tenant for the purpose of constructing its Tenant Improvements therein at least four (4) months prior to said one year anniversary of the Commencement Date, but Landlord may be delayed in delivering the 8th Floor by said date as a result of the occupancy by the current tenant and subtenants. To the extent Landlord is so delayed in delivering the entire 8th Floor Premises, the time period in (i) above shall be extended by the number of days of delay; provided, however, in the event the entire 8th Floor Premises is not delivered within 420 days following the Commencement Date, Tenant may elect, by written notice to Landlord prior to the date said 8th Floor Premises are delivered, not to expand into said 8th Floor Premises.

The term "Building" includes the entire complex consisting of two office buildings and a parking garage currently known as the Arco Center and the land and improvements surrounding the complex and designated from time to time by Landlord as land or common areas appurtenant to the complex together with utilities, facilities, drives, walkways and other amenities appurtenant to or servicing the complex. Each office building is designated herein by its address of 200 Oceangate or 300 Oceangate.

1.2 As used in this Lease, the term "rentable area" shall be computed by Landlord in accordance with its modified standards of the Building Owners and Managers Association (BOMA). In all events, the rentable area of a floor shall be computed by measuring to the inside surface of the exterior glass building surface and no deductions shall be made for columns, projections, and penetrations necessary to the Building. The rentable area of an office on a floor shall be computed by multiplying the usable area of the office by the quotient of the division of the rentable area of the floor by the usable area of the floor.

2. TERM

2.1 The Premises are leased for a term (herein called the "Term") to commence and expire on the following dates: The Commencement Date of the Term shall be the later of November 1, 2002 or four (4) months after Landlord has delivered possession of Floors 2, 6 and 7 to Tenant. Landlord shall deliver possession of Floors 2, 6 and 7 to Tenant at such time as this Lease has been fully executed. If Landlord does not deliver possession of any portion of the Premises to Tenant at such time as this Lease is fully executed, then Tenant shall not be obligated to pay Monthly Base Rental or Additional Rent with respect to the entire floor(s) related thereto until four (4) months after the delivery of possession of said entire full floor. The expiration date of the Term shall be the 10th anniversary of the Commencement Date, unless the Term shall sooner terminate as hereinafter provided

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2.2 The dates upon which the Term shall commence and expire are herein called the "Commencement Date" and the "Expiration Date," respectively.

2.3 Notwithstanding anything to the contrary herein contained, in the event that Landlord shall not have delivered possession of Floors 2, 6 and 7 to Tenant on or before August 1, 2002, or 14 days after this Lease is fully executed, whichever occurs later, Tenant shall have the right, by written notice to Landlord delivered before possession is so delivered, to terminate this Lease and both parties hereto shall thereupon be released from all obligations hereunder.

3. RENT

3.1 Tenant shall pay to Landlord throughout the Term, the Monthly Base Rental specified below (herein called the "Monthly Base Rental"), which sum shall be payable by Tenant on or before the first day of each month, in advance, at the address specified for Landlord in the Basic Lease Information, or such other place as Landlord shall designate, without any notice or prior demand therefor and without any deductions or set-off whatsoever. If the Commencement Date should occur on a day other than the first day of a calendar month, or the Expiration Date should occur on a day other than the last day of a calendar month, then the Monthly Base Rental for such fractional month shall be prorated upon a daily basis based upon a thirty (30) day month. Upon Tenant's execution of this Lease, Tenant shall deliver to Landlord the Monthly Base Rental for the first full month of the Term.

The Monthly Base Rental for the Premises shall be based on its then rentable square footage and shall be as follows:

Lease Term Months Commencing on the Commencement Date	Monthly Base Rental
Months 1 — 30	\$1.55 per rentable square foot of Premises
Months 31 — 60	\$1.75 per rentable square foot of Premises
Months 61 — 90	\$1.95 per rentable square foot of Premises
Months 91 — 120	\$2.15 per rentable square foot of Premises

3.2 In addition to the Monthly Base Rental, Tenant shall pay to Landlord all charges and other amounts required under this Lease (herein called "Additional Rent"), including, without limitation, additional rent resulting from increased operating expenses and taxes pursuant to the provisions of Article 4 hereof. All such Additional Rent shall be payable to Landlord at the place where the Monthly Base Rental is payable, shall be considered "rent" for all legal purposes and Landlord shall have the same remedies for a default in the payment of Additional Rent as for a default in the payment of Monthly Base Rental.

4. ADDITIONAL RENT FOR INCREASED OPERATING EXPENSES AND TAXES

4.1 For purposes of this Article 4, the following terms shall have the meanings hereinafter set forth:

(a) "Tenant's Share" shall mean the percentage figure computed by dividing the rentable area of the Premises, as the same may increase or decrease from time to time, by the total rentable area of the office space in the Building. In the event that the total rentable area of the office space of the Building is changed by Landlord in its commercially reasonable discretion, Landlord shall give Tenant at least six months advance notice of any such change and shall provide Tenant with the formulas and basis of such change. Tenant's Share may, at Landlord's election and upon said six months prior notice to Tenant, be appropriately adjusted, and, as to the Tax Year or Expense Year (as said terms are hereinafter defined) in which such adjustment occurs, Tenant's Share shall be determined on the basis of the number of days during such Tax Year and Expense Year at each such percentage.

(b) "Tax Year" shall mean each twelve (12) month consecutive period commencing January 1st of each year during the Term, including any partial years during which the Lease may commence or end;

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provided that Landlord, upon notice to Tenant, may change the Tax Year from time to time to any other twelve (12) month consecutive period and, in the event of any such change, Tenant's Share of Excess Taxes (as hereinafter defined) shall be equitably adjusted for the Tax Years involved in any such change.

(c) "Real Estate Taxes" shall mean all taxes, assessments and charges levied upon or with respect to the Building or any personal property of Landlord used in the operation thereof, or Landlord's interest in the Building or such personal property. Real Estate Taxes shall include, without limitation, all general real property taxes and general and special assessments, charges, fees or assessments for transit, housing, police, fire, improvement districts, or other governmental services or purported benefits to the Building, service payments in lieu of taxes, and any tax, fee or excise on the act of entering into this Lease or any other lease of space in the Building, or on the use or occupancy of the Building or any part thereof, or on the rent payable under any lease or in connection with the business of renting space in the Building, that are now or hereafter levied or assessed against Landlord by the United States of America, the State of California, or any political subdivision, public corporation, district or other political or public entity, and shall also include any other tax, fee or other excise, however described, that may be levied or assessed as a substitute for, or as an addition to, in whole or in part, any other Real Estate Taxes, whether or not now customary or in the contemplation of the parties on the date of this Lease. Real Estate Taxes shall not include franchise, transfer, inheritance or capital stock taxes or income taxes measured by the net income of Landlord from all sources, unless, due to a change in the method of taxation, any of such taxes is levied or assessed against Landlord as a substitute for, or as an addition to, in whole or in part, any other tax that would otherwise constitute a Real Estate Tax. Real Estate Taxes shall also include reasonable legal fees, costs and disbursements incurred in connection with proceedings to contest, determine or reduce Real Estate Taxes.

Notwithstanding the foregoing, the following percentage of increases in Real Estate Taxes which Landlord may incur solely as a result of a sale, refinance, or transfer of ownership of the Building during the initial Lease Term shall be excluded during the applicable months of the initial Term from the total amount upon which Tenant's Share is based:

Months of Lease Term Commencing with the Commencement Date	Percentage of increased Real Estate Taxes which are excluded
Months 1-60	100%
Months 61-end of initial Lease Term	0%

(d) "Excess Taxes" with respect to any Tax Year shall mean the amount, if any, by which Real Estates Taxes for such Tax Year exceed the Base Tax Amount set forth in the Basic Lease Information.

(e) "Expense Year" shall mean each twelve (12) month consecutive period commencing January 1st of each year during the Term, including any partial years during which the Lease may commence or end; provided that Landlord, upon notice to Tenant, may change the Expense Year from time to time to any other twelve (12) month consecutive period, and, in the event of any such change, Tenant's Share of Excess Expenses (as hereinafter defined) shall be equitably adjusted for the Expense Years involved in any such change.

(f) "Expenses" shall mean all reasonable costs and expenses paid or incurred by Landlord in connection with the management, operation, maintenance and repair of the Building, including, without limitation, (i) the cost of air conditioning, electricity, steam, heating, mechanical, ventilating, escalator and elevator systems and all other utilities and the cost of supplies and equipment and maintenance and service contracts in connection therewith, (ii) the cost of repairs and general maintenance cleaning, (iii) the cost of fire, extended coverage, boiler, sprinkler, public liability, property damage, rental interruption, earthquake and other insurance together with any deductibles charged to or paid by Landlord, (iv) wages, salaries and other labor costs, including taxes, insurance, retirement, medical and other employee benefits, (v) management fees (which for off-site management services shall not exceed 5% of scheduled Building gross annual revenue for a 95% occupied Building), consulting fees, legal fees and accounting fees, of all independent contractors engaged by Landlord or reasonably charged by Landlord if Landlord performs management services in connection with the Building, (vi) the cost of supplying, replacing and cleaning employee uniforms, (vii) the fair market rental value of Landlord's and the property manager's offices in the

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Building, (viii) the cost of any capital improvements made to the Building as a labor-saving device or to effect other economies in the operation or maintenance of the Building, or that are required under a governmental law or regulation that was not applicable to the Building at the time that permits for the construction thereof were obtained, such cost to be amortized over such period as is similar to the period used by other comparable office buildings in the Long Beach area, together with interest on the unamortized balance at the rate of ten percent (10%) per annum, and (ix) any other commercially reasonable expenses of any other kind whatsoever reasonably incurred in managing, operating, maintaining, and repairing the Building. For purposes of computing Tenant's Additional Rent pursuant to this Article 4, Expenses for the entire Building that are not, in Landlord's sole discretion, allocable or chargeable solely to either the office or retail space of the Building shall be allocated between and charged to the office and retail space of the Building on an equitable basis as determined by Landlord. To the extent the Building is less than 95% occupied, Expenses shall be adjusted to reflect a ninety-five percent (95%) occupancy of the Building during any period in which the Building is not at least ninety-five percent (95%) occupied.

(g) The following are specifically excluded from the definition of Expenses:

(i) Any ground lease rental;

(ii) Costs of items considered capital repairs, replacements, improvements and equipment under generally accepted accounting principles consistently applied or otherwise ("Capital Items"), except for (1) the annual amortization (amortized over the useful life) of costs, including financing costs, if any, incurred by Landlord after the Commencement Date for any capital improvements installed or paid for by Landlord and required by any new (or change in) laws, rules or regulations of any governmental or quasi-governmental authority which are enacted after the Commencement Date; and (2) the annual amortization (amortized over the useful life) of costs, including financing costs, if any, or any equipment, device or capital improvement purchased or incurred in connection with normal Building maintenance and repair or as a labor-saving measure or to affect other economies in the operation or maintenance of the Building;

(iii) Rentals for items (except when needed in connection with normal repairs and maintenance) which if purchased, rather than rented, would constitute a Capital Item which is specifically excluded under Subsection (ii) above (excluding, however, equipment not affixed to the Building);

(iv) Costs incurred by Landlord for the repair of damage to the Building, to the extent that Landlord is reimbursed by insurance proceeds, and the cost of earthquake repairs in excess of \$250,000 per earthquake (which for this purpose an earthquake is defined collectively as the initial earthquake and the aftershocks related thereto);

(v) Costs, including permit, license and inspection costs, incurred with respect to the installation of tenants' or other occupants' improvements in the Building or incurred in renovating or otherwise improving, decorating, painting or redecorating vacant space for tenants or other occupants of the Building;

(vi) Depreciation;

(vii) Marketing costs including without limitation leasing commissions, attorneys' fees in connection with the negotiation and preparation of letters, deal memos, letters of intent, leases, subleases and/or assignments, space planning costs and other costs and expenses incurred in connection with lease, sublease and/or assignment negotiations and transactions with present or prospective tenants or other occupants of the Building;

(viii) Expenses in connection with services or other benefits which are not offered to Tenant or for which Tenant is charged for directly but which are provided to another tenant or occupant of the Building;

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- (ix) Costs incurred by Landlord due to violation by Landlord or any tenant of the terms and conditions of any lease of space in the Building;
- (x) Overhead and profit increment paid to Landlord or to subsidiaries or affiliates of Landlord for goods and/or services in the Building to the extent the same exceeds the costs of such goods and/or services rendered for comparable buildings;
- (xi) Interest, principal, points and fees on debts or amortization on any mortgage or mortgages or any other debt instrument encumbering the Building or the Land (except as permitted in subsection (ii) above);
- (xii) Landlord's general corporate overhead and general and administrative expenses except to the extent reasonably allocated to the Building and to the extent the cost does not exceed the costs of such services at comparable buildings;
- (xiii) Any compensation paid to clerks, attendants or other persons in commercial concessions operated by Landlord;
- (xiv) Advertising and promotional expenditures and costs of signs in or on the Building that are for the sole purpose of identifying the owner of the Building or other tenant's signs;
- (xv) The cost of any electric power used by any tenant in the Building in excess of the Building-standard amount to the extent Landlord is reimbursed therefor, or electric power costs for which any tenant directly contracts with the local public service company or of which any tenant is separately metered or sub-metered and pays Landlord directly;
- (xvi) Costs incurred in connection with upgrading the Building to comply with the interpretation, as of the Commencement Date, of disability, life, fire and safety codes, ordinances, statutes or other laws in effect prior to the Commencement Date, including without limitation, the Americans With Disabilities Act, and including penalties or damages incurred due to such non-compliance;
- (xvii) Tax penalties incurred as a result of Landlord's negligence, inability or unwillingness to make payments and/or to file any tax or informational returns when due;
- (xviii) Costs arising from the negligence or fault of Landlord, or from the negligence or fault of other tenants if such cost is reimbursed to Landlord;
- (xix) Any and all costs arising from the release of hazardous materials or substances in or about the Building in violation of applicable law including, without limitation, hazardous substances in the ground water or soil, not placed in the Building by Tenant;
- (xx) Costs arising from Landlord's charitable or political contributions;
- (xxi) Costs arising during the contractual warranty period from construction defects in the base, shell or core of the Building or improvements installed by Landlord;
- (xxii) Costs in connection with the initial construction of the Building arising from any mandatory or voluntary special assessment on the Building by any transit district authority or any other governmental entity having the authority to impose such assessment;
- (xxiii) Costs for sculpture, paintings or other objects of art unless of a commercially reasonable nature and in a commercially reasonable amount;

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(xxiv) Costs (including in connection therewith all attorneys' fees and costs of settlement judgments and payments in lieu thereof) arising from claims, disputes, or potential disputes in connection with potential or actual claims, litigation or arbitration pertaining to the Landlord and/or the Building and/or the Land;

(xxv) Costs associated with the operation of the business of the partnership or entity which constitutes Landlord as the same are distinguished from the costs of operation of the Building, including partnership accounting and legal matters, costs of defending any lawsuits with any mortgagee (except as the actions of Tenant may be in issue), costs of selling, syndicating, financing, mortgaging or hypothecating any of Landlord's interest in the Building, costs of any disputes between Landlord and its employees (if any) not engaged in Building operation, disputes of Landlord with Building management, or outside fees paid in connection with disputes with other tenants;

(xxvi) Costs of any "tap fees" or any sewer or water connection fees for the benefit of any particular tenant in the Building;

(xxvii) Any entertainment, dining or travel expenses of Landlord for any purpose not related to the operation or management of the Building;

(xxviii) Any "validated" parking for any entity;

(xxix) Any "finders fees," brokerage commissions, job placement costs or job advertising cost, other than with respect to the Building management, maintenance, and other staff;

(xxx) Any "above-standard" cleaning related to private parties/events and specific tenant requirements in excess of service provided to Tenant, including related trash collection, removal, hauling and dumping;

(h) "Excess Expenses" with respect to any Expense Year shall mean the amount, if any, by which Expenses for such Expense Year exceed the amount of Expenses for the Base Expense Year set forth in the Basic Lease Information.

4.2 Tenant shall pay to Landlord as Additional Rent one twelfth (1/12th) of Tenant's Share of the Excess Taxes of each Tax Year on or before the first day of each month during such Tax Year, in advance, in an amount estimated by Landlord and billed by Landlord to Tenant; provided that Landlord shall have the right initially to determine monthly estimates and to revise such estimates from time to time. With reasonable promptness after Landlord has received the tax bills for any Tax Year, Landlord shall furnish Tenant with a statement (herein called "Landlord's Tax Statement") setting forth the amount of Real Estate Taxes for such Tax Year, and Tenant's Share, if any, of Excess Taxes. If the actual Excess Taxes for such Tax Year exceed the estimated Excess Taxes paid by Tenant for such Tax Year, Tenant shall pay to Landlord the difference between the amount paid by Tenant and the actual Excess Taxes within thirty (30) days after the receipt of Landlord's Tax Statement, and if the total amount paid by Tenant for any such Tax Year shall exceed the actual Excess Taxes for such Tax Year, such excess shall be credited against the next installment of Excess Taxes due from Tenant to Landlord hereunder.

4.3 Tenant shall pay to Landlord as Additional Rent one-twelfth (1/12th) of Tenant's Share of the Excess Expenses for each Expense Year on or before the first day of each month of such Expense Year, in advance, in an amount estimated by Landlord and billed by Landlord to Tenant; provided that Landlord shall have the right initially to determine monthly estimates and to revise such estimates from time to time. With reasonable promptness after the expiration of each Expense Year, Landlord shall furnish Tenant with a statement (herein called "Landlord's Expense Statement"), setting forth in reasonable detail the Expenses for the Expense Year, and Tenant's Share, if any, of Excess Expenses. If the actual Excess Expenses for such Expense Year exceed the estimated Excess Expenses paid by Tenant for such Expense Year, Tenant shall pay to Landlord the difference between the amount paid by Tenant and the actual Excess Expenses within thirty (30) days after the receipt of Landlord's Expense Statement, and if the total amount paid by Tenant for any such Expense Year shall exceed the actual Excess

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Expenses for such Expense Year, such excess shall be credited against the next installment of the estimated Excess Expenses due from Tenant to Landlord hereunder.

4.4 If the Expiration Date of the Term shall occur on a date other than the end of a Tax Year or Expense Year, Tenant's Share of Excess Taxes, if any, and Excess Expenses, if any, for the Tax Year and the Expense Year in which the Expiration Date falls shall be in the proportion that the number of days from and including the first day of the Tax Year or Expense Year in which the Expiration Date occurs to and including the Expiration Date bears to 365; provided, however, Landlord may, pending the determination of the amount, if any, of Excess Taxes and Excess Expenses for such partial Tax Year and Expense Year, furnish Tenant with statements of estimated Excess Taxes, estimated Excess Expenses, and Tenant's Share of each thereof for such partial Tax Year and Expense Year. Within thirty (30) days after receipt of such estimated statement, Tenant shall remit to Landlord, as Additional Rent, the amount of Tenant's Share of such Excess Taxes and Excess Expenses. After such Excess Taxes and such Excess Expenses have been finally determined and Landlord's Tax Statement and Landlord's Expense Statement have been furnished to Tenant pursuant to Articles 4.2 and 4.3 hereof, if there shall have been an underpayment of Tenant's Share of Excess Taxes or Excess Expenses, Tenant shall remit the amount of such underpayment to Landlord within thirty (30) days of receipt of such statements, and if there shall have been an overpayment, Landlord shall remit the amount of any such overpayment to Tenant, but only if Tenant has provided Landlord with a valid forwarding address, within thirty (30) days of the issuance of such statements.

4.5 Landlord shall maintain adequate records of Expenses and Real Estate Taxes in accordance with accounting principles similar to those used by landlords of similar buildings in the Long Beach area. Any statements provided by Landlord in connection with Tenant's Share thereof shall be final and binding on Tenant unless Tenant, within one year of its receipt thereof, shall contest any item therein by giving written notice to Landlord, specifying each item contested and the reasons therefor. In such event, Landlord and Tenant shall endeavor in good faith to promptly resolve any disagreement set forth in Tenant's notice provided that Tenant shall not withhold payment of any contested or disputed item.

5. LATE CHARGES

Tenant hereby acknowledges that late payment by Tenant to Landlord of any Monthly Base Rental, Additional Rent, or other sums due hereunder will cause Landlord to incur costs not contemplated by this Lease, the exact amount of which will be extremely difficult to ascertain. Such costs include, but are not limited to, processing and accounting charges, and late charges which may be imposed on Landlord by the terms of any mortgage or deed of trust covering the Building. Accordingly, if any installment of Monthly Base Rental, Additional Rent, or any other sum due from Tenant shall not be received by Landlord or Landlord's designated agent within three (3) days after such amount shall be due, then, so long as Landlord has delivered written notice to Tenant specifying the payment amount not received and Tenant fails to pay such amount within five (5) days of receipt of said written notice, Tenant shall pay to Landlord a late charge equal to five percent (5%) of such overdue amount. The foregoing written notice shall only be required two (2) times per calendar year. The parties hereby agree that such late charge represents a fair and reasonable estimate of the costs Landlord will incur by reason of late payment by Tenant. Acceptance of such late charge by Landlord shall in no event constitute a waiver of Tenant's default with respect to such overdue amount, nor prevent Landlord from exercising any of the other rights and remedies granted hereunder. Notwithstanding any other provision in this Lease, Tenant shall have thirty (30) days from receipt of any invoice for payment of Additional Rent prior to incurring any late charges under this Article 5.

6. LANDLORD'S WORK

6.1 Except as set forth in the Workletter attached to this Lease as Exhibit B, Landlord is performing no work in connection with its delivery of the Premises to Tenant and Tenant is accepting the Premises in its "AS-IS condition.

6.2 The manner in which the common areas are maintained and operated and the expenditures therefor shall be at the reasonable discretion of Landlord, but such common areas shall be maintained and operated consistent with Class "A" buildings in Long Beach, and the use of such areas and facilities shall be subject to such reasonable rules and regulations as Landlord shall make from time to time. The term "common areas" as used herein shall mean

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the pedestrian sidewalks, malls, truckways, loading docks, hallways, lobbies, corridors, delivery areas, parking areas, elevators and escalators and stairs not contained in the leased areas, public bathrooms and comfort stations and all other areas or improvements that may be provided by Landlord for the convenience and use of the tenants of the Building and their respective sub-tenants, agents, employees, customers, invitees and any other licensees of Landlord. Landlord reserves the rights, from time to time, to utilize portions of the common areas for entertainment, displays, product shows, the leasing of kiosks or such other uses that, in Landlord's judgment, do not unreasonably interfere with Tenant's use and enjoyment of the Premises.

6.3 The purpose of attached Exhibit A is to show the approximate location of the Premises in the Building and Landlord hereby reserves the right, at any time and from time to time, to make alterations or additions to the Building and the common areas. Landlord also reserves the right at any time and from time to time to construct other improvements in the Building (including within the common areas) and to enlarge same and make alterations therein or additions thereto.

6.4 Notwithstanding anything in this Lease to the contrary, Landlord shall maintain the common areas and the Building in substantially the same physical condition as exists on the Commencement Date and so as to not permanently and unreasonably interfere with Tenant's use and enjoyment thereof.

7. CONDUCT OF BUSINESS BY TENANT

7.1 Tenant shall use and occupy the Premises during the Term of this Lease solely for the use specified in the Basic Lease Information and for no other use or uses without the prior written consent of Landlord.

7.2 Tenant shall not use or occupy, or permit the use or occupancy of, the Premises or any part thereof for any use other than the use specifically set forth in Article 7.1 hereof, or in any manner that, in Landlord's sole judgment, would adversely affect or interfere with any services required to be furnished by Landlord to Tenant or to any other tenant or occupant of the Building, or with proper and economical rendition of any such service, or with the use or enjoyment of any part of the Building by any other tenant or occupant.

8. ALTERATIONS AND TENANT'S PROPERTY

8.1 Tenant shall make no changes or alterations in or to the Premises of any nature without Landlord's prior written approval, except for the following: provided Landlord has been given advance written notice, Tenant may make changes or alterations costing less than \$50,000 per full floor but only if (i) they are of a non-structural nature, (ii) they do not affect or involve Building systems, (iii) they do not involve demolition or construction of walls, and (iv) they do not involve any electrical, mechanical, plumbing or fire/life-safety work. Prior to commencing any work in the Premises, Tenant shall submit to Landlord complete drawings, plans and specifications (herein collectively referred to as "Tenant's Plan") for the improvements and installations to be made by Tenant (herein collectively referred to as "Tenant's Work"). Tenant's Plan shall be fully detailed and shall show complete dimensions, shall not be in conflict with Landlord's basic plans for the Building, shall not require any changes in the structure of the Building or result in Landlord incurring any cost or having to perform any work in connection therewith, and shall not be in violation of any laws, orders, rules or regulations of any governmental department or bureau having jurisdiction over the Premises.

After submission to Landlord of Tenant's Plan, Landlord shall either approve same or shall set forth in writing the particulars in which Landlord does not approve same, in which latter case Tenant shall, within 5 days after Landlord's notification, return to Landlord appropriate corrections thereto. Such corrections shall be subject to Landlord's approval. Tenant shall pay to Landlord, promptly upon being billed and as Additional Rent, any charges or expenses Landlord may incur in reviewing Tenant's Plan. Tenant agrees that any review or approval by Landlord of Tenant's Plan is solely for Landlord's benefit, and without any representation or warranty whatsoever to Tenant with respect to the adequacy, correctness or efficiency thereof or otherwise.

Tenant further agrees that if Tenant makes any changes in Tenant's Plan subsequent to its approval by Landlord and if Landlord consents to such changes, Tenant shall pay to Landlord all costs and expenses incurred by Landlord and caused by such changes; it being understood and agreed, however, that Landlord shall have the right

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to refuse to consent to any such changes. Any charges payable under this Section 8.1 shall be paid by Tenant from time to time upon demand as Additional Rent, whether or not the Lease Term shall have commenced.

Following compliance by Tenant with its obligations under the foregoing sections of this article, Tenant shall timely commence Tenant's Work in order to complete same within a reasonable period of time. Tenant's Work shall be diligently pursued and shall be performed in a good and workmanlike manner.

Tenant agrees that in the performance of Tenant's Work (i) neither Tenant nor its agents or employees shall interfere with any work being done by Landlord and its agents and employees, (ii) that Tenant shall comply with any reasonable work schedule, rules and regulations imposed by Landlord, its agents and employees, (iii) that the labor employed by Tenant shall be harmonious and compatible with the labor employed by Landlord in the Building, it being agreed that if in Landlord's judgment the labor is incompatible Tenant shall forthwith upon Landlord's demand withdraw such labor from the Premises, (iv) that Tenant shall procure and deliver to Landlord worker's compensation, public liability, property damage and such other insurance policies, in such amounts as shall be reasonably acceptable to Landlord in connection with Tenant's Work, and shall upon Landlord's request cause Landlord to be named as an insured thereunder, (v) that Tenant shall hold Landlord harmless from and against any costs Landlord may incur in connection with or as a result of Tenant's Work and all claims arising from or in connection with any act or omission of Tenant or its agents or employees, (vi) that Tenant's Work shall be performed in accordance with the approved Tenant's Plan and in compliance with the laws, orders, rules and regulations of any governmental department or bureau having jurisdiction over the Premises, and (vii) that Tenant shall promptly pay for Tenant's Work in full and shall not permit any lien to attach to the Premises or the Building. As a condition precedent to any such written consent of Landlord, Tenant shall deliver to Landlord written and unconditional waivers of mechanics' and materialmen's liens upon the Building for all work, labor and services to be performed and material to be furnished in connection with the proposed alterations.

With respect to any changes or alterations that requires Landlord's approval (with the exception of the initial improvement of the Premises) Tenant shall pay to Landlord upon demand, as compensation to Landlord for its services in overseeing the work performed pursuant to this Paragraph 8.1, and regardless of whether the work is performed by Landlord's or Tenant's contractor, an administrative fee equal to 5% of the first \$100,000 of the cost of the work and 2.5% of the cost of the work in excess of \$100,000, calculated on a per project basis. In addition to the foregoing, with respect to all changes or alterations, Tenant shall reimburse Landlord for all direct expenses actually incurred in connection therewith, including but not limited to after hours access control, additional janitorial, after hours engineering, etc.

8.2 All appurtenances, fixtures, improvements, additions and other property attached to or installed in the Premises, whether by Landlord or by or on behalf of Tenant, and whether at Landlord's expense or Tenant's expense, or at the joint expense of Landlord and Tenant, shall be and remain the property of Landlord. Any trade fixtures, furnishings and personal property placed in the Premises by Tenant, whether the property of Tenant or leased by Tenant, are herein sometimes called "Tenant's Property." Any replacements of any property of Landlord, whether made at Tenant's expense or otherwise, shall be and remain the property of Landlord.

8.3 Any of Tenant's Property remaining on the Premises at the expiration of the Term shall be removed by Tenant at Tenant's cost and expense, and Tenant shall, at its cost and expense, repair any damage to the Premises or the Building caused by such removal. Any of Tenant's Property not removed from the Premises prior to the expiration of the Term shall, at Landlord's option, become the property of Landlord or Landlord may remove such Tenant's Property, and Tenant shall pay to Landlord, Landlord's cost of removal and of any repairs in connection therewith within ten (10) days after the receipt of a bill therefor. Tenant's obligation to pay any such costs shall survive any termination of this Lease.

9. REPAIRS

9.1 Except to the extent Landlord is obligated to do so pursuant to Paragraph 9.2 hereof, Tenant shall, when and if needed or whenever requested by Landlord to do so, at Tenant's sole cost and expense, maintain and make repairs to the Premises and every part thereof and keep, maintain and preserve the Premises in first class condition and repair, normal wear and tear excepted. Any such maintenance and repair shall be performed by

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Landlord's contractor, or by such contractor or contractors as Tenant may choose from an approved list to be submitted to Landlord following Tenant's request. All costs and expenses incurred in such maintenance and repair shall be paid by Tenant as Additional Rent within ten (10) days after billing by Landlord or such contractor or contractors. Landlord shall not be liable for and, except as provided in Article 14 hereof, there shall be no abatement of Rent with respect to any injury to or interference with Tenant's business arising from any repairs, maintenance, alteration or improvement in or to any portion of the Building, including the Premises, or in or to the fixtures, appurtenances and equipment therein. Tenant hereby waives and releases its right to make repairs at Landlord's expense under Sections 1941 and 1942 of the California Civil Code or under any similar law, statute or ordinance now or hereafter in effect.

9.2 Notwithstanding anything contained in subparagraph 9.1 to the contrary, (except for Tenant's cabling wherever located, Tenant's light fixtures, Tenant's trade fixtures and other non-standard Building items, supplemental HVAC units, and items within the inside perimeter of the Premises which are below the ceiling tiles and above the slab; all of which shall be maintained by Tenant at its sole cost and expense) Landlord shall replace, repair and maintain all aspects of the Building, the Building structure, the Building plumbing, heating, ventilating, air-conditioning and electrical systems installed or furnished by Landlord, and the common areas in a manner consistent with other Class "A" office buildings in Long Beach, unless such maintenance or repairs are caused in part or in whole by the act, neglect, fault or omission of any duty by Tenant, its agents, servants, employees or invitees, in which case Landlord shall cause the necessary maintenance or repair to be performed and Tenant shall pay to Landlord on demand as Additional Rent, the reasonable cost of such maintenance and repairs.

9.3 All repairs and replacements made by or on behalf of Tenant or any person claiming through or under Tenant shall be made and performed (a) at Tenant's cost and expense and at such time and in such manner as Landlord may designate, (b) by contractors or mechanics approved by Landlord, (c) so that same shall be at least equal in quality, value, and utility to the original work or installation, and (d) in accordance with the Rules and Regulations for the Building adopted by Landlord from time to time and in accordance with all applicable laws and regulations of governmental authorities having jurisdiction over the Premises. If Landlord gives Tenant notice of the necessity of any repairs or replacements required to be made by Tenant under Articles 9.1 and 9.2 above and Tenant fails to commence diligently to effect the same within 10 days thereafter, Landlord may proceed to make such repairs or replacements and the expenses incurred by Landlord in connection therewith shall be due and payable from Tenant upon demand as Additional Rent; provided that Landlord's making any such repairs or replacements shall not be deemed a waiver of Tenant's default in failing to make the same.

10. LIENS

Tenant shall keep the Premises free from any liens arising out of any work performed, material furnished or obligations incurred by or for Tenant or any person or entity claiming through or under Tenant. In the event that Tenant shall not, within ten (10) days following the imposition of any such lien, cause same to be released of record by payment or posting of a proper bond, Landlord shall have, in addition to all other remedies provided herein and by law, the right but not the obligation to cause same to be released by such means as it shall deem proper, including payment of the claim giving rise to such lien. All such sums paid by Landlord and all expenses incurred by it in connection therewith shall be considered Additional Rent and shall be payable to it by Tenant on demand. Any such action by Landlord shall not in any event be deemed a waiver of Tenant's default with respect thereto. Landlord shall have the right at all times to post and keep posted on the Premises any notices permitted or required by law, or that Landlord shall deem proper, for the protection of Landlord, the Premises, the Building, and any other party having an interest therein, from mechanics' and materialmen's liens, and Tenant shall give to Landlord at least ten (10) business days' prior notice of commencement of any construction on the Premises.

11. COMPLIANCE WITH LAWS AND INSURANCE REQUIREMENTS

11.1 Tenant, at Tenant's cost and expense, shall comply with all laws, orders and regulations of federal, state, county and municipal authorities, and with all directions, pursuant to law, of all public officers, that shall impose any duty upon Landlord or Tenant with respect to the Premises, except that (i) Tenant shall not be required to make any structural Alterations in order to comply unless such Alterations shall be necessitated or occasioned, in whole or in part, by the acts, omissions or negligence of Tenant or any person claiming through or under Tenant, or

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any of their servants, employees, contractors, agents, visitors or licensees, by Tenant's Work, or by use or occupancy or manner of use of occupancy of the Premises by Tenant or any such person, and (ii) Landlord shall keep and maintain the Premises elevator signage and controls as well as the restrooms within the Premises in compliance with applicable laws pertaining to the disabled. All costs incurred by Landlord in connection therewith shall be treated as an Expense to the extent such costs comply with the requirements of Article 4 hereof. Any work or installations made or performed by or on behalf of Tenant or any person claiming through or under Tenant pursuant to the provisions of this Article 11 shall be made in conformity with, and subject to the provisions of, Article 9 hereof.

11.2 Tenant shall not do anything, or permit anything to be done, in or about the Premises which shall (a) invalidate or be in conflict with the provisions of any fire or other insurance policies covering the Building or any property located therein, or (b) result in a refusal by fire insurance companies of good standing to insure the Building or any such property in amounts reasonably satisfactory to Landlord, or (c) subject Landlord to any liability or responsibility for injury to any person or property by reason of any business operation being conducted in the Premises, or (d) cause any increase in the fire insurance rates applicable to the Building or property located therein at the beginning of the Term or at any time thereafter. Tenant, at Tenant's expense, shall comply with all rules, orders, regulations or requirements of the American Insurance Association (formerly the National Board of Fire Underwriters) and with any similar body that shall hereafter perform the function of such Association.

12. SUBORDINATION

Within 30 days following the full execution of this Lease, Landlord shall supply Tenant with a non-disturbance agreement from the current mortgagee of the Building on the mortgagee's standard form, a copy of which is attached hereto as Exhibit E. In addition, as a condition to any future subordination by Tenant, Landlord shall supply Tenant with a non-disturbance agreement from the applicable mortgagee or lienholder containing substantially the same protections for Tenant as are contained in the form attached as Exhibit E. Provided Landlord has complied with the aforesaid condition, Tenant agrees to execute and return any requested subordination agreements within 14 business days of Landlord's demand.

Provided Landlord has complied with its obligations under the foregoing paragraph, then, without the necessity of any additional document being executed by Tenant for the purpose of effecting a subordination, Tenant agrees that at Landlord's option, this Lease and Tenant's tenancy hereunder are and shall be automatically subject and subordinate at all times to (a) all ground leases or underlying leases that may now exist or hereafter be executed affecting the Building, (b) the lien of any mortgage, deed or trust or similar security instrument that may now exist or hereafter be executed in any amount for which the Building, ground leases or underlying leases, or Landlord's interest or estate in any of said items is specified as security, and (c) all renewals, modifications, consolidations, replacements and extensions of any of the foregoing. Notwithstanding the foregoing, upon 30 days prior written notice from Landlord to Tenant, Landlord shall have the right to subordinate or cause to be subordinated any such ground leases or underlying leases or any such liens to this Lease. In the event that any ground lease or underlying lease is terminated for any reason or any mortgage or deed of trust is foreclosed or a conveyance in lieu of foreclosure is made for any reason, Tenant shall, notwithstanding any subordination of this Lease to any ground lease, underlying lease or lien, attorn to and become the tenant of the successor in interest to Landlord at the option of such successor in interest. Upon such attornment this Lease shall continue in full force and effect as a direct Lease between the successor landlord and Tenant upon all of the terms, conditions and covenants as are set forth in this Lease, except that, unless otherwise agreed to in the applicable non-disturbance agreement, the successor landlord shall not (a) be liable for any previous act or omission of Landlord; (b) be subject to any offset not expressly provided for in this Lease, which theretofore shall have accrued to Tenant against Landlord; or (c) be bound by any previous modification of this Lease or by any previous prepayment of more than one month's Monthly Base Rental or Additional Rent, unless such modification or prepayment shall have been expressly approved in writing by the lessor of the superior lease or the holder of the superior mortgage through or by reason of which the successor Landlord shall have succeeded to the rights of Landlord under this Lease. Tenant covenants and agrees to execute and deliver, upon demand by Landlord and in the form requested by Landlord, any additional documents evidencing the priority or subordination of this Lease with respect to any such ground leases or underlying leases or the lien of any such mortgage or deed of trust. Notwithstanding anything in this Lease to the contrary, Tenant's Monthly Base Rental and Share of Increased Expenses shall not increase by way of Landlord entering into a ground lease relating to the Building or land underlying the Building.

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13. INABILITY TO PERFORM

If Landlord is unable to furnish or is delayed in furnishing any utility or service required to be furnished by Landlord under the provisions of Article 17 or of any other Article of this Lease or of any collateral instrument, or is unable to perform or make or is delayed in performing or making any installations, decorations, repairs, alterations, additions or improvements, whether required to be performed or made under this Lease or under any collateral instrument, or is unable to fulfill or is delayed in fulfilling any of Landlord's other obligations under this Lease or any collateral instrument, no such inability or delay shall constitute an actual or constructive eviction, in whole or in part, or entitle Tenant to any abatement or diminution of Monthly Base Rental or Additional Rent, or relieve Tenant from any of its obligations under this Lease, or impose any liability upon Landlord or its agents by reason of inconvenience or annoyance to Tenant or by reason of injury to or interruption of Tenant's business, or otherwise; provided, however if such inability or occurrence renders the Premises unusable, was not the result of Tenant's negligent act or intentional misconduct, and is not remedied within 30 days from the date of the inability or occurrence, Tenant's Monthly Base Rental shall thereafter be abated to the extent and for the period of time that the Premises continue to be unusable. Tenant hereby waives and releases its right to terminate this Lease under Section 1932(1) of the California Civil Code or under any similar law, statute or ordinance now or hereafter in effect.

14. DESTRUCTION

14.1 If the Premises shall be damaged by fire or other casualty insured against by Landlord's fire and extended coverage insurance policy covering the Building, Landlord, at Landlord's expense, shall repair such damage; provided, however, that Landlord shall have no obligation to repair any damage to or to replace Tenant's Property, Tenant's Work or any other property or effects of Tenant. Except as otherwise provided in this Article 14, if the entire Premises shall be rendered untenantable by reason of any such damage, the Monthly Base Rental and Additional Rent shall abate for the period from the date of such damage to the date when such damage to the Premises shall have been repaired, and if only a part of the Premises shall be rendered untenantable, the Monthly Base Rental and Additional Rent shall abate for such period in the proportion that the rentable area of the part of the Premises so rendered untenantable bears to the total rentable area of the Premises; provided, however, if, prior to the date when all of such damage shall have been repaired, any part of the Premises so damaged shall be rendered tenantable or shall be used or occupied by Tenant or any person or persons claiming through or under Tenant, then the amount by which the Monthly Base Rental and Additional Rent shall abate shall be equitably apportioned for the period from the date of any such use or occupancy to the date when all such damage shall have been repaired.

14.2 Notwithstanding the provisions of Article 14.1 hereof, if, prior to or during the Term (a) the Premises shall be totally damaged or rendered wholly untenantable by fire or other casualty, and if Landlord shall determine, in its sole discretion, not to restore the Premises, or (b) the Building shall be so damaged by fire or other casualty that, in Landlord's opinion, substantial alteration, demolition or reconstruction of the Building shall be required (whether or not the Premises shall have been damaged or rendered untenantable), then, in any of such events, Landlord, at Landlord's option, may give to Tenant, within ninety (90) days after such fire or other casualty, a thirty (30) days' notice of termination of this Lease and, in the event such notice is given, this Lease and the Term shall terminate upon the expiration of such thirty (30) days with the same effect as if the date of expiration of such thirty (30) days were the Expiration Date; and the Rent and Additional Rent shall be apportioned as of such date and any prepaid portion of Rent or Additional Rent for any period after such date shall be refunded by Landlord to Tenant.

14.3 Landlord shall attempt to obtain and maintain, throughout the Term, in Landlord's property insurance policies, provisions to the effect that such policies shall not be invalidated should the insured waive, in writing, prior to loss, any or all right of recovery against any party for loss occurring to the Building. In the event that at any time Landlord's property insurance carriers shall exact an additional premium for the inclusion of such or similar provisions, Landlord shall give Tenant notice thereof. In such event, if Tenant agrees in writing to reimburse Landlord for such additional premium for the remainder of the Term, Landlord shall require the inclusion of such or similar provisions by Landlord's property insurance carriers. Tenant and Landlord, as long as such or similar provisions are included in Landlord's property insurance policies then in force, hereby waive any right of recovery against each other for any loss occasioned by fire or other casualty that is covered by insurance. In the event that at

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any time Landlord's property insurance carriers shall not include such or similar provisions in Landlord's property insurance policies, the waiver by Landlord, as set forth in the foregoing sentence shall be deemed of no further force or effect.

14.4 Except to the extent expressly provided in Article 14.3 hereof, nothing contained in this Lease shall relieve Tenant of any liability to Landlord or to its insurance carriers which Tenant may have under law or under the provisions of this Lease in connection with any damage to the Premises or the Building by fire or other casualty.

14.5 Notwithstanding the provisions of Article 14.1 hereof, if any such damage is due to the fault or neglect of Tenant, any person claiming through or under Tenant, or any of their servants, employees, agents, contractors, visitors or licensees, then there shall be no abatement of Monthly Base Rental or Additional Rent by reason of such damage, and Tenant shall be liable to Landlord for any insurance deductible payable in connection therewith, unless Landlord is reimbursed for such abatement of Monthly Base Rental or Additional Rent or deductibles pursuant to any rental insurance policies or other insurance policies that Landlord may, in its sole discretion, elect to carry.

14.6 The provisions of this Lease, including this Article 14, constitute an express agreement between Landlord and Tenant with respect to any and all damage to, or destruction of, all or any part of the Premises or any other portion of the Building, and any statute or regulation of the State of California, including, without limitations, Sections 1932(2) and 1933(4) of the California Civil Code, with respect to any rights or obligations, concerning damage or destruction in the absence of any express agreement between the parties, and any other statute or regulation, now or hereafter in effect, shall have no application to this Lease or to any damage or destruction to all or any part of the Premises or the Building.

14.7 Notwithstanding anything in this Lease to the contrary, in the event any such damage to the Premises was not caused by Tenant's negligence or intentional misconduct, and the repairs that Landlord is required to make so as to render the Premises usable will not be substantially completed within two hundred and seventy (270) days from the date the damage occurred, Tenant shall have the right to terminate this Lease upon thirty (30) days prior written notice to Landlord, provided such notice is given to Landlord within 30 days from the date Tenant is informed by Landlord in writing that such repairs will not be substantially completed within said 270 day period.

15. EMINENT DOMAIN

15.1 If all of the Premises is condemned or taken in any manner for public or quasi-public use, including but not limited to a conveyance or assignment in lieu of a condemnation or taking, this Lease shall automatically terminate as of the earlier of the date of the vesting of title or the date of dispossession of Tenant as a result of such condemnation or other taking. If a part of the Premises is so condemned or taken, this Lease shall automatically terminate as to the portion of the Premises so taken as of the earlier of the date of the vesting of title or the date of dispossession of Tenant as a result of such condemnation or taking. If such portion of the Building is condemned or otherwise taken so as to require, in the opinion of Landlord, a substantial alteration or reconstruction of the remaining portions thereof, this Lease may be terminated by Landlord, as of the earlier of the date of the vesting of title or the date of dispossession of Tenant as a result of such condemnation or taking, by written notice to Tenant within sixty (60) days following notice to Landlord of the date on which said vesting or dispossession will occur. If such portion of the Premises is taken so as to render the remaining portion untenable and unusable by Tenant, or greater than 20% of the Premises is condemned and Landlord does not make other reasonably comparable space available to Tenant at the same time Tenant's right to use the condemned portion of the Premises is lost, this Lease may be terminated by Tenant as of the earlier of the date of the vesting of title or the date of dispossession of Tenant as a result of such condemnation or taking, by written notice to Landlord within sixty (60) days following notice to Tenant of the date on which said vesting or dispossession will occur.

15.2 Landlord shall be entitled to the entire award in any condemnation proceeding or other proceeding for taking for public or quasi-public use, including, without limitation, any award made for the value of the leasehold estate created by this Lease; provided, however any bonus value attributable to the leasehold estate created hereby shall be divided equally between Landlord and Tenant. No award for any partial or entire taking shall be

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apportioned, and Tenant hereby assigns to Landlord any award that may be made in such condemnation or other taking, together with any and all rights of Tenant now or hereafter arising in or to same or any part thereof; provided, however, that nothing contained herein shall be deemed to give Landlord any interest in or to require Tenant to assign to Landlord any award made to Tenant specifically for its relocation expenses or the taking of personal property and fixtures belonging to Tenant.

15.3 In the event of a partial condemnation or other taking that does not result in a termination of this Lease as to the entire Premises, the Monthly Base Rental and Additional Rent shall abate in proportion to the portion of the Premises taken by such condemnation or other taking.

15.4 If all or any portion of the Premises is condemned or otherwise taken for public or quasi-public use for a limited period of time, this Lease shall remain in full force and effect and Tenant shall continue to perform all of the terms, conditions and covenants of this Lease; provided, however, the Monthly Base Rental and Additional Rent shall abate during such limited period in proportion to the portion of the Premises that is rendered untenable and unusable as a result of such condemnation or other taking. Landlord shall be entitled to receive the entire award made in connection with any such temporary condemnation or other taking.

16. ASSIGNMENT

16.1 Tenant shall not directly or indirectly, voluntarily or by operation of law, sell, assign, encumber, pledge or otherwise transfer or hypothecate all or any part of the Premises or Tenant's leasehold estate hereunder (collectively, "Assignment"), or permit the Premises or any portion thereof to be occupied by anyone other than Tenant or sublet the Premises (collectively, "Sublease") without Landlord's prior written consent in each instance, and which consent shall not be unreasonably withheld or delayed; provided, however, Landlord shall have the right at its option, to recapture and terminate this Lease with respect to (i) the entire Premises in the event of a proposed Assignment of this Lease or (ii) any space Tenant is proposing to Sublease to an existing tenant in the Building that Landlord has been negotiating to take additional space during the prior six months, or (iii) any space Tenant is proposing to Sublease if Tenant's occupancy in the Building will be less than 49,000 rentable square feet as a result of said Sublease.

16.2 Notwithstanding the foregoing, but provided that the subtenant or assignee is of good character and business reputation, will use the Premises for a use permitted by this Lease, and will not potentially overburden the Building facilities or require an increased level of services, Tenant shall have the right to Assign this Lease or Sublease any portion of the Premises to (i) Tenant's parent company or any wholly-owned subsidiary thereof, (ii) any entity "doing business with Tenant", (iii) any entity controlled by (meaning more than a 25% ownership interest in such entity) any controlling principals of Tenant (meaning principals with at least 25% ownership interest in Tenant) or (iv) an entity acquiring all of Tenant's assets and business; provided in (i), (iii) and (iv) above that the acquiring entity's net worth is equal to or greater than Tenant as of the Commencement Date, and provided that (ii) above shall only apply to Subleases which in the aggregate, at any one time, cover less than 20% of the Premises (collectively, "Affiliate") by notifying Landlord in writing at least 30 days in advance thereof, but without having to obtain Landlord's prior written consent thereto. For purposes of this paragraph, the term entity "doing business with Tenant" shall mean: (i) Tenant has entered into a significant business relationship with the entity; (ii) Tenant has delivered to Landlord a copy of the written documentation illustrating the significant business relationship with the entity; and (iii) Landlord has been given the opportunity to meet with Tenant and the entity to fully understand the extent of the business relationship between Tenant and the entity. In the event the significant business relationship is terminated or expires, such entity shall be deemed a Sublessee or Assignee, as appropriate, and shall be required to vacate the Premises or be subject to Landlord's right to consent thereto in accordance with the Section 16.3 below. Any such transfer shall not be deemed an Assignment or Sublease for purposes of this Lease so long as the "Affiliate" relationship between the two entities continues. Any profits attributable to a transfer to an Affiliate shall be retained by Tenant.

16.3 If Tenant desires at any time to enter into an Assignment of this Lease or a Sublease of the Premises or any portion thereof, it shall first give written notice to Landlord of its desire to do so, which notice shall contain (a) the name of the proposed assignee or subtenant, (b) the nature of the proposed assignee's or subtenant's business to be carried on in the Premises, (c) the portion(s) (including all) of the Premises to be subject to such

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Assignment or Sublease and the other terms and conditions of the proposed Assignment or Sublease, and (d) such financial information as Landlord may reasonably request concerning the proposed assignee or subtenant. Each such notice shall be given to Landlord together with a non-refundable deposit of One Thousand Dollars (\$1,000) as reasonable consideration for Landlord's considering and processing the request for consent.

16.4 Landlord shall not be obligated to consent to any proposed Assignment or Sublease if it has reasonable objections thereto, including but not limited to if the subtenant or assignee does not meet Landlord's financial requirements, or if the subtenant or assignee is not of good character and business reputation, will use the Premises for a use not permitted by this Lease, or will potentially overburden the Building facilities or require an increased level of services. In addition, Tenant shall not be permitted to Sublease any portion of the Premises or Assign this Lease to any then existing tenant of the Building or to any other party which Landlord has been in active lease negotiations during the prior six months.

16.5 At any time within fifteen (15) days after Landlord's receipt of the notice specified in Article 16.3 hereof, Landlord shall by written notice to Tenant elect either to (a) consent to the Sublease or Assignment, or (b) disapprove the Sublease or Assignment with reasonable basis therefor, or (c) recapture the space or Premises if permitted to do so as set forth above. If Landlord consents to the Sublease or Assignment, Tenant may thereafter within ninety (90) days after Landlord's consent, but not later than the expiration of said ninety (90) days, enter into such Assignment or Sublease of the Premises or portion thereof, upon the terms and conditions set forth in the notice furnished by Tenant to Landlord pursuant to Article 16.3 hereof.

16.6 No consent by Landlord to any Assignment or Sublease by Tenant shall relieve Tenant of any obligation to be performed by Tenant under this Lease, whether arising before or after the Assignment or Sublease. The consent by Landlord to any Assignment or Sublease shall not relieve Tenant from the obligation to obtain Landlord's express written consent to any other Assignment or Sublease. Any Assignment or Sublease that is not in compliance with this Article 16 shall be void and, at the option of Landlord, shall constitute a material default by Tenant under this Lease. The acceptance of Rent or Additional Rent by Landlord from a proposed assignee or sublessee shall not constitute the consent to such Assignment or Sublease by Landlord.

16.7 Each assignee, sublessee, or other transferee, other than Landlord, shall assume, as provided in this Article 16.7, all obligations of Tenant under this Lease and shall be and remain liable jointly and severally with Tenant for the payment of Monthly Base Rental and Additional Rent, and for the performance of all the terms, covenants, conditions and agreements herein contained on Tenant's part to be performed for the Term; provided, however, that the assignee, subleases, mortgagee, pledges or other transferee shall be liable to Landlord for Monthly Base rental and Additional Rent only in the amount set forth in the Assignment or Sublease. No Assignment shall be binding on Landlord unless the assignee or Tenant shall deliver to Landlord a counterpart of the Assignment and an instrument in recordable form that contains a covenant of assumption by the assignee satisfactory in substance and form to Landlord, consistent with the requirements of this Article 16.7, but the failure or refusal of the assignee to execute such instrument of assumption shall not release or discharge the assignee from its liability as set forth above.

16.8 Any net profits attributable to any Assignment or Sublease shall be shared equally by Tenant and Landlord. Net profits shall be determined by subtracting from the rent and other consideration to be paid by the subtenant or assignee, the Monthly Base Rental and Additional Rent due to Landlord for the applicable period; provided however that Tenant shall be entitled to reimbursement, out of such net profits, for any reasonable amount expended by Tenant for subleasing brokers commissions, abated rent, and costs of demising or otherwise improving the space for the particular subtenant or assignee.

16.9 In no event shall this Lease be assigned or assignable by operation of law or by voluntary or involuntary bankruptcy proceedings or otherwise, and in no event shall this Lease or any rights or privileges hereunder be an asset of Tenant under any bankruptcy, insolvency, reorganization or other debtor relief proceedings.

17. UTILITIES

17.1 Tenant shall have access to and use of the Premises (including Building elevator usage, access to the parking garage, and use of electricity and water) 365 days per year, 24 hours per day, subject to Articles 17.2,

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17.3 and 17.4 hereof. Landlord shall furnish to the Premises during the period from 8:00 a.m. to 6:00 p.m., Monday through Friday, except for New Year's Day, Washington's Birthday, Memorial Day, Independence Day, Labor Day, Thanksgiving, Christmas and such other holidays as are generally recognized in the area where the Building is located, and subject to reasonable rules and regulations from time to time established by Landlord, heating, air conditioning and ventilation in amounts required, in Landlord's reasonable judgment, for the use and occupancy of the Premises. Heating, air conditioning and ventilation shall also be provided in accordance with Building procedures from 8:00 a.m. to 12:00 noon on Saturdays, holidays excepted. Landlord shall also provide janitorial service five days per week (excluding holidays) generally consistent with that furnished in other first-class office buildings in the area in which the Building is located, and window washing as determined by Landlord. Anything contained herein to the contrary notwithstanding, Tenant shall not permit the electrical current for the lighting devices located upon the Premises, including, without limitation, building standard lighting fixtures, non-building standard lighting fixtures and task lighting, to at any time exceed an average of 2.2 watts per Gross Square Foot of Conditioned Floor Area (as said term is defined in the California Administrative Code, Title 24, Part 6, Division T-20, Chapter 2, Subchapter 4) of the Premises, or such higher amount as is generally permitted in first class office buildings in Long Beach.

17.2 Landlord may impose a reasonable charge and establish reasonable rules and regulations consistent with first class office buildings in Long Beach for the use of any heating, air conditioning, ventilation or electric current by Tenant at any time other than during the hours set forth in Article 17.1, and for the usage of any additional or unusual janitorial services required because of any non-building standard improvements in the Premises, the carelessness of Tenant, the nature of Tenant's business and the removal of any refuse and rubbish from the Premises except for discarded material placed in wastepaper baskets and left for emptying as an incident to Landlord's normal cleaning of the Premises. To the extent Landlord incurs additional janitorial costs, Landlord shall not be required to provide janitorial services for portions of the Premises used for preparing or consuming food or beverages, for storage, as a mail room or as a lavatory other than the lavatory rooms shown on Exhibit A attached hereto.

17.3 Landlord shall not be liable for any interruption in or failure to furnish any services or utilities when such interruption or failure is caused by acts of God, accidents, breakage, repairs, strikes, lockouts, other labor disputes, the making of repairs, alterations or improvements to the Premises or the Building, the inability to obtain an adequate supply of fuel, steam, water, electricity, labor or other supplies or by any other condition beyond Landlord's reasonable control, including, without limitation, any governmental energy conservation program, and Tenant shall not be entitled to any damages resulting from such failure nor shall such failure relieve Tenant of the obligation to pay the full Monthly Base Rental and Additional Rent reserved hereunder, except as otherwise provided in Article 13, or constitute or be construed as a constructive or other eviction of Tenant. In the event any governmental entity promulgates or revises any statute, ordinance or building, fire or other code or imposes mandatory or voluntary controls or guidelines on Landlord or the Building or any part thereof, relating to the use or conservation of energy, water, gas, light or electricity or the reduction of automobile or other emissions or the provision of any other utility or service provided with respect to this Lease or in the event Landlord is required or elects to make alterations to any part of the Building in order to comply with such mandatory or voluntary controls or guidelines, Landlord may, in its sole discretion, comply with such mandatory or voluntary controls or guidelines or make such alterations to the Building. Such compliance and the making of such alterations shall in no event entitle Tenant to any damages, relieve Tenant of the obligation to pay the full Monthly Base Rental and Additional Rent reserved hereunder or constitute or be construed as a constructive or other eviction of Tenant.

17.4 If Tenant shall consumes electricity in excess of that typically consumed by normal office usage, Landlord shall have the right to install an electric current meter in the Premises to measure the amount of electric current consumed on the Premises. The cost of any such meter and separate conduit, wiring or panel requirements and the installation, maintenance and repair thereof shall be paid for by Tenant and Tenant agrees to reimburse Landlord promptly upon demand therefor by Landlord for all such excess electric current as shown by said meter, at the rates charged for such services by the city in which the Building is located or the local public utility furnishing the same, plus any additional expense incurred in keeping the account of the electric current so consumed. If the temperature otherwise maintained in any portion of the Premises by the heating, air conditioning or ventilation systems is affected as a result of (a) any lights, machines or equipment (including without limitation electronic data processing machines) used by Tenant in the Premises, (b) the occupancy of the Premises by more than one person per one hundred seventy-five (175) square feet of rentable area therein, or (c) an electrical load in excess of three (3)

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watts per square foot of rentable area of the Premises, Landlord shall have the right to install any machinery and equipment that Landlord reasonably deems necessary to restore temperature balance, including, without limitation, modifications to the standard air conditioning equipment, and the cost thereof, including the cost of installation (including design and engineering) and any additional cost of operation and maintenance incurred thereby, shall be paid by Tenant to Landlord as Additional Rent hereunder upon demand by Landlord.

17.5 Tenant shall also be separately billed for all electricity and other utilities consumed by non-Building Standard HVAC equipment, which usage shall be metered by submeters installed at Tenant's sole cost and expense.

18. DEFAULT

18.1 The occurrence of any of the following shall constitute an event of default on the part of Tenant:

- (a) Failure to pay any installment of Monthly Base Rental or Additional Rent when due and payable hereunder; such failure continuing for three (3) days after written notice of such failure;
- (b) Failure to perform any obligations, agreements or covenants under this Lease other than those matters specified in subparagraph (a) of this Article 18.1, such failure continuing for five (5) days after written notice of such failure or such longer period as may be reasonably necessary to cure such failure;
- (c) Abandonment (without payment of Rent) of the Premises for a continuous period in excess of five (5) business days. Tenant waives any right to notice Tenant may have under Section 1951.3 of the Civil Code of the State of California, the terms of this subparagraph (c) being deemed such notice to Tenant as required by said Section 1951.3;
- (d) A general assignment by Tenant for the benefit of creditors;
- (e) The filing of any voluntary petition in bankruptcy by Tenant, or the filing of an involuntary petition by Tenant's creditors, which involuntary petition remains undischarged for a period of ten (10) business days;
- (f) The employment of a receiver to take possession of substantially all of Tenant's assets or the Premises, if such receivership remains undissolved for a period of ten (10) business days after creation thereof;
- (g) The attachment, execution or other judicial seizure of all or substantially all of Tenant's assets or the Premises, if such attachment or other seizure remains undismissed or undischarged for a period of ten (10) business days after the levy thereof; and
- (h) The admission by Tenant in writing of its inability to pay its debts as they become due, the filing by Tenant of a petition seeking any reorganization, arrangement, composition, readjustment, liquidation, dissolution or similar relief under any present or future statute, law or regulation, the filing by Tenant of any answer admitting or failing timely to contest a material allegation of a petition filed against Tenant in any such proceeding or, if within ten (10) days after the commencement of any proceeding against Tenant seeking any reorganization, or arrangement, composition, readjustment, liquidation, dissolution or similar relief under any present or future statute, law or regulation, such proceeding shall not have been dismissed.

18.2 Upon the occurrence of any event of default by Tenant which is not cured by Tenant within the grace periods specified in Article 18.1 hereof, Landlord shall have the following rights and remedies in addition to all other rights or remedies available to Landlord in law or equity:

- (a) The rights and remedies provided by California Civil Code Section 1951.2, including but not limited to the right to terminate Tenant's right to possession of the Premises and to recover the worth at the time of award of the amount by which the unpaid Monthly Base Rental and Additional Rent for the balance of the Term after the time of award exceeds the amount of rental loss for the same period that the Tenant proves could be

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reasonably avoided. The “worth at the time of award” of the amounts referred to in Paragraphs (1) and (2) of subdivision (a) of Section 1951.2 shall be computed by allowing interest at the maximum lawful rate. The “worth at the time of award” of the amount referred to in Paragraph (3) of subdivision (a) of Section 1951.2 shall be computed by discounting such amount at the discount rate of the Federal Reserve Bank of San Francisco at the time of award plus one percent (1%);

(b) The rights and remedies provided by California Civil Code Section 1951.4, that allows Landlord to continue this Lease in effect and to enforce all of its rights and remedies under this Lease, including the right to recover Monthly Base Rental and Additional Rent as they become due, for so long as Landlord does not terminate Tenant’s right to possession; provided, however, if Landlord elects to exercise its remedies described in this subsection (b) and Landlord does not terminate this Lease, and if Tenant requests Landlord’s consent to an Assignment of this Lease or a Sublease of the Premises at such time as Tenant is in default, Landlord shall not unreasonably withhold its consent to such assignment or sublease. Acts of maintenance or preservation, efforts to relet the Premises or the appointment of a receiver upon the Landlord’s initiative to protect its interest under this Lease shall not constitute a termination of Tenant’s right to possession;

(c) The right to terminate this Lease by giving notice to Tenant in accordance with applicable law;

(d) The right and power, as attorney-in-fact for Tenant, to enter the Premises and remove therefrom all persons and property, to store such property in a public warehouse or elsewhere at the cost of and for the account of Tenant, and to sell such property and apply the proceeds therefrom pursuant to applicable California law. Landlord, as attorney-in-fact for Tenant, may from time to time sublet the Premises or any part thereof for such term or terms (which may extend beyond the Term) and at such rent and at such other terms as Landlord in its sole discretion may deem advisable, with the right to make alterations and repairs to the Premises. Upon each such subletting, (i) Tenant shall be immediately liable for payment to Landlord of, in addition to indebtedness other than Monthly Base rental and Additional Rent due hereunder, the cost of such subletting and such alterations and repairs incurred by Landlord in the amount, if any, by which the Monthly Base Rental and Additional Rent for the period of such subletting (to the extent such period does not exceed the Term) exceeds the amount to be paid as Monthly Base Rental and Additional Rent for the Premises for such period, or (ii) at the option of Landlord, rents received from such subletting shall be applied, first, to payment of any indebtedness other than Monthly Base Rental and Additional Rent due hereunder from Tenant to Landlord; second, to the payment of any costs of such subletting and of such alterations and repairs; third, to payment of Monthly Base Rental and Additional Rent due and unpaid hereunder; and the residue, if any, shall be held by Landlord and applied in payment of future Monthly Base Rental and Additional Rent as the same become due hereunder. If Tenant has been credited with any rent to be received by such subletting under clause (i) and such rent shall not be promptly paid to Landlord by the subtenant(s), or if such rentals received from such subletting under clause (ii) during any month are less than those to be paid during that month by Tenant hereunder, Tenant shall pay any such deficiency to Landlord. Such deficiency shall be calculated and paid monthly. For all purposes set forth in this Article 18.2(d), Landlord is hereby irrevocably appointed attorney-in-fact for Tenant, with power of substitution. No taking possession of the Premises by Landlord, as attorney-in-fact for Tenant, shall be construed as an election on its part to terminate this Lease unless a written notice of such intention is given to Tenant. Notwithstanding any such subletting without termination, Landlord may at any time thereafter elect to terminate this Lease for such previous breach;

(e) The right to have a receiver appointed for Tenant, upon application by Landlord, to take possession of the Premises and to apply any rental collected from the Premises and to exercise all other rights and remedies granted to Landlord as attorney-in-fact for Tenant pursuant to Article 18.2(d) hereof; and

(f) The right, without notice, to remedy default for Tenant’s account and at Tenant’s expense, without thereby waiving any other rights or remedies of Landlord with respect to such default.

19. INDEMNITY

19.1 Tenant agrees to indemnify, defend and hold Landlord harmless from any and all loss, cost, liability, damage and expense including, without limitation, penalties, fines and reasonable counsel fees, incurred in

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connection with or arising from any act or omission of Tenant in or about the Premises, including, without limiting the generality of the foregoing, (a) any default by Tenant in the observance or performance of any of the items, covenants or conditions of this Lease on Tenant's part to be observed or performed, or (b) the use or occupancy or manner of use or occupancy of the Premises by Tenant or any person claiming through or under Tenant, or (c) the condition of the Premises for which Tenant is responsible or any occurrence or happening on the Premises, or (d) any acts, omissions or negligence of Tenant or any person claiming through or under Tenant, or of the contractors, agents, servants, employees, visitors or licensees of Tenant or any such person, in or about the Premises or the Building, either prior to, during, or after the expiration of, the Term including, without limitation, any acts, omissions or negligence in the making or performing of any alterations.

19.2 Tenant further agrees that Tenant shall not cause or permit any Hazardous Materials, as hereinafter defined, to be brought upon, kept or used in or about the Premises by Tenant, its agents, employees, contractors or invitees. If Tenant breaches the obligations stated in the preceding sentence, then Tenant shall indemnify, defend and hold Landlord harmless from and against any and all claims, judgments, damages, penalties, fines, costs, liabilities or losses (including, without limitation, diminution in value of the Premises and the Building generally, damages for the loss or restriction on use of space or of any amenity of the Building generally, damages from any adverse impact on marketing of space in the Building, and sums paid in settlement of claims, reasonable attorneys' fees, reasonable consultant fees and reasonable expert fees) which arise during or after the Term as a result of such breach. This indemnification of Landlord by Tenant includes, without limitation, costs incurred in connection with any investigation of site conditions and any cleanup, remedial, removal or restoration work required by any governmental authority because of Hazardous Material present in the soil or ground water or under the Premises or the Building generally. As used herein (i) "Environmental Laws" means the Clean Air Act, the Resource Conservation Recovery Act of 1976, the Hazardous Material Transportation Act, the Comprehensive Environmental Response, Compensation and Liability Act of 1980, the Resource Conservation and Recovery Act, the Toxic Substances Control Act, the Occupational Safety and Health Act, the Consumer Product Safety Act, the Clean Water Act, the Federal Water Pollution Control Act, the National Environmental Policy Act, as each of the foregoing shall be amended from time to time, and any similar or successor laws, federal, state or local, or any rules or regulations promulgated thereunder; and (ii) "Hazardous Materials" means and includes asbestos, oil, petroleum products and their by-products; hazardous substances; hazardous wastes and toxic substances, as those terms are used in Environmental Laws; or any substances or materials listed as hazardous or toxic by the United States Department of Transportation, or by the Environmental Protection Agency or any successor agency under any Environmental Laws but excluding immaterial quantities of substances customarily and prudently used in the normal course of general office use, so long as any such use is lawful and not otherwise disturbing to the use and enjoyment of the Building by other tenants.

20. TENANT'S INSURANCE

Tenant shall procure at its sole cost and expense and keep in effect from the date of this Lease until the end of the Term, Commercial General Liability insurance applying to the use and occupancy of the Premises or the Building, or any part of either, or any areas adjacent thereto, and the business operated by Tenant, or any other occupant, on the Premises. Such insurance shall include Broad Form Contractual liability insurance coverage insuring all of Tenant's indemnity obligations under this Lease. Such coverage shall have a minimum combined single limit of liability of at least Two Million Dollars (\$2,000,000.00), and a general aggregate limit of liability of at least Five Million Dollars (\$5,000,000.00). All such policies shall be written to apply to all bodily injury, property damage, personal injury and other covered losses, however occasioned, occurring during the policy term, shall be endorsed to add Landlord as an additional insured, to provide that such coverage shall be primary and that any insurance maintained by Landlord shall be excess insurance only. Such coverage shall also contain endorsements: (i) deleting any employee exclusion on personal injury coverage; (ii) including employees as additional insureds; (iii) deleting any liquor liability exclusion; (iv) providing coverage for fire legal liability in an amount of not less than \$300,000; and (v) providing for coverage of employer's automobile non-ownership liability. All such insurance shall provide for severability of interests; shall provide that an act or omission of one of the named insureds shall not reduce or avoid coverage for all claims based on acts, omissions, injury and damage, which claims occurred or arose (or the onset of which occurred or arose) in whole or in part during the policy period. Tenant shall also maintain (i) Workers' Compensation insurance in accordance with California law, (ii) employers liability insurance with a limit no less than \$1,000,000 per employee and \$1,000,000 per occurrence, and (iii) replacement cost fire and extended

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coverage insurance, with vandalism and malicious mischief, sprinkler leakage and earthquake sprinkler leakage endorsements, in an amount sufficient to cover not less than 100% of the full replacement cost, as the same may exist from time to time, of all of Tenant's personal property, fixtures, equipment and tenant improvements. All coverages described in this Section shall be endorsed to waive the insurer's right of subrogation against Landlord and to provide Landlord with 30 days' notice of cancellation or change in terms, and with 10 day's notice of cancellation for non-payment of premium. If at any time during the Term, the amount or coverage of insurance which Tenant is required to carry under this Section is, in Landlord's reasonable judgment, materially less than the amount or type of insurance coverage typically carried by owners or lessees of properties located in Los Angeles/Long Beach, California, which are similar to and operated for similar purposes as the Building, Landlord shall have the right to require Tenant to increase the amount or change the types of insurance coverage required under this Section.

All insurance policies required to be carried under this Lease shall (i) be written by companies rated A-VII or better in "Best's Insurance Guide" and authorized to do business in California, and (ii) name any parties designated by Landlord as additional insureds. Tenant shall deliver to Landlord on or before the Commencement Date, and thereafter at least thirty (30) days before the expiration dates of expiring policies, certified copies of its insurance policies, or a certificate evidencing the same issued by the insurer thereunder, showing that all premiums have been paid for the full policy period; and, in the event Tenant shall fail to procure such insurance, or to deliver such policies or certificates, Landlord may, at its option and in addition to Landlord's other remedies in the event of a default by Tenant hereunder, procure the same for the account of Tenant, and the cost thereof shall be paid to Landlord upon demand as Additional Rent.

21. LIMITATION OF LANDLORD'S LIABILITY

Unless caused by the gross negligence or intentional misconduct of Landlord, Landlord shall not be responsible for or liable to Tenant for any loss or damage that may be occasioned by or through the acts or omissions of persons occupying adjoining premises or any part of the Building or for any loss or damage resulting to Tenant or its property from burst, stopped or leaking water, gas, sewer or steam pipes or for any damage or loss of property within the Premises from any causes whatsoever, including theft.

22. ACCESS TO PREMISES

Landlord reserves and shall have the right to enter the Premises at all reasonable times to supply any service to be provided by Landlord to Tenant hereunder, or in the event of an emergency. In addition, upon 24 hours notice and subject to Tenant's representative having the right to be present, Landlord shall have the right to enter the Premises to show the Premises to prospective purchasers, mortgagees or tenants, to post notices of non-responsibility, to inspect the same and to alter, improve or repair the Premises and any portion of the Building, without abatement of Rent or Additional Rent, and may for that purpose erect, use and maintain scaffolding, pipes, conduits and other necessary structures in and through the Premises where reasonably required by the character of the work to be performed, provided that the entrance to the Premises shall not be blocked thereby, and further provided that the business of Tenant shall not be interfered with unreasonably. Tenant hereby waives any claim for damages for any injury or inconvenience to or interference with Tenant's business, any loss of occupancy or quiet enjoyment of the Premises or any other loss occasioned thereby, for each of the aforesaid purposes, Landlord shall at all times have and retain a key with which to unlock all of the doors in, upon and about the Premises, excluding Tenant's vaults and safes, or special security areas (designated in advance), and Landlord shall have the right to use any and all means that Landlord may deem necessary or proper to open said doors in an emergency. In order to obtain entry to any portion of the Premises, and any entry to the Premises or portions thereof obtained by Landlord by any of said means, or otherwise, shall not under any circumstances be construed or deemed to be a forcible or unlawful entry into, or a detainer of, the Premises, or an eviction, actual or constructive, of Tenant from the Premises or any portion thereof. Landlord shall also have the right at any time, without same constituting an actual or constructive eviction and without incurring any liability to Tenant therefor, to change the arrangement and/or location of entrances or passageways, doors and doorways, and corridors, elevators, stairs, toilets and other public parts of the Building.

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23. NOTICES

Except as otherwise expressly provided in this Lease, any bills, statements, notices, demands, requests or other communications given or required to be given under this Lease shall be effective only if rendered or given in writing, sent by registered or certified mail or delivered personally, (or if given by Landlord, by regular first-class U.S. mail) (a) to Tenant (i) at Tenant's address set forth in the Basic Lease Information, if sent prior to Tenant's taking possession of the Premises, or (ii) at the Building if sent subsequent to Tenant's taking possession of the Premises, or (iii) at any place where Tenant or any agent or employee of Tenant may be found if sent subsequent to Tenant's vacating, deserting, abandoning or surrendering the Premises, or (b) to Landlord at Landlord's address set forth in the Basic Lease Information, or (c) to such other address as either Landlord or Tenant may designate as its new address for such purpose by notice given to the other in accordance with the provisions of this Article 23. Any such bill, statement, notice, demand, request or other communication shall be deemed to have been rendered or given two (2) days after the date when it shall have been mailed as provided in this Article 23 or upon the date personal delivery is made. If Tenant is notified of the identity and address of Landlord's mortgagee or ground or underlying lessor, Tenant shall give to such mortgagee or ground or underlying lessor notice of any default by Landlord under the terms of this Lease in writing sent by registered or certified mail, and such mortgagee or ground or underlying lessor shall be given a reasonable opportunity to cure such default prior to Tenant exercising any remedy available to it.

24. NO WAIVER

No failure by Landlord to insist upon the strict performance of any obligation of Tenant under this Lease or to exercise any right, power or remedy consequent upon a breach thereof, no acceptance of full or partial Monthly Base Rental or Additional Rent during the continuance of any such breach, and no acceptance of the keys to or possession of the Premises prior to the termination of the Term by any employee of Landlord shall constitute a waiver of any such breach or of such term, covenant or condition or operate as a surrender of this Lease. No payment by Tenant or receipt by Landlord of a lesser amount than the aggregate of all Monthly Base Rental and Additional Rent then due under this Lease shall be deemed to be other than on account of the first items of such Monthly Base Rental and Additional Rent then accruing or becoming due, unless Landlord elects otherwise; and no endorsement or statement on any check and no letter accompanying any check or other payment of Monthly Base Rental or Additional Rent in any such lesser amount and no acceptance of any such check or other such payment by Landlord shall constitute an accord and satisfaction, and Landlord may accept such check or payment without prejudice to Landlord's right to recover the balance of such Monthly Base Rental or Additional Rent or to pursue any other legal remedy.

25. CERTIFICATES

Tenant, at any time and from time to time, within ten (10) days from receipt of written notice from Landlord, shall execute, acknowledge and deliver to Landlord and, at Landlord's request, to any prospective purchaser, ground or underlying lessor or mortgagee of any part of the Building, a certificate of Tenant stating: (a) that Tenant has accepted the Premises (or, if Tenant has not done so, that Tenant has not accepted the Premises and specifying the reasons therefor), (b) the Commencement and Expiration Dates of this Lease, (c) that this Lease is unmodified and in full force and effect (or, if there have been modifications, that same is in full force and effect as modified and stating the modifications), (d) whether or not there are then existing any defenses against the enforcement of any of the obligations of Tenant under this Lease (and, if so, specifying same), (e) whether or not there are then existing any defaults by Landlord in the performance of its obligations under this Lease (and, if so, specifying same), (f) the dates, if any, to which the Monthly Base Rental and Additional Rent and other charges under this Lease have been paid, and (g) any other information that may reasonably be required by any of such persons. It is intended that any such certificate of Tenant delivered pursuant to this Article 25 may be relied upon by Landlord and any prospective purchaser, ground or underlying lessor or mortgagee of any part of the Building.

At Tenant's request, and within the same time period specified above, Landlord shall execute and deliver to Tenant a certificate of Landlord, confirming such matters with respect to this Lease as may be reasonably requested by Tenant.

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26. RULES AND REGULATIONS

Tenant shall faithfully observe and comply with the rules and regulations attached to this Lease as Exhibit C and all modifications thereof and additions thereto from time to time put into effect by Landlord. Landlord shall not be responsible for the nonperformance by any other tenant or occupant of the Building of any said rules and regulations. In the event of an express and direct conflict between the terms, covenants, agreements and conditions of this Lease and the terms, covenants, agreements and conditions of such rules and regulations, as modified and amended from time to time by Landlord, this Lease shall control.

27. TAX ON TENANT'S PERSONAL PROPERTY AND BUILDING NON-STANDARD WORK

27.1 At least ten (10) days' prior to delinquency, Tenant shall pay all taxes levied or assessed upon Tenant's equipment, furniture, fixtures and other personal property located in or about the Premises. If the assessed value of Landlord's property is increased by the inclusion therein of a value placed upon Tenant's equipment, furniture, fixtures or other personal property, Tenant shall pay to Landlord, upon written demand, the taxes so levied against Landlord, or the portion thereof resulting from said increase in assessment.

27.2 Tenant shall pay to Landlord, upon written demand, such portion of all real estate taxes levied or assessed against Landlord that are attributable to the value of the tenant improvements placed in the Premises in excess of the value of the Building Standard Work for the Premises. If the assessing authority allocated a specific value to said Building Non-Standard Work, the amount payable by Tenant shall be the tax attributable to such specific value. If the assessing authority does not allocate a specific value to said Building Non-Standard Work, the amount payable by Tenant pursuant to this Article 27.2 shall be an amount equal to the total tax assessed against improvements that include said Tenant improvements multiplied by a fraction, the numerator of which is the cost of said Building Non-Standard Work in excess of the cost of the Building Standard Work for the Premises and the denominator of which is the total cost of the improvements covered by assessment.

27.3 The portion of real estate taxes payable by Tenant pursuant to Article 27.1 and 27.2 hereof and by other tenants of the Building pursuant to similar provisions in their leases shall be excluded from Real Estate Taxes for purposes of computing the Additional Rent to be paid under Article 4 hereof.

28. SECURITY DEPOSIT

Upon the full execution of this Lease, no security deposit shall be required of Tenant. However, in the event (i) Tenant ever becomes more than 30 days delinquent in the payment of Monthly Base Rental or Additional Rent or (ii) Tenant's annual "net income", as shown on any annual audited financial statement of Tenant, is less than \$9,500,000.00, or (iii) Tenant's ratio of "current assets" to "current liabilities", as shown on any annual audited financial statement of Tenant, is less than 1.3:1, Tenant shall deliver to Landlord within 5 days of Landlord's request, a cash amount equal to 2 month's Monthly Base Rental then payable hereunder, to be held by Landlord as security for the faithful performance of all terms, covenants and conditions of this Lease. The amount of any security deposit delivered to Landlord shall be increased from time to time so as to always equal 2 month's Monthly Base Rental. In connection therewith, Tenant shall deliver to Landlord, within 30 days of the close of each year, Tenant's annual financial statements prepared by Tenant's independent accounting firm, certified as true and correct by Tenant's Chief Financial Officer, and disclosing Tenant's current financial condition and "net worth".

Tenant shall also pay such reasonable additional security deposit that Landlord may require for the issuance of each "key card" Landlord may issue to Tenant.

Tenant agrees that Landlord may, without waiving any of Landlord's other rights and remedies under this Lease upon the occurrence of any of the events of default described in Article 18 hereof, apply the security deposit to remedy any failure by Tenant to pay Monthly Base Rental or Additional Rent, to repair or maintain the Premises, or to perform any other terms, covenants or conditions contained herein. If Tenant has kept and performed all terms, covenants and conditions of this Lease during the Term, Landlord will within thirty (30) days following the termination hereof return said sum to Tenant or the last permitted assignee of Tenant's interest hereunder at the expiration of the Term. Should Landlord use any portion of the security deposit to cure any default by Tenant hereunder, Tenant shall forthwith upon demand replenish the security deposit to the original amount. Landlord shall

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not be required to keep the security deposit separate from its general funds, and Tenant shall not be entitled to interest on any such security deposit.

29. AUTHORITY

If Tenant signs as a corporation or a partnership, each of the persons executing this Lease on behalf of Tenant does hereby covenant and warrant that Tenant is a duly authorized and existing entity, that Tenant has and is qualified to do business in California, that Tenant has full right and authority to enter into this Lease, and that each and both of the persons signing on behalf of Tenant are authorized to do so. Upon Landlord's request, Tenant shall provide Landlord with evidence reasonably satisfactory to Landlord confirming the foregoing covenants and warranties.

30. MISCELLANEOUS

30.1 The words "Landlord" and "Tenant" as used herein shall include the plural as well as the singular. The words used in the neuter gender include the masculine and feminine. If there is more than one person or entity comprising Tenant, the obligations under this Lease imposed on Tenant shall be joint and several. The captions preceding the articles of this Lease have been inserted solely as a matter of convenience and such captions in no way define or limit the scope or intent of any provision of this Lease.

30.2 The terms, covenants and conditions contained in this Lease shall bind and inure to the benefit of Landlord and Tenant and, except as otherwise provided herein, their respective personal representatives and successors and assigns; provided, however, upon the sale, assignment or transfer by the Landlord named herein (or by any subsequent landlord) of its interest in the Building, including any transfer by operation of law, the Landlord (or subsequent landlord) shall be relieved from all subsequent obligations or liabilities under this Lease, and all obligations subsequent to such sale, assignment or transfer (but not any obligations or liabilities that have accrued prior to the date of such sale, assignment or transfer) shall be binding upon the grantee, assignee or other transferee, who, by accepting such interest, shall be deemed to have assumed such subsequent obligations and liabilities.

30.3 If any provision of this Lease or the application thereof to any person or circumstance shall, to any extent, be invalid or unenforceable, the remainder of this Lease, or the application of such provision to persons or circumstances other than those as to which it is invalid or unenforceable, shall not be affected thereby, and each provision of this Lease shall be valid and enforceable to the fullest extent permitted by law.

30.4 This Lease shall be construed and enforced in accordance with the laws of the State of California.

30.5 Submission of this instrument for examination or signature by Tenant does not constitute a reservation of or an option for lease, and it is not effective as a lease or otherwise until execution and delivery by both Landlord and Tenant.

30.6 This instrument, including the Exhibits hereto, which are made a part of this Lease, contains the entire agreement between the parties and all prior negotiations and agreements are merged herein. Neither Landlord nor Landlord's agents have made any representations or warranties with respect to the Premises, the Building or this Lease except as expressly set forth herein, and no rights, easements or licenses are or shall be acquired by Tenant by implication or otherwise unless expressly set forth herein.

30.7 The review, approval, inspection or examination by Landlord of any item to be reviewed, approved, inspected or examined by Landlord under the terms of this Lease or the exhibits attached hereto shall not constitute the assumption of any responsibility by Landlord for either the accuracy or sufficiency of any such item or the quality or suitability of such item for its intended use. Any such review, approval, inspection or examination by Landlord is for the sole purpose of protecting Landlord's interests in the Building and under this Lease, and no third parties, including, without limitation, Tenant or any person or entity claiming through or under Tenant, or the contractors, agents, servants, employees, visitors or licensees of Tenant or any such person or entity, shall have any rights hereunder.

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30.8 In the event that either Landlord or Tenant fails to perform any of its obligations under this Lease or in the event a dispute arises concerning the meaning or interpretation of any provision of this Lease, the defaulting party or the party not prevailing in such dispute, as the case may be, shall pay any and all costs and expenses incurred by the other party in enforcing or establishing its rights hereunder, including, without limitation, court costs and reasonable counsel fees.

30.9 Upon the expiration or sooner termination of the Term, Tenant will quietly and peacefully surrender to Landlord the Premises in the condition in which they are required to be kept as provided in Article 9 hereof, ordinary wear and tear and the provisions of Article 14 excepted.

30.10 Upon Tenant paying the Monthly Base Rental and Additional Rent and performing all of Tenant's obligations under this Lease, Tenant may peacefully and quietly enjoy the Premises during the Term as against all persons or entities lawfully claiming by or through Landlord; subject, however, to the provisions of this Lease and to any mortgages or ground or underlying leases referred to in Article 12 hereof.

30.11 Tenant covenants and agrees that no diminution of light, air or view by any structure that may hereafter be erected (whether or not by Landlord) shall entitle Tenant to any reduction of Monthly Base Rental or Additional Rent under this Lease, result in any liability of Landlord to Tenant, or in any other way affect this Lease or Tenant's obligations hereunder.

30.12 Any holding over after the expiration of the Term with the consent of Landlord shall be construed to be a tenancy from month to month at one hundred seventy-five percent (175%) of the Monthly Base Rental herein specified (prorated on a monthly basis), unless Landlord shall specify a different rent in its sole discretion, together with an amount estimated by Landlord for the monthly Additional Rent payable under this Lease, and shall otherwise be on the terms and conditions herein specified so far as applicable. Any holding over without Landlord's consent shall constitute a default by Tenant and entitle Landlord to reenter the Premises and pursue its remedies as provided in Article 18 hereof.

30.13 Neither this Lease nor any term or provision hereof may be changed, waived, discharged or terminated orally, and no breach thereof shall be waived, altered or modified, except by a written instrument signed by the party against which the enforcement of the change, waiver, discharge or termination is sought. No waiver of any breach shall affect or alter this Lease, but each and every term, covenant and condition of this Lease shall continue in full force and effect with respect to any other then existing or subsequent breach thereof.

30.14 Tenant herein covenants by and for itself, its heirs, executors, administrators and assigns, and all persons claiming under or through it, and this Lease is made and accepted upon and subject to the following conditions: that there shall be no discrimination against or segregation of any person or group of persons, on account of race, color, creed, religion, sex, marital status, age, handicap, national origin or ancestry, in the leasing, subleasing, transferring, use, occupancy, tenure or enjoyment of the Premises herein leased nor shall the Tenant itself, or any person claiming under or through it, establish or permit any such practice or practices of discrimination or segregation with reference to the selection, location, number, use or occupancy, of tenants, lessees, subtenants, sublessees or vendees in the Premises herein leased.

30.15 Tenant shall look only to Landlord's estate in the Building for the satisfaction of Tenant's remedies or for the collection of a judgment (or other judicial process) requiring the payment of money by Landlord in the event of any default by Landlord hereunder, and no other property or assets of Landlord or its partners or principals, disclosed or undisclosed, shall be subject to levy, execution or other enforcement procedure for the satisfaction of Tenant's remedies under or with respect to this Lease, the relationship of Landlord and Tenant hereunder or Tenant's use or occupancy of the Premises.

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30.16 If Tenant shall request Landlord's consent and Landlord shall fail or refuse to give such consent, Tenant shall not be entitled to any damages for any withholding by Landlord of its consent, it being intended that Tenant's sole remedy shall be an action for specific performance or injunction, and that such remedy shall be available only in those cases where Landlord has expressly agreed in writing not to unreasonably withhold its consent or where as a matter of law Landlord may not unreasonably withhold its consent.

PACIFIC TOWERS ASSOCIATES, a California Limited Partnership

MOLINA HEALTHCARE, INC., a California corporation

By: SIC — Long Beach, a California Limited Partnership,
General Partner of Pacific Towers Associates

By: /s/ Illegible
Its: EVP

By: The Swig Company, a California Corporation, General
Partner of SIC — Long Beach

By: /s/ C. Joseph Heinz
Its: AVP/CAO

By: /s/ Kennard P. Perry
Title: VICE PRESIDENT

If Tenant is a corporation, this Lease must be executed by (1) the Chairman, President, or Vice-President and (2) the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer.

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PACIFIC TOWERS ASSOCIATES LEASE ADDENDUM
TENANT: MOLINA HEALTHCARE, INC.,
a California corporation

THIS ADDENDUM is attached to and is a part of the Standard Form Office Lease ("Lease") dated July 10th 2002, between Pacific Towers Associates and the aforementioned Tenant. Any conflict between the terms of the printed form Lease and this Addendum shall be resolved in favor of the provisions of this Addendum. For purposes of this Addendum, the term "Building" refers to the entire ARCO Center, Long Beach California, as designated and defined in Paragraph 1.1 of the Lease, and each building therein is designated by its address of 200 Oceangate or 300 Oceangate.

1. TENANT'S RIGHT TO REDUCE SIZE OF PREMISES. Provided Tenant is not then in default under the Lease and the Lease is in full force and effect, effective at the conclusion of the sixth (6th) year of the initial Lease Term, Tenant shall have a one (1) time option to give back to Landlord a portion of the Premises consisting of the lesser of (i) 20% of the Premises then leased by Tenant or (ii) one (1) full floor. In addition, Tenant shall not be able to give back any space below the 6th Floor. Tenant shall be responsible for any and all costs associated with demising the proposed Premises to be given back, including but not limited to the construction of corridors and any other applicable code compliance items, and as may be needed in order for the space given back and Tenant's remaining space to be leaseable by Landlord and comply with applicable building, life safety and other codes, laws, and regulations. Tenant shall propose the location of any space to be given back and Landlord shall reasonably approve said location. All space to be given back shall be contiguous.

In the event Tenant does give back space, Tenant shall be required to pay to Landlord (in addition to any demising and other costs outlined above) a termination fee equal to the sum of (i) the unamortized portion (using an interest rate of 10% per annum) of the Tenant Improvement Allowance applicable to the space, assuming the Tenant Improvement Allowance was being amortized over the initial Lease Term, and (ii) the unamortized portion (using an interest rate of 10% per annum) of a pro-rata portion of all brokerage commissions paid in connection with the space assuming they were being amortized over the initial Lease Term therefor, and (iii) the rent differential of the overall effective Monthly Base Rental rate for the space for the initial Lease Term versus the effective Monthly Base Rental rate Tenant has paid up to the termination date. Tenant shall pay said termination fee within 30 days following its notice of contraction as set forth below.

If Tenant decides to exercise the contraction option set forth in this Paragraph 1, Tenant must provide Landlord with written notice thereof no later than twelve (12) months prior to the effective date therefor. Upon Tenant's surrender of the Premises pursuant to this option, Tenant's parking privileges shall be reduced accordingly by the parking ratio of 4.5 per 1,000 rentable square feet.

2. TENANT'S OPTION TO EXTEND LEASE TERM. Provided Tenant is not then in default under the Lease and the Lease is in full force and effect, and further provided that Tenant has not assigned its interest in this Lease or subleased any portion of the Premises and is then leasing a minimum of 40,000 rentable square feet in the Building, Tenant shall have the option to extend the term of this Lease for all space it is then leasing in the Building for two consecutive five-year periods, commencing at the expiration of the initial term. In order to exercise said options, written notice thereof ("Renewal Option Notice") must be delivered to and received by Landlord not more than twenty four (24) months and not less than fifteen (15) months prior to the then expiration date of the term, with time being of the essence with respect to such notice. In the event one or both such options are exercised, Tenant's occupancy shall continue on all the same terms and conditions contained herein, but (i) with no options to further extend the term, (ii) the Monthly Base Rental shall be increased to reflect the then Fair Market Rental for the Premises, as determined below; but in no event shall said Monthly Base Rental be less than that payable by Tenant upon the expiration of the Lease term then in effect, (iii) Landlord shall have no obligation to perform or pay for any tenant improvement work in connection with the extension of the term, (iv) there shall be no abatement of rent or parking charges, and (v) there shall be no rights of expansion, rights of first refusal, rights of first negotiation, rights of contraction or rights of early termination.

a. Procedure for Determining Fair Market Rental. "Fair Market Rental" shall be defined as the

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rate being charged non-equity tenants for comparable space in comparable office buildings in the surrounding Downtown Long Beach area during the proposed extension period, based on highest and best use and taking into consideration when evaluating comparables: location, tenant improvements provided or to be provided, rental abatements and other forms of rental concessions, lease term, and any other relevant factors. Fair Market Rental for the extension term shall be determined by Landlord by written notice given to Tenant not later than ninety (90) days prior to the commencement date of the extension term, subject to Tenant's right of arbitration set forth below. Failure on the part of Tenant to demand arbitration within thirty (30) days after receipt of notice from Landlord of Landlord's determination of Fair Market Rental shall bind Tenant to the Fair Market Rental as determined by Landlord. Should Tenant elect to arbitrate and should the arbitration not have been concluded as of the commencement date of the extension term, Tenant shall pay as Rent the Fair Market Rental as determined by Landlord. If the Fair Market Rental as determined by arbitration is greater or less than Landlord's determination, any adjustment required to correct the amount previously paid shall be paid by the appropriate party within ten (10) days after such determination of the Fair Market Rental.

b. Arbitration Procedure. If Tenant disputes the amount claimed by Landlord as Fair Market Rental, Tenant may require that the dispute be submitted to binding arbitration. The judgment or the award rendered in any such arbitration may be entered in any court having jurisdiction and shall be final and binding between the parties. The arbitration shall be conducted and determined in the City of Long Beach and County of Los Angeles in accordance with the then prevailing rules of the American Arbitration Association or its successor for arbitration of commercial disputes except that the procedures mandated by such rules shall be modified as follows:

(i) Tenant shall make demand for arbitration in writing within thirty (30) days after receipt of Landlord's determination of Fair Market Rental specifying the name and address of the person to act as the arbitrator on Tenant's behalf. The arbitrator selected by Tenant shall be qualified as a real estate broker with at least seven (7) years experience with office leasing in Long Beach, California. Failure on the part of Tenant to make a timely and proper demand for such arbitration shall constitute a waiver of the right thereto. Within ten (10) business days after receipt of the demand for arbitration, Landlord shall give notice to Tenant of the name and address of the person selected by Landlord to act as arbitrator on its behalf who shall be similarly qualified.

(ii) When the two (2) arbitrators are chosen, they shall meet within ten (10) business days after the second arbitrator is appointed and, if within ten (10) business days after such first meeting the two arbitrators shall be unable to agree promptly upon a determination of Fair Market Rental, they shall appoint a third arbitrator, who shall be a competent and impartial person who satisfies the qualifications set forth above. In the event they are unable to agree upon such appointment within five (5) business days after expiration of such ten (10) business day period, the third arbitrator shall be selected by the parties themselves, if they can agree thereon, within a further period of ten (10) business days. If the parties do not so agree, either party, on behalf of both, may request appointment of such a qualified person by the then Presiding Judge of the Los Angeles County Superior Court, and the other party shall not raise any question as to such Judge's full power and jurisdiction to entertain the application for and make the appointment. The three (3) arbitrators shall decide the dispute by following the procedure set forth below.

(iii) In the event a third arbitrator is selected, the arbitrators selected by each of the parties shall state in writing his determination of the Fair Market Rental supported by the reasons therefor with counterpart copies to each party. The arbitrators shall arrange for a hearing at which the proposed determinations of the two arbitrators shall be simultaneously exchanged and at which hearing testimony may be presented and which shall be conducted in accordance with the rules of the American Arbitration Association. The role of the third arbitrator shall be to determine the Fair Market Rental based on the proposed determinations submitted by the two arbitrators. The third arbitrator shall be required to select which of the two determinations most closely determines the Fair Market Rental and his decision shall be final and binding upon the parties.

(iv) The arbitrators appointed by Landlord and Tenant shall have the right to consult with experts and competent authorities in order to obtain factual information or evidence pertaining to a determination of Fair Market Rental, but any such consultation shall be made in the presence of both parties and with full right on their part to cross-examine. The arbitrators shall have no power to modify the provisions of this Lease.

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(v) In the event of a failure, refusal or inability of any arbitrator to act, his successor shall be appointed by the party who appointed him and in the case of the third arbitrator, his successor shall be appointed in the same manner as provided for appointment of the third arbitrator. Any decision in which the arbitrator appointed by Landlord and the arbitrator appointed by Tenant concur shall be binding and conclusive upon the parties. Each party shall pay the fee and expenses of its respective arbitrator and both shall share the fee and expenses of the third arbitrator, if any. The attorneys' fees and expenses of counsel for the respective parties and of witnesses shall be paid by the respective party engaging such counsel or calling such witnesses.

3. TENANT'S RIGHT OF FIRST NEGOTIATION. Provided that Tenant has not assigned its interest in this Lease or subleased any portion of the Premises, and further provided that Tenant is not in default under this Lease; then, subject to continued occupancy by the existing tenant or occupant and/or the rights of other existing tenants, Landlord agrees that at such time as other office space becomes vacant and available for lease on Floors 3, 4, 5, 9 or 10 in 200 Oceangate during the initial term or any extensions thereof, Landlord shall advise Tenant of the availability thereof. Tenant shall have fifteen (15) business days after its receipt of Landlord's notice within which to notify Landlord that it desires to lease such space. Landlord shall thereafter notify Tenant of the rental and other terms and conditions Landlord is seeking with respect to such space, which (i) with respect to the first 16,575 rentable square feet of space leased by Tenant during the initial 36 months of the Term, shall be at the same Monthly Base Rental and Additional Rental as applies to the initial Premises leased hereunder and with the same per square foot Tenant Improvement Allowance as applies to the initial Premises leased hereunder, prorated to the extent the initial term applicable to the offered space is less than 10 full years, and (ii) with respect to all other space offered under this paragraph, shall be at the then prevailing fair market rental rate for such space in the Building, as determined by Landlord in accordance with the definition of fair market rental rate set forth in Paragraph 2a above, and which shall be for a term that is coterminous with the remainder of the Premises, but in no event less than 3 years. Tenant shall then have fifteen (15) business days within which to accept or reject in writing any proposals submitted by Landlord, and, unless a binding written agreement to lease such space is reached within such fifteen (15) business day period, Tenant's right of first negotiation with respect to such space shall terminate and be of no further force or effect, and Landlord shall be entitled to pursue negotiations with any other party on any terms and at any rent Landlord deems appropriate and which may differ from what was offered to Tenant. This right of first negotiation is intended solely to allow the parties an opportunity to negotiate for such space and is not intended to restrict the rights of either party in the event a final and binding agreement does not result within fifteen (15) business days as a result of negotiations initiated pursuant to this Paragraph. In addition to and in amplification of the foregoing, this Paragraph shall not apply and Tenant shall have no right of first negotiation with respect to any space in which the then current tenant or occupant is negotiating an extension or renewal of its lease.

4. PARKING. Tenant shall be provided with a parking ratio of four and one-half (4.5) parking passes per 1,000 square feet of rentable square footage of Tenant's initial Premises and 8th Floor Premises. Said parking passes shall include single reserved, single unreserved and tandem parking, with the allocation as follows: 40% tandem, 8% reserved, and 52% unreserved. Landlord shall provide Tenant with additional parking on a month-to-month basis, as needed and as available.

Beginning at the Commencement Date of the Lease term and throughout the first five (5) years of the initial lease term, the monthly parking costs for parking allocated in connection with the 2nd, 6th, 7th and 8th Floor Premises then leased by Tenant shall be in accordance with the following schedule: \$70.00 per non reserved parking pass per month; \$125.00 per reserved parking pass per month; \$45.00 per tandem parking pass per month. Thereafter, the rates shall be the then prevailing ARCO Center rates in accordance with Exhibit D of the Lease.

Parking ratios and rates for all parking allocated in connection with any expansion of the 2nd, 6th, 7th and 8th Floor Premises leased hereunder shall be in the ratio of 4 passes per 1,000 rentable square feet of expansion premises, for the first 16,575 rentable square feet of expansion premises, and thereafter in the ratio of three passes per 1,000 rentable square feet of expansion premises, and shall be at the prevailing ARCO Center rates. The allocation of such passes to the categories of parking shall be subject to Landlord's reasonable discretion with respect to the first 16,575 rentable square feet of expansion premises and shall thereafter be in compliance with ARCO Center standards.

Notwithstanding anything to the contrary, Landlord reserves the right to fulfill all or a portion of Tenant's

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parking allocation with staffed valet parking.

5. SIGNAGE. From and after the Commencement Date and throughout the term, Tenant shall have the right to install one sign at its sole cost and expense on the existing can sign on the concrete wall signage area in front of 200 Oceangate, identifying Tenant and in a size, style and location that is acceptable to Landlord. In addition, in the event and during such time as Tenant (but not any Subtenant or Assignee (as defined in Article 16 of the Lease) of Molina Healthcare, Inc.) is contractually committed to both leasing and personally occupying at least five full floors in 200 Oceangate, Tenant, at Tenant's cost and expense, shall have the right to install one sign on the top of the exterior facade of 200 Oceangate, identifying Tenant and in a size, style and location that is acceptable to Landlord. All signage is subject to all municipal codes, the approval of all applicable governmental agencies, and Landlord's review and approval, which approval shall not be unreasonably withheld, conditioned or delayed. All signage rights related to the top of the exterior facade of 200 Oceangate granted to Tenant under this Paragraph are non-assignable with the exception that Tenant may assign such rights in accordance with Article 16.2 and Tenant may assign such rights to an Assignee who is to both leasing and personally occupying at least five full floors in 200 Oceangate, who is of good reputation and whose business is of an institutional nature, whose identification on the Building will not, in Landlord's good faith determination, result in a loss of reputation or value to the Building, conflict with any rights given to other tenant's or be objectionable to other tenants of the Building or Landlord's lender, or otherwise be objectionable to Landlord. All access to signage on the Building facade shall be coordinated with the Building Manager through the office of the Building. At the expiration of this Lease, all signage shall be removed and all damage related thereto shall be restored at Tenant's sole cost and to Landlord's satisfaction.

During any period that Tenant has the right to install signage of the top of the exterior facade of 200 Oceangate, Landlord agrees that no other companies competing with Tenant and providing health maintenance services shall be granted the right by Landlord to install their signage on the exterior facades of either 200 Oceangate or 300 Oceangate. Within 10 business days of Landlord's written request, Tenant shall inform Landlord in writing as to whether any particular company identified by Landlord falls within the parameters of the foregoing sentence.

6. INSTALLATION OF ROOF ANTENNA. Subject to Landlord's prior approval which shall not be unreasonably withheld, conditioned or delayed, at any point during the term or extension thereof, Tenant shall have the right to install and use in connection with Tenant's business operations, on the roof of 200 Oceangate, at no monthly rental charge, a roof mounted antenna and/or satellite dish in an area not to exceed 6 feet in diameter, provided there is room on the roof at that time. Landlord will guarantee that there is roof space available up to one year from the Commencement Date, although Landlord does not guarantee the availability of any exact location or that the available location will be suitable for Tenant's equipment. Tenant shall conform with all applicable laws and ordinances and with Landlord's reasonable rules and regulations with regard to use, installation and maintenance of the device requested by Tenant. All access to the roof shall be arranged and coordinated with the Building Manager through the office of the Building. Tenant's roof top equipment shall not interfere with any equipment in the Building or with any equipment that exists on the roof at the time of installation and any existing equipment at that time shall not be relocated in order to accommodate Tenant. All permits, application fees, and all installation, repair, and maintenance costs associated with the aforementioned shall be the responsibility of Tenant. Tenant shall be responsible for repair and maintenance of the roof where the equipment has been installed, as well as all damage to other portions caused by the installation, maintenance or removal of such equipment. The rights of Tenant as set forth in this Paragraph are personal to Molina Healthcare, Inc., and Molina Healthcare, Inc. shall not have the right to transfer, assign, or license the roof rights granted hereunder.

7. TERMINATION RIGHT. Landlord and Tenant are executing this Lease prior to the finalization of the Workletter (Exhibit B) and the execution and delivery of a non-disturbance agreement from Landlord's current lender. Landlord and Tenant shall diligently pursue the finalization of the Workletter and non-disturbance agreement but in the event (i) the Workletter has not been finalized and executed by Landlord and Tenant within 30 days following the full execution of this Lease, or (ii) the non-disturbance agreement referred to in the first sentence of Article 12 of this Lease has not been fully executed within 30 days following the full execution of this Lease, Tenant may terminate this Lease prior to the execution of said Workletter and non-disturbance agreement by written notice to Landlord. In addition, in the event the Workletter and non-disturbance agreement have not been fully executed within 45 days following the full execution of this Lease, Landlord may terminate this Lease prior to the execution of said Workletter and non-disturbance agreement by written notice to Tenant.

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Except as set forth in this Addendum, the Lease shall remain unamended and in full force and effect.

PACIFIC TOWERS ASSOCIATES, a California Limited Partnership

By: SIC — Long Beach, a California Limited Partnership,
General Partner of Pacific Towers Associates

By: The Swig Company, a California Corporation, General
Partner of SIC — Long Beach

By: /s/ Kennard P. Perry
Title: VICE PRESIDENT

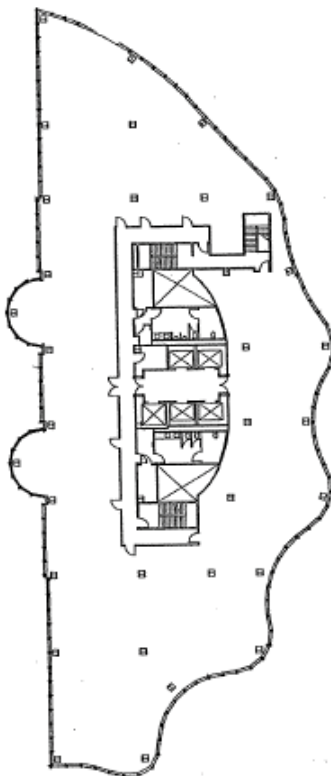
MOLINA HEALTHCARE, INC.,
a California corporation

By: /s/ C. Joseph Heinz
Its: AVP/CAO

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PACIFIC TOWERS ASSOCIATES
STANDARD FORM OFFICE LEASE
EXHIBIT A
FLOOR PLAN
200 TOWER — 2ND FLOOR

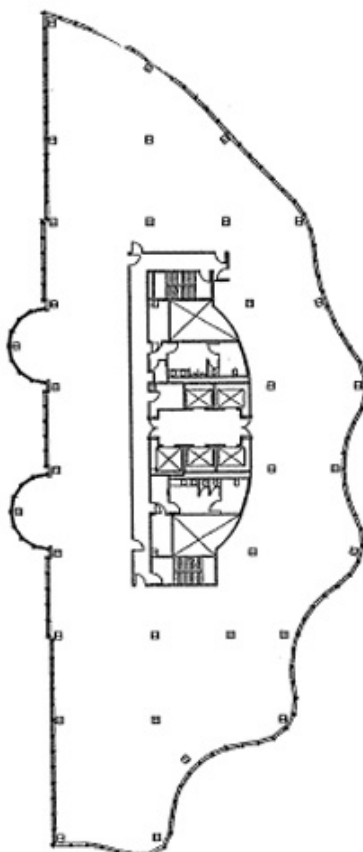


PACIFIC TOWERS ASSOCIATES
STANDARD FORM OFFICE LEASE

EXHIBIT A

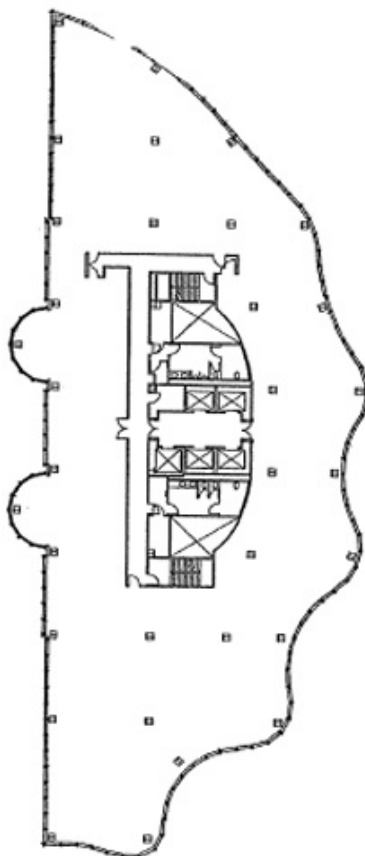
FLOOR PLAN

200 TOWER — 6TH FLOOR



PACIFIC TOWERS ASSOCIATES
STANDARD FORM OFFICE LEASE

EXHIBIT A
FLOOR PLAN
200 TOWER — 7TH FLOOR



PACIFIC TOWERS ASSOCIATES

OFFICE LEASE

EXHIBIT C

RULES AND REGULATIONS

1. BUILDING RULES AND REGULATIONS

(a) The sidewalks, halls, passages, exits, entrances, elevators, shopping areas, escalators and stairways of the Building ("common areas") shall not be obstructed by Tenant or used by it for any purpose other than for ingress to and egress from the Premises. The common areas are not for the use of the general public, and Landlord shall in all cases retain the right to control and prevent access thereto by all persons whose presence in the judgment of Landlord would be prejudicial to the safety, character, reputation and interests of the Building and its tenants. Tenant shall not go upon the roof of the Building.

(b) No sign, placard, picture, name, advertisement or notice visible from the exterior of the Premises shall be inscribed, painted, affixed or otherwise displayed by Tenant on any part of the Building. Landlord will furnish to Tenant general Building Standard guidelines relating to signs inside the Building, in both the main lobby and on the office floors. Tenant agrees to conform to such guidelines. All Building Standard approved signs shall be ordered and installed by Landlord at the expense of Tenant.

(c) The Premises shall not be used for the storage of merchandise held for sale to the general public or for lodging. No cooking shall be done or permitted by Tenant on the Premises, except that use by Tenant of Underwriters' Laboratory approved equipment for brewing coffee, tea, hot chocolate and similar beverages shall be permitted, provided that such use is in accordance with all applicable federal, state and city laws, codes, ordinances, rules and regulations.

(d) Tenant shall not employ any person or persons other than the janitor of Landlord for the purpose of cleaning the Premises, unless otherwise agreed to by Landlord in writing. No person or persons other than those approved by Landlord shall be permitted to enter the Building for the purpose of cleaning the Premises or any portion of the Building. Tenant shall not cause any unnecessary labor by reason of Tenant's carelessness or indifference in the preservation of good order and cleanliness. Janitorial service will not be furnished on nights when rooms are occupied after 9:30 P.M. unless, by agreement in writing, service is extended to a later hour for specifically designated rooms.

(e) Landlord will furnish Tenant with two (2) keys to the Premises free of charge. No additional locking devices shall be installed without the prior written consent of Landlord. Landlord may impose a reasonable charge for any additional lock or any bolt installed on any door of the Premises without the prior consent of Landlord. Tenant shall in each case furnish Landlord with a key for any such lock. Tenant, upon the termination of its tenancy, shall deliver to Landlord all keys to doors in the Premises.

(f) The freight elevator shall be available for use by Tenant, subject to such reasonable scheduling as Landlord shall deem appropriate. The persons employed by Tenant to move equipment or other items in or out of the Building must be acceptable to Landlord. Landlord shall have the right to prescribe the weight, size and position of all equipment, materials, supplies, furniture or other property brought into the Building. Heavy objects shall, if considered necessary by Landlord, stand on wood strips of such thickness as is necessary to properly distribute the weight of such objects, Landlord will not be responsible for loss of or damage to any such property from any cause, and all damage done to the Building by moving or maintaining Tenant's property shall be repaired at the expense of Tenant.

(g) Tenant shall not use or keep in the Premises or the Building any kerosene, gasoline or flammable or combustible fluid or materials or use any method of heating or air conditioning other than that supplied

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by Landlord. Tenant shall not use, keep or permit or suffer the Premises to be occupied or used in a manner offensive or objectionable to Landlord or other occupants of the Building by reason of noise, odors, and/or vibrations, or interfere in any way with other tenants or those having business in the Building.

(h Landlord reserves the right to exclude from the Building between the hours of 6 P.M. and 8 A.M. and at all hours on Saturdays, Sundays, and legal holidays all persons who do not present a pass to the Building signed by Landlord. Landlord will furnish passes to persons for whom Tenant requests same in writing. Tenant shall be responsible for all persons for whom it requests passes and shall be liable to Landlord for all acts of such persons. Landlord shall in no case be liable for damages for any error with regard to the admission to or exclusion from the Building of any person. In the case of invasion, mob, riot, public excitement or other circumstances rendering such action advisable in Landlord's opinion, Landlord reserves the right to prevent access to the Building during the continuance of same by such action as Landlord may deem appropriate, including closing doors.

(i The directory of the Building will be provided for the display of the name and location of tenants and a reasonable number of the principal officers and employees of tenants, and Landlord reserves the right to exclude any other names therefrom. Any additional name that Tenant shall desire to place upon the directory must first be approved by Landlord and, if so approved, a charge will be made therefor.

(j No curtains, draperies, blinds, shutters, shades, screens or other coverings, hangings or decorations shall be attached to, hung or placed in, or used in connection with any window of the Building without the prior written consent of Landlord. In any event, with the prior written consent of Landlord, such items shall be installed on the office side of Landlord's standard window covering and shall in no way be visible from the exterior of the Building.

(k Tenant shall not obtain for use in the Premises ice, drinking water, food, beverage, towel or other similar services, except at such reasonable hours and under such reasonable regulations as may be established by Landlord.

(l Tenant shall see that the doors of the Premises are closed and locked and that all water faucets, water apparatus, equipment, and utilities are shut off before Tenant or Tenant's employees leave the Premises, so as to prevent waste or damage, and for any default or carelessness in this regard Tenant shall make good all injuries sustained by other tenants or occupants of the Building or Landlord. On multiple-tenancy floors, all tenants shall keep the doors to the Building corridors closed at all times except for ingress and egress.

(m The toilet rooms, toilets, urinals, wash bowls and other apparatus shall not be used for any purpose other than for which they were constructed. No foreign substance of any kind whatsoever shall be deposited therein, and any damage resulting to same from Tenant's misuse thereof shall be paid by Tenant.

(n Except with the prior consent of Landlord, Tenant shall not sell, or permit the sale from the Premises of, or use or permit the use of any sidewalk or area adjacent to the Premises for the sale of, newspapers, magazines, periodicals, theater tickets or any other goods, merchandise or service, nor shall the Premises be used for manufacturing of any kind, or for any business or activity other than that specifically provided for in Tenant's lease.

(o Tenant shall not install any radio or television antenna, satellite dish, communication equipment, loudspeaker, or other device on the roof or exterior walls of the Building.

(p Tenant shall not use in any space, or in the common areas of the Building, any hand trucks except those equipped with rubber tires and side guards or such other material handling equipment as Landlord may approve. No bicycle or vehicle of any kind shall be brought by Tenant into the Building or kept in or about the Premises.

(q Tenant shall store all its trash and garbage within the Premises until removal of same to such location in the Building as may be designated from time to time by Landlord. No material shall be placed in the Building trash boxes or receptacles if such material is of such nature that it may not be disposed of in the ordinary

Initials /s/ Illegible
07/17/02

Initials /s/ Illegible

and customary manner of removing and disposing of trash and garbage in the City of Long Beach without being in violation of any law or ordinance governing such disposal.

(r All loading and unloading of merchandise, supplies, materials, garbage and refuse shall be made only through such entryways and elevators and at such time as Landlord shall designate. In its use of the loading areas, Tenant shall not obstruct or permit the obstruction of said loading areas, and at no time shall Tenant park vehicles therein except for loading and unloading.

(s Canvassing, soliciting, peddling or distribution of handbills or any other written material in the Building is prohibited.

(t Tenant shall immediately, upon request from Landlord (which request need not be in writing), reduce its lighting and other electricity usage in the Premises for temporary periods designated by Landlord, when required in Landlord's judgment to prevent overloads of the mechanical or electrical systems of the Building.

(u Landlord reserves the right to select the name of the Building and to make such change or changes of name as it may deem appropriate from time to time, and Tenant shall not refer to the Building by any name other than: (1) the name selected by Landlord (as same may be changed from time to time), or (2) the postal address approved by the United States Post Office. Tenant shall not use the name of the Building in any respect other than as an address of its operation in the Building without the prior written consent of Landlord.

(v The requirements of Tenant will be attended to only upon application by telephone or writing or in person at the office of the Building. Employees of Landlord shall not perform any work or do anything outside of their regular duties unless under special instructions from Landlord.

(w Landlord may waive any one or more of these Rules and Regulations for the benefit of any particular tenant or tenants, but no such waiver by Landlord shall be construed as a waiver of these Rules and Regulations in favor of any other tenant or tenants, nor prevent Landlord from thereafter enforcing any such Rules and Regulations against any or all of the tenants of the Building.

(x Wherever the word "Tenant" occurs in these Rules and Regulations, it is understood and agreed that it shall include Tenant's assigns, agents, contractors, employees and visitors. Wherever the word "Landlord" occurs in these Rules and Regulations, it is understood and agreed that it shall include Landlord's assigns, agents, contractors, employees and visitors.

(y These Rules and Regulations are in addition to and shall not be construed in any way to modify, alter or amend, in whole or part, the terms, covenants, agreements and conditions of any lease of premises in the Building.

(z Landlord reserves the right to make such other and reasonable rules and regulations as in its judgment may from time to time be needed for the safety, care and cleanliness of the Building, and for the preservation of good order therein.

2. PARKING RULES AND REGULATIONS

Tenant and its agents, employees, invitees and other authorized users (collectively "Authorized Users") shall strictly comply at all times with the following rules and regulations in their use of the Arco Center parking facilities.

(a Tenant and its Authorized Users shall not park vehicles in any parking areas designated by Landlord as areas for parking by visitors to the Building.

(b Tenant and Authorized Users shall not leave vehicles in the Building parking areas overnight nor park any vehicles in the Building parking areas other than automobiles, motorcycles, motor driven or

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07/17/02

Initials /s/ Illegible

non-motor driven bicycles or four-wheeled trucks; said non-authorized vehicles shall be subject to towing at Tenant's expense. Landlord may, in its sole discretion, designate separate areas for bicycles and motorcycles.

- (c) Cars must be parked entirely within the stall lines painted on the floor.
- (d) All directional signs and arrows must be observed.
- (e) The speed limit shall be 5 miles per hour.
- (f) Parking is prohibited, unless a floor parking attendant approved by Landlord directs otherwise:
 - (i) In areas not striped for parking;
 - (ii) In aisles;
 - (iii) Where "No Parking" or "Handicap" signs are posted;
 - (iv) On ramps;
 - (v) In crosshatched areas; or
 - (vi) In such other areas as may be designated by Landlord.

(g) Parking stickers or any other device or form of identification supplied by Landlord shall remain the property of Landlord. Such parking identification device must be displayed as requested and may not be mutilated in any manner. The serial number of the parking identification device may not be obliterated. Devices are not transferable, and any device in the possession of an unauthorized holder will be void. There will be a nominal non-refundable fee for the issuance of each magnetic parking card and a minimum replacement charge of \$35.00 for loss of any magnetic parking card or other parking identification device. Tenant acknowledges that Tenant shall not be entitled a greater number of parking stickers or other devices or forms of identification than parking privileges allotted to Tenant.

(h) Garage managers or attendants are not authorized to make or allow any exceptions to these Rules and Regulations.

(i) Every Authorized User is requested to park and lock his own car. All responsibility for damage or theft to cars is assumed by Authorized Users, and in no event will any claim be made against Landlord, the garage attendants or managers with respect thereto. Tenant shall repair or cause to be repaired at its sole cost and expense any and all damage to the Building parking facility or any part thereof caused by Tenant or its Authorized Users.

(j) Loss or theft of parking identification devices from automobiles must be reported to the garage manager immediately. Any parking identification devices found on any unauthorized car will be confiscated and the illegal holder will be subject to prosecution. Lost or stolen devices previously reported and then found must be reported to the garage manager immediately.

(k) Spaces are for the express purpose of one automobile per space unless a parking attendant approved by Landlord directs otherwise. Washing, waxing, cleaning or servicing of any vehicle by the Authorized Users and/or his agents is prohibited.

(l) Landlord reserves the right to refuse the issuance of monthly stickers or other parking identification devices to any Tenant or Authorized User who willfully refuses to comply with these Rules and Regulations or any city, state or federal ordinance, law or agreement.

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07/17/02

Initials /s/ Illegible _____

(m Authorized Users shall not load or unload in areas other than those designated by Landlord for such activities.

(n Authorized Users and unauthorized users parked in prohibited areas are subject to towing at their own expense.

(o Landlord reserves the right to revoke parking privileges for vehicles creating or causing a nuisance, as such shall be determined by Landlord in Landlord's sole discretion.

Initials /s/ Illegible

07/17/02

Initials /s/ Illegible

PACIFIC TOWERS ASSOCIATES

OFFICE LEASE

EXHIBIT D

PARKING AGREEMENT

THIS CONTRACT LIMITS OUR LIABILITY — READ IT

The undersigned, as Landlord and Tenant respectively, are executing, simultaneously with this Parking Agreement, a written Lease covering Premises as described in the Lease and hereby attach this Parking Agreement to said Lease as Exhibit D thereto.

Landlord shall make available to Tenant the right to park in the Building (on a non-reserved, self-parking basis or on such other basis as may be determined by Landlord) throughout the Term of this Lease up to at least the number of parking spaces specified in the Basic Lease Information. Tenant must specify in writing to Landlord no later than the commencement of the Term of this Lease the number of parking spaces desired by Tenant during the Term of this Lease. Tenant shall pay to Landlord at the beginning of the Lease Term the monthly amount specified in the Basic Lease Information per parking space, and thereafter the then current fair market rental as defined below. In the event that Tenant, at any time, is not utilizing its full parking allowance, Landlord shall have the right to make such unused spaces available to other tenants of the Building and Tenant's allowance of parking spaces shall be reduced accordingly. Landlord may individually contract with Tenant or Tenant's employees for the parking spaces referred to above. The "fair market rental" for parking in the Building shall be that rent which is reasonably determined by Landlord to be the then current fair market rental rate for such spaces giving consideration to the parking charges for similar space in buildings within the same community boundaries as the Building. All parking by Tenant and its agents, employees, and invitees, shall be in accordance with the Parking Rules and Regulations, which are contained in Exhibit C to the Lease, IN NO EVENT WILL LANDLORD OR ITS AGENTS BE RESPONSIBLE FOR ANY FIRE, THEFT, DAMAGE OR LOSS TO ANY VEHICLE OR ITS CONTENTS.

	PACIFIC TOWERS ASSOCIATES, a California Limited Partnership	MOLINA HEALTHCARE, INC., a California corporation
By:	SIC — Long Beach, a California Limited Partnership, General Partner of Pacific Towers Associates	By: /s/ C. Joseph Heinz Its: AVP/CAO
By:	The Swig Company, a California Corporation, General Partner of SIC - Long Beach	By: /s/ Illegible Its: EVP
By:	/s/ Kennard P.Perry Title: VICE PRESIDENT	If Tenant is a corporation, this Lease must be executed by (1) the Chairman, President, or Vice-President and (2) the Secretary, any Assistant Secretary, the Chief Financial Officer or any Assistant Treasurer.

Initials /s/ Illegible
07/17/02

Initials /s/ Illegible

FIRST AMENDMENT TO OFFICE LEASE

This First Amendment to Office Lease is entered into as of the 5th day of November 2002, by and between PACIFIC TOWERS ASSOCIATES, a California Limited Partnership, as "Landlord", and MOLINA HEALTHCARE, INC., a California corporation, as "Tenant".

RECITALS

WHEREAS, Landlord and Tenant entered into that certain Office Lease ("Lease") dated July 10, 2002 for premises ("Premises") commonly known as Suites 200, 600 and 700, Arco Center, 200 Oceangate, Long Beach, California; and

WHEREAS, Landlord and Tenant now desire to amend the Lease in connection with certain details pertaining to the Tenant Improvement Allowance and the improvement obligations of Tenant, and to confirm the satisfaction of certain obligations under the Lease.

NOW, THEREFORE, Landlord and Tenant hereby agree as follows:

1. Additional Tenant Improvement Allowance. Paragraph 10(b) of the Tenant Improvement Workletter is hereby amended by increasing the Tenant Improvement Allowance (i) by the sum of \$26,000 for each full Floor of the Premises initially leased by Tenant (Floors 2, 6 and 7) and (ii) with respect to the 8th Floor, when leased by Tenant pursuant to the second paragraph of Article 1.1 of the Lease, by the sum of \$26,000. In the event Tenant is obligated to pay back to Landlord, as part of a termination fee pursuant to Paragraph 1 of the Lease Addendum or otherwise, a portion of the Tenant Improvement Allowance, said Tenant Improvement Allowance shall include the increased amounts as set forth above.

In return for said increased Tenant Improvement Allowance, Tenant agrees that Tenant shall complete the following work on the 2nd, 6th and 7th Floors (and on the 8th Floor if that Floor is leased by Tenant pursuant to the second paragraph of Article 1.1 of the Lease) of 200 Oceangate, in accordance with ARCO Center Building Standards and using current ARCO Center Building Standard materials and finishes, at its sole cost and expense.

Elevator Lobby

Install soffit and recessed lighting, refinish elevator lobby walls, refinish elevator doors/jambs and casings.

Reconstruct walls around new elevator lobby doors per ADA requirements.

Install new elevator lobby carpet consistent with other refurbished ADA compliant elevator lobbies in the Building.

Replace elevator lobby fire doors and associated hardware (ADA compliant).

Corridors

Replace bathroom doors from corridor and associated hardware (ADA compliant).

Replace storage room door and hardware (ADA compliant).

Paint stairwell doors (the side inside the tenant suite only; not the side in the stairwell).

Replace all VAV boxes (including controls) and thermostats; together with all associated high and low pressure ducts from the main trunk loop.

Replace electric strip heaters for supplemental heat for northwest perimeter zones.

All work shall be completed in conjunction with Tenant's initial occupancy of the applicable Floor.

2. Delivery and Acceptance of Possession of Premises. In accordance with the terms and conditions of the Lease, Tenant confirms that the Lease has been fully executed by both Landlord and Tenant, that Tenant has received a copy of the fully executed lease, and that possession of Floors 2, 6 and 7 was delivered to Tenant on August 5, 2002. In addition, Landlord and Tenant hereby confirm (i) that the Workletter, as referred to in the Lease, has been fully executed, (ii) that the non-disturbance agreement, as referred to in the Lease, has been fully executed, (iii) that no default exists on the part of Landlord or Tenant under the Lease, and (iv) that the Lease is in full force and effect and that the Termination Right, as set forth in Paragraph 7 of the Lease Addendum, has expired and is no longer applicable.

Except as set forth in this First Amendment to Lease, the Lease shall remain unamended and in full force and effect.

PACIFIC TOWERS ASSOCIATES, a California Limited Partnership

By: SIC — Long Beach, a California Limited Partnership,
General Partner of Pacific Towers Associates

By: The Swig Company, a California Corporation,
General Partner of SIC — Long Beach

By: /s/ Kennard P. Perry
Title: VICE PRESIDENT

MOLINA HEALTHCARE, INC., a California corporation

By: /s/ Illegible
Its: Executive Vice President

By: /s/ C. Joseph Heinz
Its: Associate V.P./ CAO

RECORDING REQUESTED BY
AND WHEN RECORDED RETURN TO:

Gibson, Dunn & Crutcher
333 South Grand Avenue
Los Angeles, CA 90071
Attention: Jesse Sharf

SUBORDINATION, NON-DISTURBANCE AND
ATTORNMENMENT AGREEMENT

NOTICE: THE SUBORDINATION PROVIDED FOR IN THIS AGREEMENT RESULTS IN YOUR LEASEHOLD ESTATE IN THE PROPERTY BECOMING SUBJECT TO AND OF LOWER PRIORITY THAN THE SECURITY INTEREST IN THE PROPERTY CREATED BY SOME OTHER OR LATER INSTRUMENT.

WHEREAS, RED RIVER LIMITED PARTNERSHIP, a Delaware limited partnership, successor in interest to Teacher Retirement System of Texas, a public pension fund created under the laws of the state of Texas ("Lienholder"), is the holder and owner of that certain Second Amended and Restated Promissory Note executed by Pacific Towers Associates, a California limited partnership ("Landlord"), effective January 1, 2001 ("Note"), which is secured by a Deed of Trust and Fixture Filing of even date therewith, filed for record in the official records of Los Angeles County, California, as thereafter amended from time to time ("Deed of Trust"), which covers, among other property, certain property and improvements in Los Angeles County, California, more particularly described in Exhibit A attached hereto and in the Deed of Trust ("Building Site"); and

WHEREAS, Landlord's predecessor in interest entered into a Lease Agreement dated as of July 15, 2002 (said lease, as amended with the prior written approval of Lienholder, being herein referred to as "Lease") with Molina Healthcare Inc., a California corporation ("Tenant") covering a portion of the improvements on the Building Site ("Leased Premises"); and

WHEREAS, Lienholder and Tenant desire that the Lease remain in effect notwithstanding any foreclosure or other proceedings for enforcement of the Deed of Trust or foreclosure of any other lien securing the Note and held by Lienholder on all or any portion of the Building Site;

WHEREAS, Lienholder requires that the Deed of Trust be and unconditionally remain a lien on the Building Site, prior and superior to all rights of Tenant under the lease;

NOW, THEREFORE, in consideration of the premises and good and valuable considerations each to the other paid, the parties hereto agree as follows:

WITNESSETH

Section 1. Lienholder agrees, for the benefit of Landlord, Tenant and Lienholder, that notwithstanding any foreclosure by Lienholder under the Deed of Trust or foreclosure by Lienholder under any other lien, assignment of leases, assignment of rents or other instrument securing the Note now owned and held by Lienholder covering all or any Portion of the Building Site, and notwithstanding any exercise by Lienholder of any prior rights of Lienholder with respect to the Building Site. Tenants right of possession of the Leased Premises shall not be disturbed or affected by Lienholder so long as no default by Tenant exists under the terms of the Lease (after notice and an opportunity to cure, if any, as provided in the Lease) as would enable Landlord to terminate the Lease or would cause termination of the Lease or would entitle Landlord to dispossess Tenant under the Lease. Except as herein expressly provided to the contrary and subject to the further terms and provisions hereof, in the event of foreclosure under the Deed of Trust or any other lien or instrument in favor of

Lienholder or exercise of any other prior rights of Lienholder with respect to the Building Site, or in the event of a deed in lieu of foreclosure under the Deed of Trust, Lienholder or the purchaser at such foreclosure sale, shall be deemed to have assumed and agreed to perform the duties of Landlord under the Lease during such period, if any, as Lienholder or such purchaser is collecting or entitled to collect rent from Tenant thereunder, except that the person acquiring the interests of Lienholder and Landlord, or of either of them, as a result of any such action or proceeding, shall not be (a) liable for, nor subject to, any offsets or defenses or defaults arising prior to the date of Lienholder's acquisition of title except to the extent: (i) such offsets, defenses or defaults continue after the date of Lienholder's acquisition of title but only to the extent of liabilities arising after the date of Lienholder's acquisition of title (by example, failure to continue to provide janitorial or other building services after the date of Lienholder's acquisition of title), or (ii) such offsets, defenses or defaults arise out of acts or omissions by Lienholder occurring from and after the date of Lienholder's acquisition of title; (b) bound by any rent or additional rent which Tenant might have paid for more than one month in advance of the due dates under the terms of the Lease; (c) liable for any security deposit which Tenant might have paid pursuant to the Lease unless such security deposit has been paid over to Lienholder or such purchaser and if not paid over to the Lienholder or such purchaser, Tenant shall have rent abated at the end of Term to receive a credit for said Security Deposit; or (d) bound by any amendment or modification of the Lease made without Lienholder's prior written consent.

Section 2.

(a) Landlord and Tenant declare and acknowledge that each hereby intentionally waives, relinquishes and subordinates the priority and superiority of the Lease, the leasehold interests and estates created thereby, and the rights, privileges and powers of the Landlord and Tenant thereunder, in favor of the Deed of Trust, and that each understands that in reliance upon, and in consideration of, this waiver, relinquishment and subordination, Lienholder is making the loan referred to hereinabove, which would not be made but in said reliance upon this waiver, relinquishment and subordination.

(b) It is expressly understood and agreed that this Agreement shall supersede, to the extent inconsistent herewith, the provisions of the Lease relating to the subordination of the Lease and the leasehold interests and estates created thereby to the lien or charge of the Deed of Trust.

(c) Tenant further agrees with Lienholder that a foreclosure, acceptance of a deed in lieu of foreclosure or other action or proceeding under the Deed of Trust, or under any other deed of trust affecting the Building Site which is subordinate to the Deed of Trust, shall not terminate the Lease and Tenant shall not be relieved of the Tenant's obligations thereunder, unless Lienholder or any purchaser at foreclosure under the Deed of Trust, or any other proceedings for enforcement of the Deed of Trust, elects to terminate the Lease pursuant to any right to do so under Section 1 above. So long as the Lease remains in effect as above provided, Tenant shall be bound to perform all of its obligations under the Lease for the term thereof, and Lienholder in possession or any purchaser or purchasers at any sale under the Deed of Trust shall have all rights of Landlord under the Lease (including without limitation, any extensions or renewals thereof that may be effected in accordance with any option therefor in the Lease) and Tenant shall be deemed to have attorned to Lienholder or such purchaser or purchasers (including without limitation, Lienholder if it be the purchaser) as such landlord, and for the duration of possession by such purchaser or by Lienholder, then, subject to the limitations on liability set forth in the Lease, Tenant shall have the same rights against such Lienholder in possession or purchaser or purchasers as it has against Landlord under the Lease, except as otherwise provided in Section 1 above. The attornment of Tenant provided for in the immediately preceding sentence hereof is to be effective and self-operative without the execution of any further instruments by Lienholder or a purchaser or purchasers succeeding to the interest of Landlord under the Lease, but Tenant agrees to execute and acknowledge such documents as Lienholder or a purchaser or purchasers succeeding to the interest of Landlord under the Lease or of Lienholder under the Lease may reasonably request to evidence Tenant's attornment hereunder.

(d) Tenant will make no payments or prepayments of rent more than one (1) month in advance of the time when the same becomes due under the lease.

Section 3. Notwithstanding any provisions of the Lease to the contrary, after any foreclosure (or any deed in lieu of foreclosure) of any first lien mortgage or deed of trust, the purchaser in foreclosure (or

otherwise) shall have no personal liability for the obligations of the landlord, and the tenant shall have the right to enforce any monetary judgment against the successor to the landlords interest under the Lease only against such successor's interest in the real property and improvements.

Section 4. The provisions hereof shall inure to the benefit of and be binding upon the undersigned parties and their respective successors and assigns.

Section 5. This agreement may be executed simultaneously in two or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

EXECUTED in multiple counterparts, each of which shall have the force and effect of an original, as of the ____ day of ____, 2002.

“Lienholder”

RED RIVER LIMITED PARTNERSHIP, a
Delaware limited partnership

By: /s/ Illegible
Name: Illegible
Title: Illegible

“Tenant”

MOLINA HEALTHCARE INC., a California corporation

By: /s/ Joseph M. Molina MD
Name: JOSEPH M. MOLINA MD
Title: CHAIRMAN

By: /s/ C. Joseph Heinz
Name: C. Joseph Heinz
Title: ASSOCIATIVE V.P./CAO

“Landlord”

PACIFIC TOWERS ASSOCIATES, a
California limited partnership

By: SIC—Long Beach, a California limited
partnership, which is a general partner of
Pacific Towers Associates

By: The Swig Company, a California
corporation, which is the sole
general partner of SIC — Long Beach

By: /s/ Jeanne Myerson
Jeanne Myerson
President

EXHIBIT A TO
SUBORDINATION, NON-DISTURBANCE AND
ATTORNMENr AGREEMENT

Description of the Land

Parcels 2 and 3, located in the City of Long Beach, County of Los Angeles, State of California, as shown on Parcel Map No. 5196, filed in Book 71, Page 14 of Parcel Maps, in the Office of the County Recorder of said County.

EXCEPT therefrom, all oil, gas, hydrocarbon substances and minerals of every kind and character lying more than 500 feet below the surface of said land, together with the right to drill into, through and to use and occupy all parts of said land lying more than 500 feet below the surface thereof for any and all purposes incidental to the exploration for and production of oil, gas, hydrocarbon substances or minerals from said or other land or any portion of said land within 500 feet of the surface for any purpose or purposes whatsoever as, reserved by various Deeds of Record, among them, being the Deed recorded July 19, 1965, in Book D—2981, at Page 153, as Instrument No. 885, Official Records.



CALIFORNIA ALL-PURPOSE ACKNOWLEDGMENT

State of California

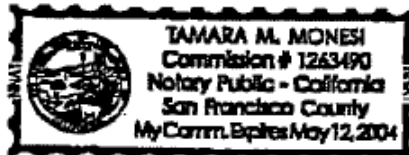
County of San Francisco } ss.

on August 21, 2002 before me, Tamara M. Monesi, NP
Date Name and Title of Officer (a.g., "Jane Doe, Notary Public")

personally appeared Jeanne Myerson
Name of Signer(s)

- ☒ personally known to me
☐ proved to me on the basis of satisfactory evidence

to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their authorized capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.



Place Notary Seal Above

WITNESS my hand and official seal.

Tamara M. Monesi
Signature of Notary Public

OPTIONAL

Though the information below is not required by law, it may prove valuable to persons relying on the document and could prevent fraudulent removal and reattachment of this form to another document.

Description of Attached Document

Title or Type of Document: _____

Document Date: _____ Number of Pages: _____

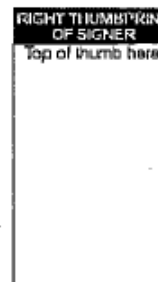
Signer(s) Other Than Named Above: _____

Capacity(ies) Claimed by Signer

Signer's Name: _____

- ☐ Individual
☐ Corporate Officer — Title(s): _____
☐ Partner — ☐ Limited ☐ General
☐ Attorney in Fact
☐ Trustee
☐ Guardian or Conservator
☐ Other: _____

Signer Is Representing: _____



State of Maryland

County of Carroll

On this 22nd day of August, 2002, before me, the undersigned officer, personally appeared Rinse A. Brink, known to me (or satisfactorily proven) to be the person(s) whose name(s) is/are subscribed to within the instrument and acknowledged that he/she/they executed the same for the purpose therein contained.

As Witness, my hand and notarial seal.

/s/ Debra Jarrell-Crabbs

Debra Jarrell-Crabbs

[Notary Seal]

Notary Public

My commission expires 10/27/04

ARCO CENTER
NOTICE OF DELIVERY OF POSSESSION

Molina Healthcare, Inc.
Attn: Mr. C. Joseph Heinz
One Golden Shore Drive
Long Beach, CA 90802

Re: Lease between Pacific Towers Associates and Molina
Healthcare, Inc., dated July 10, 2002, Arco Center, Long
Beach, CA

Dear Mr. Heinz:

In accordance with the terms and conditions of the above references lease ("Lease"), this letter will confirm that the Lease has now been fully executed by both the Landlord and the Tenant, that you have received a copy of the fully executed lease, and that possession of Floors 2, 6 and 7 has been delivered to Molina Healthcare, Inc. as of this date, August 5, 2002.

Please confirm the foregoing and return a copy of this letter to the undersigned.

Cory J. Kristoff, CPM®, RPA
General Manager
Pacific Towers Associates
The Swig Company
200 Oceangate, Suite 310
Long Beach, CA 90802

Tenant hereby confirms the foregoing and acknowledges that possession of Floors 2, 6 and 7 has been delivered to Tenant as of the date set forth above.

MOLINA HEALTHCARE, INC.

By: _____

cc: eRealty Commercial
Attn: Damian McKinney
12780 High Bluff Drive, Suite 100
San Diego, Ca 92130

SECOND AMENDMENT TO OFFICE LEASE

This Second Amendment to Office Lease is entered into as of the 5th day of December 2002, by and between PACIFIC TOWERS ASSOCIATES, a California Limited Partnership, as "Landlord", and MOLINA HEALTHCARE, INC., a California corporation, as "Tenant".

RECITALS

WHEREAS, Landlord and Tenant entered into that certain Office Lease ("Lease") dated July 10, 2002, as amended by that certain First Amendment to Office Lease dated November 5, 2002, for premises ("Premises") commonly known as Suites 200, 600 and 700, Area Center, 200 Oceangate, Long Beach, California; and

WHEREAS, Landlord and Tenant now desire to amend the Lease in connection with (i) Tenant's Expansion onto the 3rd and 4th Floors, and (ii) Tenant's "must take" space.

NOW, THEREFORE, Landlord and Tenant hereby agree as follows:

1. Expansion of Premises to Include Entire 3rd and 4th Floors. Subject to the terms and conditions contained herein, the Premises are hereby expanded to include the entire 3rd and 4th Floors of 200 Oceangate, comprising a total expansion of 33,150 rentable square feet (the "Expansion Premises"). The Expansion Premises are leased to Tenant for a term ("Expansion Premises Lease Term") commencing 120 days after the date Landlord delivers possession thereof to Tenant, or upon Tenant commencing business operations therein, whichever occurs first, and expiring on December 4, 2012.
2. Monthly Base Rental for Expansion Premises. Beginning on the first day of the Expansion Premises Lease Term and continuing throughout the Expansion Premises Lease Term, the Monthly Base Rental for the Expansion Premises shall be the same per rentable square foot Monthly Base Rental (with the same increases) as is then applicable to the Premises originally leased by Tenant under the Lease.
3. Tenant Improvement Allowance. In connection with Tenant's leasing of the Expansion Premises, Landlord shall provide the same \$20.00 per usable square foot Tenant Improvement Allowance that Landlord is providing in connection with the initial Premises leased under the Lease. Said Tenant Improvement Allowance for the Expansion Premises shall be delivered to Tenant on the same terms and conditions as provided for the original Premises, as set forth in the Workletter, but any reference therein to the Commencement Date shall mean the commencement date of the Lease term for the Expansion Premises.
4. Additional Tenant Improvement Allowance. In addition to the Tenant Improvement Allowance set forth above, Landlord shall provide, with respect to the 3rd and 4th Floors, the same \$26,000 per floor additional Tenant Improvement Allowance that was provided to Tenant pursuant to the First Amendment to Office Lease. Said additional Tenant Improvement Allowance shall be delivered to Tenant on the same terms and conditions, and with Tenant having the same improvement obligations on the applicable Floor, as set forth in said First Amendment to Office Lease, but said \$26,000 per Floor amount shall be reduced by \$6,000 with respect to the 3rd floor to reflect the fact that on the 3rd Floor the elevator lobby fire doors, related walls and associated hardware are already in place and are ADA code compliant.
5. Additional Terms and Condition. Except as set forth in this Second Amendment to Office Lease, the 3rd and 4th Floors shall be leased to Tenant on the same terms and conditions as the original Premises; provided however, (i) parking provided in connection with the leasing of the 3rd and 4th Floors shall be in the ratio of 4.5/1,000 rentable square feet for the 3rd Floor and 4.0/1,000 rentable square feet

for the 4th Floor, and (ii) on the 3rd and 4th Floors, as well as on the "Must Take" Floor (as defined below) the total connected electrical load shall not exceed 6 watts per usable square foot, determined on a Floor by Floor basis. Landlord shall supply electrical current as is needed to meet said connected electrical load of up to 6 watts per usable square foot of 3rd and 4th Floor Premises, as well as on the "Must Take" Floor, in accordance with the terms and conditions of the Lease.

6. Amendments Pertaining to 8th Floor "Must Take" Floor.

Landlord and Tenant agree that the "must take" Floor that Tenant is currently obligated to take pursuant to Article 1.1 of the Lease shall be modified so that Landlord can deliver either the 5th Floor or the 8th Floor, and that the delivery date therefor shall be sometime in the calendar year 2005. Landlord shall give Tenant at least 120 days prior written notice of the approximate intended delivery date and shall provide Tenant with updates as to the exact delivery date, as such information becomes available to Landlord.

Accordingly, the second paragraph of Article 1.1 of the Lease is hereby deleted in its entirety and is replaced with the following:

"Commencing on the earlier of (i) four months following the date that Landlord delivers possession thereof to Tenant, or (ii) the date that Tenant commences business operations therein, the Premises shall be further expanded to include the entire 5th Floor or 8th Floor (at Landlord's election) of 200 Oceangate, containing, in either case, 16,575 rentable square feet. The target date for Landlord's delivery of possession is sometime in the calendar year 2005, (with Landlord giving Tenant at least 120 days prior written notice of the approximate intended delivery date) but Landlord may be delayed in delivering the Floor by said date as a result of the occupancy by the current tenants and subtenants, but in no event shall the delay extend beyond December 31, 2006. To the extent Landlord is so delayed beyond December 31, 2005 in delivering the entire 5th or 8th Floor Premises. Tenant may elect, by written notice to Landlord prior to March 31, 2007 or such earlier date as possession of said 5th or 8th Floor Premises are delivered, not to expand into said 5th or 8th Floor Premises."

In connection with the foregoing, the reference to the 8th Floor in the Basic Lease Information, the references to the 8th Floor in Paragraph 10 of the Tenant Improvement Workletter, and the references to the 8th Floor in the First Amendment to Office Lease are hereby amended by replacing the words "8th Floor" with the words "5th Floor or 8th Floor, depending on which Floor Tenant expands into pursuant to the second paragraph of Article 1.1 of the Lease, as amended by the Second Amendment to Office Lease".

7. Amendments in Parking Provisions. As a result of the amendments made to the Lease pursuant to this Second Amendment to Office Lease, Paragraph 4 of the Lease Addendum is hereby deleted in its entirety and is replaced with the following.

"4. PARKING. Tenant shall be provided with a parking ratio of four and one-half (4.5) parking passes per 1,000 square feet of rentable square footage of the 2nd, 3rd, 6th and 7th Floor Premises and in the ratio of four (4) parking passes per 1,000 rentable square feet with respect to the 4th Floor Premises. Said parking passes shall include single unreserved and tandem parking, with the allocation as follows: 40% tandem and 60% single unreserved. Landlord shall provide Tenant with additional parking on a month-to-month basis, as needed and as available, and at prevailing ARCO Center rates.

From December 5, 2002 through December 4, 2007, the monthly parking costs for parking allocated in connection with the 2nd, 3rd, 6th, and 7th Floor Premises then leased by Tenant shall be in accordance with the following schedule: \$70.00 per single unreserved parking pass per month and \$45.00 per tandem parking pass per

month. Thereafter, the rates shall be the then prevailing ARCO Center rates in accordance with Exhibit D of the Lease.

The monthly parking costs for parking allocated in connection with the 4th Floor Premises shall be the then prevailing ARCO Center rates in accordance with Exhibit D of the Lease.

Parking ratios and rates for all parking allocated in connection with any expansion beyond the 2nd, 3rd, 4th, 6th, and 7th Floor Premises leased hereunder shall be in the ratio and at rates as are negotiated between Landlord and Tenant; provided, however, in no event shall the parking ratio be less than 3.0 passes per 1,000 rentable square feet of expansion space. Landlord shall use its reasonable efforts to provide 3.5 passes per 1,000 rentable square feet of expansion space if and to the extent Landlord and the Building is not adversely affected thereby and Landlord does not incur any additional cost, loss of revenue or loss of parking for anticipated Building needs, including but not limited to the needs of existing or future tenants, or visitors, as a result thereof. Under no circumstances shall Tenant have any right to dispute any determination of Landlord in connection with the quantity of parking passes provided.

Notwithstanding anything to the contrary, Landlord reserves the right to fulfill all or a portion of Tenant's parking allocation with staffed valet parking.

Except as set forth in this Second Amendment to Lease, the Lease as previously amended shall remain unamended and in full force and effect.

PACIFIC TOWERS ASSOCIATES, a California Limited Partnership

By: SIC — Long Beach, a California Limited Partnership,
General Partner of Pacific Towers Associates

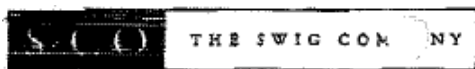
By: The Swig Company, a California Corporation,
General Partner of SIC — Long Beach

By: /s/ Kennard P. Perry
Title: VICE PRESIDENT

MOLINA HEALTHCARE, INC., a California corporation

By: /s/ Illegible
Its: Executive V.P.

By: /s/ C. Joseph Heinz
Its: Associate V.P./CAO



The Swig Company
220 Montgomery Street
San Francisco
California 94104

Ph (415) 291.1100
Fx (415) 291.8373

November 16, 2004

Mr. C. Joseph Heinz
Associate Vice President / Chief Administrative Officer
Molina Healthcare, Inc.
One Golden Shore
Long Beach, CA 90802

Re: ARCO Center, 200 Oceangate Via Personal Delivery
 Must Take Space, 5th Floor

Dear Joe,

Pursuant to the Lease Agreement dated July 10, 2002, paragraph 1.1 and the Second Amendment to Lease dated December 5, 2002, paragraph 6, pertaining to the "Must Take Floor", the Landlord will deliver to Molina Healthcare the entire 5th floor in the 200 Oceangate tower consisting of 16,575 rentable square feet. The approximate intended delivery date is April 1, 2005 with rent commencing on the earlier of (i) four months following the date that Landlord delivers possession, or (ii) the date that Tenant commences business operations therein.

Sincerely,

/s/ Cory J. Kristoff

Cory J. Kristoff, CPM®, RPA

200 Oceangate, LLC,
a Delaware limited liability company

By: Pacific Towers Associates, A California Lin
Its: Sole Member

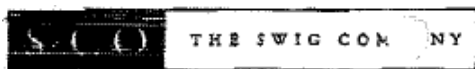
By: SIC — Long Beach, A California Lin
Its: General Partner

By: The Swig Company, a California corporation
Its: General Partner

By: /s/ Kennard P. Perry

Name: Kennard P. Perry
Its: Chief Investment Officer / Head of Asset Management

cc: Damian McKinney / e Realty



The Swig Company
220 Montgomery Street
San Francisco
California 94104

Ph (415) 291.1100
Fx (415) 291.8373

November 16, 2004

Mr. C. Joseph Heinz
Associate Vice President / Chief Administrative Officer
Molina Healthcare, Inc.
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Long Beach, CA 90802

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Dear Joe,

Pursuant to the Lease Agreement dated July 10, 2002, paragraph 1.1 and the Second Amendment to Lease dated December 5, 2002, paragraph 6, pertaining to the "Must Take Floor", the Landlord will deliver to Molina Healthcare the entire 5th floor in the 200 Oceangate tower consisting of 16,575 rentable square feet. The approximate intended delivery date is April 1, 2005 with rent commencing on the earlier of (i) four months following the date that Landlord delivers possession, or (ii) the date that Tenant commences business operations therein.

Sincerely,

/s/ Cory J. Kristoff

Cory J. Kristoff, CPM®, RPA

200 Oceangate, LLC,
a Delaware limited liability company

By: Pacific Towers Associates, A California Limited Partnership
Its: Sole Member

By: SIC — Long Beach, A California Limited Partnership
Its: General Partner

By: The Swig Company,
a California corporation
Its: General Partner

By: /s/ Kennard P. Perry

Name: Kennard P. Perry
Its: Chief Investment Officer / Head of Asset Management

cc: Damian McKinney / e Realty

SECOND AMENDMENT TO OFFICE LEASE

This Second Amendment to Office Lease is entered into as of the 5th day of December 2002, by and between PACIFIC TOWERS ASSOCIATES, a California Limited Partnership, as "Landlord", and MOLINA HEALTHCARE, INC., a California corporation, as "Tenant".

RECITALS

WHEREAS, Landlord and Tenant entered into that certain Office Lease ("Lease") dated July 10, 2002, as amended by that certain First Amendment to Office Lease dated November 5, 2002, for premises ("Premises") commonly known as (Illegible) 200, 600 and 700, Arco Center, 200 Oceangate, Long Beach, California; and

WHEREAS, Landlord and Tenant now desire to amend the Lease in connection with (i) Tenant's expansion onto the 3rd and 4th Floors, and (ii) Tenant's "must take" space.

NOW, THEREFORE, Landlord and Tenant hereby agree as follows:

1. Expansion of Premises to Include Entire 3rd and 4th Floors. Subject to the terms and conditions contained herein, the Premises are hereby expanded to include the entire 3rd and 4th Floors of 200 Oceangate, comprising a total expansion of 33,150 rentable square feet (the "Expansion Premises"). The Expansion Premises are leased to Tenant for a term ("Expansion Premises Lease Term") commencing 120 days after the date Landlord delivers possession thereof to Tenant, or upon Tenant commencing business operations therein, whichever occurs first, and expiring on December 4, 2012.
2. Monthly Base Rental for Expansion Premises. Beginning on the first day of the Expansion Premises Lease Term and continuing throughout the Expansion Premises Lease Term, the Monthly Base Rental for the Expansion Premises shall be the same per rentable square foot Monthly Base Rental (with the same increases) as is then applicable to the Premises originally leased by Tenant under the Lease.
3. Tenant Improvement Allowance. In connection with Tenant's leasing of the Expansion Premises, Landlord shall provide the same \$20.00 per usable square foot Tenant Improvement Allowance that Landlord is providing in connection with the initial Premises leased under the Lease. Said Tenant Improvement Allowance for the Expansion Premises shall be delivered to Tenant on the same terms and conditions as provided for the original Premises, as set forth in the Workletter, but any reference therein to the Commencement Date shall mean the commencement date of the Lease term for the Expansion Premises.
4. Additional Tenant Improvement Allowance. In addition to the Tenant Improvement Allowance set forth above, Landlord shall provide, with respect to the 3rd and 4th Floors, the same \$26,000 per floor additional Tenant Improvement Allowance that was provided to Tenant pursuant to the First Amendment to Office Lease. Said additional Tenant Improvement Allowance shall be delivered to Tenant on the same terms and conditions, and with Tenant having the same improvement obligations on the applicable Floor, as set forth in said First Amendment to Office Lease, but said \$26,000 per Floor amount shall be reduced by \$6,000 with respect to the 3rd floor to reflect the fact that on the 3rd Floor the elevator lobby fire doors, related walls and associated hardware are already in place and are ADA code compliant.
5. Additional Terms and Conditions. Except as set forth in this Second Amendment to Office Lease, the 3rd and 4th Floors shall be leased to Tenant on the same terms and conditions as the original Premises; provided however, (i) parking provided in connection with the leasing of the 3rd and 4th Floors shall be in the ratio of 4.5/1,000 rentable square feet for the 3rd Floor and 4.0/1,000 rentable square feet

for the 4th Floor, and (ii) on the 3rd and 4th Floors, as well as on the "Must Take" Floor (as defined below) the total connected electrical load shall not exceed 6 watts per usable square foot, determined on a Floor by Floor basis. Landlord shall supply electrical current as is needed to meet said connected electrical load of up to 6 watts per usable square foot of 3rd and 4th Floor Premises, as well as on the "Must Take" Floor, in accordance with the terms and conditions of the Lease.

6. Amendments (Illegible) To 8th Floor "Must Take" Floor.

Landlord and Tenant agree that the "must take" Floor that Tenant is currently obligated to take pursuant to Article 1.1 of the Lease shall be modified so that Landlord can deliver either the 5th Floor or the 8th Floor, and that the delivery date therefore shall be sometime in the calendar year 2005. Landlord shall give Tenant at least 120 days prior written notice of the approximate intended delivery date and shall provide Tenant with updates as to the exact delivery date, as such information becomes available to Landlord.

Accordingly, the second paragraph of Article 1.1. of the Lease is hereby (Illegible) and is replaced with the following:

"Commencing on the earlier of (i) four months following the date that Landlord delivers possession thereof in Tenant, or (ii) the date that Tenant commences business operations therein, the Premises shall be further expanded to include the entire 5th Floor or 8th Floor (at Landlord's election) of 200 Oceangate, containing, in either case, 16,575 rentable square feet. The target date for Landlord's delivery of possession is sometime in the calendar year 2005, (with Landlord giving Tenant at least 120 days prior written notice of the approximate (Illegible) delivery date) but Landlord may be delayed in delivering the Floor by said date as a result of the occupancy by the current Tenants and subtenants, but in no event shall the delay extend beyond December 31, 2006. To the (Illegible) Landlord is so delayed beyond December 31, 2005 in delivering the entire 5th or 8th Floor Premises. Tenant may elect, by written notice to Landlord prior to March 31, 2007 or such earlier date as possession of said 5th or 8th Floor Premises are delivered, not to expand into said 5th or 8th Floor Premises."

In connection with the foregoing, the reference to the 8th Floor in the Basic Lease Information, the references to the 8th Floor in Paragraph 10 of the Tenant Improvement Workletter, and the references to the 8th Floor in the First Amendment to Office Lease are hereby amended by replacing the words "8th Floor" with the words "5th Floor or 8th Floor, depending on which Floor Tenant expands into pursuant to the second paragraph of Article 1.1 of the Lease, as amended by the Second Amendment to Office Lease".

7. Amendments to Parking Provisions. As a result of the amendments made to the Lease pursuant tot this Second Amendment to Office Lease, Paragraph 4 of the Lease Addendum is hereby deleted in its entirety and is replaced with the following.

4. PARKING. Tenant shall be provided with a parking ratio of four and one half (4.5) parking passes per 1,000 square feet of rentable square footage of the 2nd, 3rd, 6th and 7th Floor Premises, and in the ratio of four (4) parking passes per 1,000 rentable square feet with respect to the 4th Floor Premises. Said parking passes shall include single unreserved and (Illegible) parking, with the allocation as follows: 40% (Illegible) and 60% single unreserved. Landlord shall provide Tenant with additional parking on a month-to-month basis, as needed and as available and at prevailing ARCO Center rates.

From December 5, 2002 through December 4, 2007, the monthly parking costs for parking allocated in connection with the 2nd, 3rd, 6th, and 7th Floor Premises then leased by Tenant shall be in accordance with the following schedule: \$70.00 per single unreserved parking pass per month and \$45.00 per (Illegible) parking pass per

month. Therefore, the rates shall be the then prevailing ARCO Center rates in accordance with Exhibit D of the Lease.

The monthly parking costs for parking allocated in connection with the 4th Floor Premises shall be the then prevailing ARCO Center rates in accordance with Exhibit D of the Lease.

Parking ratios and rates for all parking allocated in connection with any expansion beyond the 2nd, 3rd, 4th, 6th and 7th Floor Premises leased hereunder shall be in the ratio and at rates as are negotiated between Landlord and Tenant: provided, however, in no event shall the parking ratio be less than 3.0 passes per 1,000 rentable square feet of expansion space. Landlord shall use its reasonable efforts to provide 3.5 passes per 1,000 rentable square feet of expansion space if and to the extent Landlord and the Building is not adversely affected thereby and Landlord does not incur any additional cost, loss of revenue or loss of parking for anticipated Building needs, including but not limited to the needs of existing or future tenants, or visitors, as a result thereof. Under no circumstances shall Tenant have any right to dispute any determination of Landlord in connection with the quantity of parking passes provided.

Notwithstanding anything to the (Illegible), Landlord reserves the right to fulfill all or a portion of Tenant's parking allocation with staffed valet parking".

Except as set forth in this Second Amendment to Lease, the Lease as previously amended shall remain unamended and in full force and effect.

PACIFIC TOWERS ASSOCIATES, a California Limited Partnership

By: SIC — Long Beach, a California Limited Partnership,
General Partner of Pacific Towers Associates

By: The Swig Company, a California Corporation,
General Partner of SIC — Long Beach

By: /s/ Kennard P. Perry
Title: VICE PRESIDENT

MOLINA HEALTHCARE, INC., a California corporation

By: /s/ Illegible
Its: Executive V.P.

By: /s/ C. Joseph Heinz
Its: Associate V.P./CAO

THIRD AMENDMENT TO OFFICE LEASE
MOLINA HEALTHCARE, INC.

This Third Amendment to Office Lease ("Amendment") is entered into as of the 5th day of April 2006, by and between 200 OCEANGATE, LLC, a Delaware limited liability company, successor to Pacific Towers Associates, a California limited partnership, as "Landlord" and MOLINA HEALTHCARE, INC., a California corporation, as "Tenant".

RECITALS

WHEREAS, Landlord and Tenant are parties to that certain Office Lease dated July 10, 2002, as amended by that certain First Amendment to Office Lease dated November 5, 2002, and by that certain Second Amendment to Office Lease dated December 5, 2002 (collectively, the "Lease"), for premises ("Premises") commonly known as Suites 200, 300, 400, 500, 600 and 700, Arco Center, 200 Oceangate, Long Beach, California, containing approximately 99,181 rentable square feet (the "Current Premises"); and

WHEREAS, Landlord and Tenant now desire to amend the Lease in connection with (i) Tenant's expansion onto the 11th, 14th and Ground Floors of 200 Oceangate and (ii) the extension of the Lease Term to December 31, 2018; and

WHEREAS, for the purpose of this Third Amendment to Office Lease, capitalized terms, to the extent they are not defined herein, shall have the same meaning as set forth in the Lease.

NOW, THEREFORE, Landlord and Tenant hereby agree as follows:

AGREEMENT

1. Expansion of Premises to Include Entire 11th, 14th and Ground Floors. Subject to the terms and conditions contained herein, the Premises are hereby expanded to include the entire 11th Floor of 200 Oceangate ("11th Floor Expansion Premises"), the entire 14th Floor of 200 Oceangate ("14th Floor Expansion Premises") and the entire Ground Floor of 200 Oceangate ("Ground Floor Expansion Premises"), comprising a total expansion of 47,713 rentable square feet (collectively, the "Expansion Premises"). The rentable square footage of each portion of the Expansion Premises is as follows: 11th Floor Expansion Premises: 16,575 rentable square feet; 14th Floor Expansion Premises: 16,575 rentable square feet; Ground Floor Expansion Premises: 14,563 rentable square feet. The location of said Expansion Premises is more particularly shown on **Exhibit A**, attached hereto.

2. Term; Delivery of Possession.

a. Commencement Date of Term for Expansion Premises. The Expansion Premises are leased to Tenant for a Term commencing on the following dates:

14th Floor Expansion Premises:	August 1, 2006
11th Floor Expansion Premises:	April 1, 2007
Ground Floor Expansion Premises:	July 1, 2008

Upon the commencement date for each portion of the Expansion Premises, Landlord shall prepare, and Landlord and Tenant shall execute, a Commencement Date Memorandum which shall

specify, among other things, the exact commencement date for the applicable portion of the Expansion Premises and the increase to Tenant's Share resulting therefrom.

b. Expiration Date of Term for Expansion Premises. The Expansion Premises are leased to Tenant for a Term expiring on December 31, 2018.

c. Extension of Term for Current Premises. The Term of the Lease for the Current Premises (99,181 rentable square feet) is hereby extended and shall have an expiration date of December 31, 2018. In connection therewith, Tenant's option to extend the Term of the Lease pursuant to Paragraph 2 of the Lease Addendum shall be for two consecutive five-year periods commencing on January 1, 2019.

d. Delivery of Possession. Possession of the Expansion Premises shall be delivered to Tenant on the following dates:

14th Floor Expansion Premises:	Upon the full execution of this Amendment
11th Floor Expansion Premises:	February 1, 2007
Ground Floor Expansion Premises:	May 1, 2008

Said possession prior to the applicable commencement dates shall be on all of the terms and conditions set forth herein with the exception of the obligation to pay rent.

In the event Landlord is delayed in delivering any portion of the Expansion Premises, the portion shall be delivered as soon as reasonably possible and the commencement date therefor shall be extended by a like number of days.

3. Monthly Base Rental. Beginning on the commencement date of the Lease Term for each portion of the Expansion Premises and continuing through November 30, 2012, the Monthly Base Rental for each portion of the Expansion Premises shall be the same per rentable square foot Monthly Base Rental (with the same increases) as is then applicable to the Current Premises. On December 1, 2012 and on each subsequent December 1 throughout the remainder of the Term, the Monthly Base Rental for the entire Premises (both the Expansion Premises and the Current Premises) shall be increased by three percent (3%) of the Monthly Base Rent then in effect.

4. Condition of Expansion Premises. Each portion of the Expansion Premises shall be delivered to and accepted by Tenant in its then existing "as-is", "where-is" condition and state of repair. Tenant acknowledges that Landlord has no obligation to make any improvements or modifications to the Expansion Premises or to pay for any improvements made thereto.

5. Tenant's Work. Tenant shall improve the Expansion Premises at its sole cost and expense in accordance with the terms and conditions of the Workletter, together with its exhibits, attached hereto as **Exhibit B**, and Tenant shall be solely responsible throughout the Term for the maintenance and repair of all improvements it constructs and existing improvements it modifies.

Accordingly, prior to the improvement of each portion of the Expansion Premises, Landlord and Tenant shall enter into a Workletter in the form of said Exhibit B but updated to reflect any changes that have occurred in Building policies following the date of this Amendment.

Within 30 days following the issuance of the Certificate of Occupancy for each portion of the Expansion Premises, or six months after Tenant occupies the space, whichever occurs first, Tenant shall provide to Landlord the documentation required by Landlord's "Close Out Package" attached to the Workletter as **Attachment D**.

6. Additional Terms and Conditions. The following additional terms and conditions shall apply to Tenant's leasing of the Expansion Premises:

a. Parking. Parking passes provided in connection with the leasing of the Expansion Premises shall be in the ratio of 3/1,000 rentable square feet, provided to Tenant in increments at such time as the Term commencement date occurs for each portion of the Expansion Premises. Said parking passes shall include single unreserved and tandem parking, with the allocation determined by Landlord, as follows: up to 40% tandem and the balance single unreserved, and the rates shall be at the then and thereafter prevailing ARCO Center rates in accordance with Exhibit D of the Lease. Notwithstanding anything to the contrary, Landlord reserves the right to fulfill all or a portion of Tenant's parking allocation with staffed valet parking.

b. Additional Key Cards. When requested by Tenant, Landlord shall provide additional key cards to access the Building, at the Building Standard rate, currently \$15.00 per card, but at no monthly charge. Said key cards shall not enable the holder to access the parking area.

c. Electrical. The total connected electrical load in the Expansion Premises shall not exceed 6 watts per usable square foot, determined on a Floor by Floor basis.

d. Operating Expenses and Taxes.

i. Base Year.

A. The Base Expense Year for Operating Expenses for the 14th Floor Expansion Premises shall be 2006. Notwithstanding the foregoing, there shall be no Operating Expense pass throughs for the 14th Floor Expansion Premises before August 1, 2007.

B. The Base Expense Year for Operating Expenses for the 11th Floor Expansion Premises shall be 2007. Notwithstanding the foregoing, there shall be no Operating Expense pass throughs for the 11th Floor Expansion Premises before April 1, 2008.

C. The Base Expense Year for Operating Expenses for the Ground Floor Expansion Premises shall be 2008. Notwithstanding the foregoing, there shall be no Operating Expense pass throughs for the Ground Floor Expansion Premises before July 1, 2009.

ii. Tenant's Share. Tenant's Share of increased Operating Expenses and Taxes shall be increased in accordance with the Lease as the Term commences with respect to each portion of the Expansion Premises.

iii. Other Terms and Conditions. All other terms and conditions regarding Operating Expenses and Taxes shall be as set forth in the Lease.

e. Rent to be Paid Upon Execution. Upon the full execution of this Amendment, Tenant shall pay Monthly Base Rental for August 2006 for the 14th Floor Expansion Premises.

f. Signage. Landlord, at its sole cost and expense, shall provide Tenant with reasonable Building Standard directory signage for the Expansion Premises. Suite signage shall be at Tenant's sole cost and expense.

g. Commissions. In connection with Tenant's leasing of the Expansion Premises, Tenant shall pay any and all procuring side broker's commission and/or finder's fees.

h. Option to Extend. The Expansion Premises shall be included in and subject to the Option to Extend provision as contained in the Paragraph 2 of the Lease Addendum.

7. Expansion of Right of First Negotiation. Tenant's existing Right of First Negotiation contained in Paragraph 3 of the Addendum to Lease is hereby expanded to include all space in 200 Oceangate.

8. Molina Healthcare, Inc.'s Right of First Offer to Purchase Building. Prior to selling the Building to any unaffiliated third party, Landlord shall notify Molina Healthcare, Inc. of the availability of the Building for sale and the price and terms at which Landlord would be willing to sell the Building to Molina Healthcare, Inc.. Molina Healthcare, Inc. shall have twenty (20) days after receipt of such offer to notify Landlord in writing as to whether it desires to purchase the Building. If Molina Healthcare, Inc. so notifies Landlord, Landlord and Molina Healthcare, Inc. shall negotiate in good faith the terms of a purchase agreement. If Molina Healthcare, Inc. does not so notify Landlord or if, despite such good faith efforts, Landlord and Molina Healthcare, Inc. are unable to fully negotiate and execute a purchase agreement within thirty (30) days after Molina Healthcare, Inc.'s notice that it desires to purchase the Building, Landlord may thereafter sell the Building to any third party on any terms acceptable to Landlord, but at a price of not less than 97% of the price that was offered to Molina Healthcare, Inc. If Landlord fails to consummate such sale to a third party within nine (9) months after its most recent offer to Molina Healthcare, Inc. or if Landlord desires to sell the Building at a price that is less than 97% of the price that was most recently offered to Molina Healthcare, Inc., Landlord must first re-offer the Building to Molina Healthcare, Inc. in accordance with this Paragraph prior to selling the Building. This right of first offer shall terminate upon (i) the expiration or other termination of this Lease, (ii) the sale of the Building to an unaffiliated third party, or (iii) the transfer of the Building by foreclosure or deed in lieu of foreclosure, and thereafter this Paragraph shall be of no further force or effect. This right of first offer shall not apply to (i) foreclosure sales, (ii) deeds in lieu of foreclosure, (iii) sales by reason of condemnation or threatened condemnation, (iv) sales of partial interests in the Building and sales or other transfers of interests in 200 Oceangate, LLC or in the entities that own or are affiliated with the ownership of 200 Oceangate, LLC, but only if the Swig family continues to directly or indirectly own a majority interest in the Building, and (v) other sales or transfers which are not bona-fide full market value voluntary sales to unaffiliated third parties.

The rights of Molina Healthcare, Inc. pursuant to this Paragraph 8 are personal to Molina Healthcare, Inc. and are non-assignable. At such time as the Right of First Offer is no longer of any force and effect, Molina Healthcare, Inc. shall execute an Acknowledgement of Termination of Right of First Offer in such reasonable form as is prescribed by Landlord.

9. No Additional Terms and Conditions. Except as set forth in this Third Amendment to Office Lease, the Expansion Premises shall be leased to Tenant on the same terms and conditions as apply to the Current Premises.

10. No Further Amendments; Lease to Continue in Full Force and Effect . Except as set forth in this Third Amendment to Office Lease, the Lease as previously amended shall remain unamended and in full force and effect.

IN WITNESS WHEREOF, Landlord and Tenant have entered into and executed this Third Amendment to Office Lease as of the day and year first set forth above.

200 OCEANGATE, LLC,
a Delaware limited liability company

By: Pacific Towers Associates,
a California limited partnership, its sole member

By: SIC — Long Beach,
a California limited partnership, its general partner

By: The Swig Company,
a California corporation, its general partner

By: /s/ Kennard P. Perry
Title: CHIEF INVESTMENT OFFICER

MOLINA HEALTHCARE, INC.,
a California corporation

By: /s/ Illegible
Its: EVP & CFO

By: /s/ C. Joseph Heinz
Its: VP & CAO

FOURTH AMENDMENT TO OFFICE LEASE
MOLINA HEALTHCARE, INC.

This Fourth Amendment to Office Lease ("Amendment"), dated for reference purposes as of the 1st day of June 2006, is made and entered into by and between 200 OCEANGATE, LLC, a Delaware limited liability company, successor to Pacific Towers Associates, a California limited partnership, as "Landlord" and MOLINA HEALTHCARE, INC., a California corporation, as "Tenant".

RECITALS

WHEREAS, Landlord and Tenant are parties to that certain Office Lease dated July 10, 2002, as amended by that certain First Amendment to Office Lease dated November 5, 2002, by that certain Second Amendment to Office Lease dated December 5, 2002 and by that certain Third Amendment to Office Lease ("Third Amendment") dated April 5, 2006 (collectively, the "Lease"), for Premises located in the Arco Center, 200 Oceangate, Long Beach, California; and

WHEREAS, Landlord and Tenant now desire to further amend the Lease in connection with (i) Tenant's occupancy and leasing of a portion of the Ground Floor Expansion Premises prior to the May 1, 2008 delivery date and July 1, 2008 Term Commencement Date that were set forth and established in the Third Amendment, and (ii) Tenant's leasing of additional space commonly known as Suite 1050 in 200 Oceangate; and

WHEREAS, for the purpose of this Fourth Amendment to Office Lease, capitalized terms, to the extent they are not defined herein, shall have the same meaning as set forth in the Lease.

NOW, THEREFORE, Landlord and Tenant hereby agree as follows:

AGREEMENT

1. Amendments Pertaining to Ground Floor Expansion Premises.

a. Early Delivery of Possession and Leasing of a Portion of Ground Floor Expansion Premises. Paragraph 2d of the Third Amendment is hereby amended so that the delivery of possession of the Ground Floor Expansion Premises shall be as follows:

- i. Possession of 9,575 rentable square feet of the Ground Floor Expansion Premises, as shown on Exhibit A attached hereto, (the "9,575 RSF Space") shall be delivered to Tenant upon the full execution of this Fourth Amendment.
- ii. Possession of the remaining portion of the Ground Floor Expansion Premises, containing 4,988 rentable square feet (the "4,988 RSF Space") and as shown on Exhibit B attached hereto, shall be delivered to Tenant on May 1, 2008.

In the event Landlord is delayed in delivering any portion of the Ground Floor Expansion Premises, the portion shall be delivered as soon as reasonably possible and the commencement date of the term therefore shall be extended by a like number of days.

b. Commencement Date of Term for Ground Floor Expansion Premises. Paragraph 2a of the Third Amendment is hereby amended so that the Ground Floor Expansion Premises are leased to Tenant for a Term commencing on the following dates:

9,575 RSF Space: September 1, 2006
4,988 RSF Space: July 1, 2008

c. Base Year for Operating Expenses. Paragraph 6(d)(i)C of the Third Amendment is hereby amended so that the Base Expense Year for Operating Expenses for the 9,575 RSF Space shall be 2006 and for the 4,988 RSF Space shall be 2008. Notwithstanding the foregoing, there shall be no Operating Expense pass throughs for the 9,575 RSF Space before September 1, 2007 and for the 4,988 RSF Space before July 1, 2009.

2. Tenant's Leasing of Suite 1050. Landlord hereby leases to Tenant and Tenant hereby leases from Landlord Suite 1050, 200 Oceangate, containing 7,608 rentable square feet, as shown on Exhibit C attached hereto ("Suite 1050"). Possession of Suite 1050 shall be delivered to Tenant in its "AS-IS" condition upon the full execution hereof. The Commencement Date of the Term of the lease therefore and the rent commencement date applicable to Suite 1050 shall be September 1, 2006. The Base Year applicable to said Suite shall be 2006 although there shall be no Operating Expense pass throughs for Suite 1050 before September 1, 2007. Said Suite shall otherwise be leased to Tenant upon all of the terms and conditions, including at the same Monthly Base Rental rate per rentable square foot, as apply to the Expansion Premises.

3. No Further Amendments; Lease to Continue in Full Force and Effect. Except as set forth in this Fourth Amendment to Office Lease, the Lease previously amended shall remain unamended and in full force and effect.

IN WITNESS WHEREOF, Landlord and Tenant have entered into and executed this Fourth Amendment to Office Lease as of the dates set forth below.

200 OCEANGATE, LLC,
a Delaware limited liability company

By: Pacific Towers Associates,
a California limited partnership, its sole member

By: SIC — Long Beach,
a California limited partnership, its general partner

By: The Swig Company,
a California corporation, its general partner

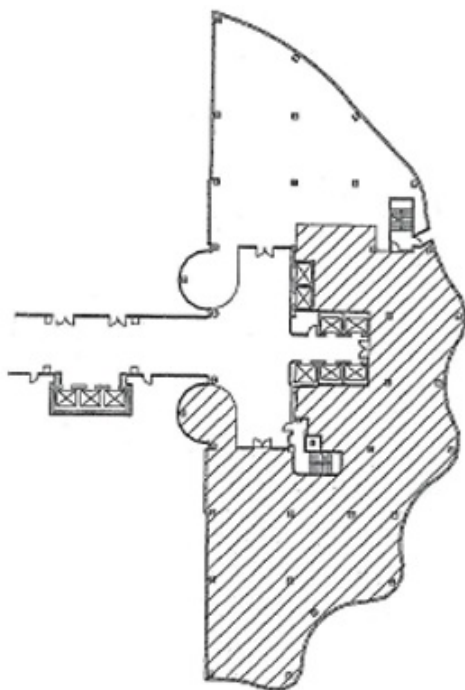
By: /s/ Kennard P. Perry
Title: CIO
Date of Execution: _____

MOLINA HEALTHCARE, INC.,
a California corporation

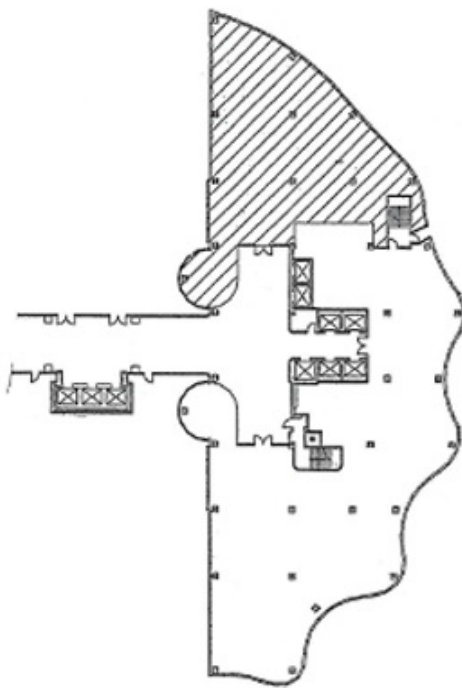
By: /s/ Illegible
Its: CFO

By: /s/ C. Joseph Heinz
Its: VP & CFO
Date of Execution: 06-14-06

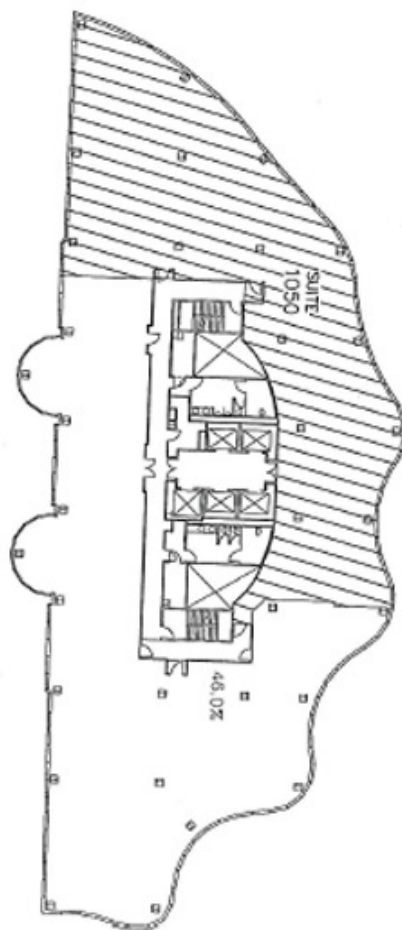
200 OCEANGATE, LLC
STANDARD FORM OFFICE LEASE
EXHIBIT A
FLOOR PLAN
GROUND FLOOR, SUITE 100
200 TOWER



200 OCEANGATE, LLC
STANDARD FORM OFFICE LEASE
EXHIBIT B
FLOOR PLAN
GROUND FLOOR, SUITE 100
200 TOWER



200 OCEANGATE, LLC
STANDARD FORM OFFICE LEASE
EXHIBIT C
FLOOR PLAN
10TH FLOOR, SUITE 1050
200 TOWER



FIFTH AMENDMENT TO OFFICE LEASE
MOLINA HEALTHCARE, INC.

This Fifth Amendment to Office Lease ("Amendment"), dated for reference purposes as of the 1st day of July 2006, is made and entered into by and between 200 OCEANGATE, LLC, a Delaware limited liability company, successor to Pacific Towers Associates, a California limited partnership, as "Landlord" and MOLINA HEALTHCARE, INC., a Delaware corporation (formerly a California corporation), as "Tenant".

RECITALS

WHEREAS, Landlord and Tenant are parties to that certain Office Lease dated July 10, 2002, as amended by that certain First Amendment to Office Lease dated November 5, 2002, by that certain Second Amendment to Office Lease dated December 5, 2002, by that certain Third Amendment to Office Lease ("Third Amendment") dated April 5, 2006 and by that certain Fourth Amendment to Office Lease dated June 1, 2006 (collectively, the "Lease"), for Premises located in the Arco Center, 200 Oceangate, Long Beach, California; and

WHEREAS, Landlord and Tenant now desire to further amend the Lease in connection with Tenant's occupancy and leasing of the 11th Floor Expansion Premises prior to the February 1, 2007 delivery date and April 1, 2007 Term Commencement Date that were set forth and established in the Third Amendment, and

WHEREAS, for the purpose of this Fifth Amendment to Office Lease, capitalized terms, to the extent they are not defined herein, shall have the same meaning as set forth in the Lease.

NOW, THEREFORE, Landlord and Tenant hereby agree as follows:

AGREEMENT

1. Amendments Pertaining to 11th Floor Expansion Premises.

a. Early Delivery of Possession and Leasing of 11th Floor Expansion Premises. Paragraph 2d of the Third Amendment is hereby amended so that possession of the 11th Floor Expansion Premises shall be delivered to Tenant on approximately September 1, 2006. In the event Landlord is delayed in delivering the 11th Floor Expansion Premises, said Expansion Premises shall be delivered as soon as reasonably possible.

b. Commencement Date of Term for 11th Floor Expansion Premises. Paragraph 2a of the Third Amendment is hereby amended so that the 11th Floor Expansion Premises are leased to Tenant for a Term commencing on the later of (i) November 1, 2006, or (ii) sixty (60) days after delivery of possession thereof.

c. Base Year for Operating Expenses. Paragraph 6(d)(i)B of the Third Amendment is hereby amended so that the Base Expense Year for Operating Expenses for the 11th Floor Expansion Premises shall be 2006. Notwithstanding the foregoing, there shall be no Operating Expense pass throughs for the 11th Floor Expansion Premises before November 1, 2007.

2. Identity of Tenant. Tenant has recently informed Landlord that Tenant has become a Delaware corporation and is no longer a California corporation. Accordingly, the Tenant under the Lease is Molina Healthcare, Inc., a Delaware corporation.

3. No Further Amendments; Lease to Continue in Full Force and Effect. Except as set forth in this Fifth Amendment to Office Lease, the Lease as previously amended shall remain unamended and in full force and effect.

IN WITNESS WHEREOF, Landlord and Tenant have entered into and executed this Fifth Amendment to Office Lease as of the dates set forth below.

200 OCEANGATE, LLC,
a Delaware limited liability company

By: Pacific Towers Associates, a California limited
partnership, its sole member

By: SIC — Long Beach, a California limited partnership, its
general partner

By: The Swig Company, a California corporation, its general
partner

By: /s/ Kennard P. Perry
Title: CEO
Date of Execution: 8/18/2006

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: /s/ Illegible
Its: CFO

By: /s/ C. Joseph Heinz
Its: VP & CAO
Date of Execution: 8-16-06

SIXTH AMENDMENT TO OFFICE LEASE
MOLINA HEALTHCARE, INC.

This Sixth Amendment to Office Lease ("Sixth Amendment"), dated for reference purposes as of the 21st day of May 2007, is made and entered into by and between 200 OCEANGATE, LLC, a Delaware limited liability company, successor to Pacific Towers Associates, a California limited partnership, as "Landlord" and MOLINA HEALTHCARE, INC., a Delaware corporation (formerly a California corporation), as "Tenant".

RECITALS

WHEREAS, Landlord and Tenant are parties to that certain Office Lease dated July 10, 2002, as amended by that certain First Amendment to Office Lease dated November 5, 2002, by that certain Second Amendment to Office Lease dated December 5, 2002, by that certain Third Amendment to Office Lease dated April 5, 2006, by that certain Fourth Amendment to Office Lease dated June 1, 2006 ("Fourth Amendment") and by that certain Fifth Amendment to Office Lease dated July 1, 2006 (collectively, the "Lease"), for Premises located in the Arco Center, 200 Oceangate, Long Beach, California; and

WHEREAS, pursuant to the Fourth Amendment, a portion of the Ground Floor Expansion Premises consisting of 9,575 rentable square feet was delivered to Tenant upon the full execution of said Fourth Amendment and the remaining portion of the Ground Floor Expansion Premises consisting of 4,988 rentable square feet is to be delivered to Tenant on May 1, 2008; and

WHEREAS, Landlord and Tenant now desire to further amend the Lease in order to document an increase in the square footage of the 9,575 portion of the Ground Floor Expansion Premises that was delivered to Tenant; and

WHEREAS, for the purpose of this Sixth Amendment, capitalized terms, to the extent they are not defined herein, shall have the same meanings as set forth in the Lease.

NOW, THEREFORE, Landlord and Tenant hereby agree as follows:

AGREEMENT

1. Amendments Pertaining to Ground Floor Expansion Premises .

- a. As a result of the expansion of the Ground Floor Expansion Premises into part of the Building's main lobby, effective June 1, 2007 (the "418 RSF Effective Date"), the rentable square footage of the 9,575 RSF Space, as referenced and defined in the Fourth Amendment, shall be increased from 9,575 to 9,993 rentable square feet by the addition of approximately 418 rentable square feet as shown on **Exhibit A**, attached hereto (the "418 RSF Space").
- b. Effective on 418 RSF Effective Date, the 418 RSF Space is leased by Tenant at the same Monthly Base Rental rate per rentable square foot, for the same term, and on the same other terms and conditions as apply to the 9,575 RSF Space, and Tenant's Share shall be increased to reflect the increased rentable square footage.
- c. The 418 RSF Space is leased to Tenant in its AS-IS condition and Landlord shall have no obligation to provide or pay for any improvements to such space.

2. No Further Amendments; Lease to Continue in Full Force and Effect. Except as set forth in this Sixth Amendment to Office Lease, the Lease as previously amended shall remain unamended and in full force and effect.

IN WITNESS WHEREOF, Landlord and Tenant have entered into and executed this Sixth Amendment to Office Lease as of the date set forth above.

200 OCEANGATE, LLC,
a Delaware limited liability company

By: Pacific Towers Associates, a California limited
partnership, its sole member

By: SIC — Long Beach, a California limited partnership, its
general partner

By: The Swig Company, a California corporation, its general
partner

By: /s/ Kennard P. Perry
Title: CIO

MOLINA HEALTHCARE, INC.,
a Delaware corporation

By: /s/ C. Joseph Heinz
Its: _____

By: _____
Its: _____

200 OCEANGATE, LLC
STANDARD FORM OFFICE LEASE
EXHIBIT A
FLOOR PLAN



Summary of 2008 Base Salary and Bonus Targets for CEO and CFO

On February 19, 2008, the Compensation Committee of the Molina Healthcare Board of Directors determined that Dr. J. Mario Molina's fiscal year 2008 base salary as Chief Executive Officer (CEO) shall be \$850,000, and that John Molina's fiscal year 2008 base salary as Chief Financial Officer shall be \$775,000.

The Compensation Committee also established Dr. Molina's fiscal year 2008 bonus opportunity pursuant to the same general formula under the 2005 Incentive Compensation Plan as had been used to establish his bonus opportunity for fiscal year 2007, subject to appropriate adjustment of the particular metrics. Under the 2005 Incentive Compensation Plan, the Compensation Committee established three independent performance measures for fiscal year 2008: (i) earnings per diluted share (EPS), (ii) premium and other operating revenue (excluding interest income), and (iii) return on equity (ROE). Each of the three measures corresponds to a baseline bonus opportunity equal to one-third of the CEO's 2008 base salary, or \$283,333. If the "threshold" amount of a performance measure is achieved, the CEO shall receive 80% of his possible bonus payout for that particular measure, or \$226,667. If the "target" amount of a performance measure is achieved, the CEO shall receive 100% of the possible bonus payout for that measure, or \$283,333. If the "maximum" amount of a performance measure is achieved or exceeded, the CEO shall receive 120% of the possible bonus payout for that measure, or \$340,000. The bonus amounts shall be interpolated linearly to correspond with the achievement of each of the measures between the 80% and 120% or greater levels, and normalized on a pro rata basis for acquisitions occurring during the course of the year. None of the three bonus amounts shall exceed the 120% payout level. The performance measures are as follows:

Measure	Performance goals and payout as % of opportunity		
	Threshold (80% payout)	Target (100% payout)	Maximum (120% payout)
EPS	\$ 2.25	\$ 2.35	\$ 2.45
Premium and other operating revenue	\$2,784 million	\$2,900 million	\$3,016 million
ROE	12.4%	12.9%	13.4%

The potential bonus of John Molina as CFO for fiscal year 2008 shall be subject to the same three performance measures and payout formula as with the CEO, only the baseline bonus opportunity for each of the three performance measures shall be equal to one-third of 75% of his 2008 base salary, or \$193,750.

Each of the CEO and CFO were also granted under the Company's 2002 Equity Incentive Plan 15,600 shares of restricted stock, vesting in one-quarter increments over 4 years.

Molina Healthcare, Inc.
Computation of Ratio of Earnings to Fixed Charges
(Dollars in thousands)

	<u>2007</u>	<u>2006</u>	<u>2005</u>	<u>2004</u>	<u>2003</u>
Earnings:					
Income before income taxes	\$ 93,696	\$ 73,458	\$ 43,851	\$ 87,685	\$ 66,413
Add: fixed charges	<u>8,619</u>	<u>5,035</u>	<u>4,381</u>	<u>3,274</u>	<u>3,183</u>
Total earnings	<u>\$102,315</u>	<u>\$ 78,493</u>	<u>\$ 48,232</u>	<u>\$90,959</u>	<u>\$69,596</u>
Fixed charges:					
Interest expense, including amortization of debt issuance costs	\$ 4,631	\$ 2,353	\$ 1,529	\$ 1,049	\$ 1,452
Interest component of rent expense	<u>3,988</u>	<u>2,682</u>	<u>2,852</u>	<u>2,225</u>	<u>1,731</u>
Total fixed charges	<u>\$ 8,619</u>	<u>\$ 5,035</u>	<u>\$ 4,381</u>	<u>\$ 3,274</u>	<u>\$ 3,183</u>
Ratio of earnings to fixed charges	<u>11.9x</u>	<u>15.6x</u>	<u>11.0x</u>	<u>27.8x</u>	<u>21.9x</u>

LIST OF SUBSIDIARIES

<u>Name</u>	<u>Jurisdiction of Incorporation</u>
Molina Healthcare of California	California
Molina Healthcare of California Partner Plan, Inc.	California
Molina Healthcare of Washington, Inc.	Washington
Molina Healthcare of Michigan, Inc.	Michigan
Molina Healthcare of Utah, Inc.	Utah
Health Care Horizons, Inc.	Michigan
Molina Healthcare of New Mexico, Inc. (indirect)	New Mexico
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Nevada, Inc.	Nevada
Molina Healthcare Insurance Company	Ohio
Alliance for Community Health LLC, dba Mercy CarePlus	Missouri
Molina Healthcare of Missouri, Inc.	Missouri
Molina Healthcare of Florida, Inc.	Florida
Molina Healthcare of Arizona, Inc.	Arizona
Molina Healthcare of Virginia, Inc.	Virginia
Molina Healthcare of Georgia, Inc.	Georgia
Molina Healthcare of Indiana, Inc.	Indiana
HCLB, Inc.	Michigan

CONSENT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

We consent to the incorporation by reference in the Registration Statements (Forms S-8, No. 333-108317 and No. 333-138552) pertaining to the Molina Healthcare, Inc. 2000 Omnibus Stock and Incentive Plan, 2002 Equity Incentive Plan, and 2002 Employee Stock Purchase Plan, and to the Registration Statement (Form S-3, No. 333-123783) and related Prospectus of Molina Healthcare, Inc. for the registration of \$300,000,000 of its securities, of our reports dated March 17, 2008, with respect to the consolidated financial statements of Molina Healthcare, Inc. and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in its Annual Report (Form 10-K) for the year ended December 31, 2007, filed with the Securities and Exchange Commission.

/s/ Ernst & Young LLP

Los Angeles, California
March 17, 2008

SECTION 302 CERTIFICATION

I, Joseph M. Molina, M.D., certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2007 of Molina Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ Joseph M. Molina

Joseph M. Molina
Chief Executive Officer and President

March 17, 2008

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2007, of Molina Healthcare, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;
 - (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and
 - (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

/s/ John C. Molina

John C. Molina, J.D.

Chief Financial Officer and Treasurer

March 17, 2008

**CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2007 as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ Joseph M. Molina

Joseph M. Molina, M.D.

Chief Executive Officer and President

March 17, 2008

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

**CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002**

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2007 as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

/s/ John C. Molina

John C. Molina, J.D.

Chief Financial Officer and Treasurer

March 17, 2008

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.