Table of Contents

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, 2006

or

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

For the transition period from to

Commission File Number 1-31719

MOLINA HEALTHCARE, INC.

(Exact name of registrant as specified in its charter)

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

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

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

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of class	**Name of each exchange on which registered**

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

Large accelerated filer ☐ Accelerated filer ☒ Non-accelerated filer ☐

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, 2006, the last business day of our most recently completed second fiscal quarter, was approximately $472,382,683 (based upon the closing price for shares of the Registrant's Common Stock as reported by the New York Stock Exchange, Inc. on such date).

As of March 8, 2007, 28,157,626 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 2007 Annual Meeting of Stockholders to be held on May 9, 2007 are incorporated by reference into Part III of this Form 10-K.

Table of Contents

MOLINA HEALTHCARE, INC.

Table of Contents

Form 10-K

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 very small number of members who are dually eligible under both the Medicaid and Medicare programs. We conduct our business primarily through seven licensed health plans in the states of California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington. The health plans are locally operated by our respective wholly owned subsidiaries in those seven 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. 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 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, 2006, approximately 1,021,000 members were enrolled in our seven 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. 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 and had approximately 76,000 members as of December 31, 2006. In September 2006, our Texas start-up health plan commenced operations and had approximately 19,000 members as of December 31, 2006. The contract of our Indiana health plan was not renewed in 2006 and thus expired as of December 31, 2006.

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 25 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 One Golden Shore Drive, 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 mandatory 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 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.

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 will initially 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 intend to 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, 2006 was approximately 2,000 members.

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, 2006, our Washington HMO served approximately 26,000 such members under one such program, that state's Basic Health Plan.

Medicaid Managed Care. Under traditional 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, providers are paid on a fee-for-service basis and 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 (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 its 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.

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 25 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 25 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 the leading managed care organization serving Medicaid, SCHIP, and other low-income members. To achieve this objective, we intend to:

Focus On Serving Low-Income Families And Individuals. We believe that the Medicaid population, characterized by low income and significant ethnic diversity, requires unique services to meet its health care needs. Our more than 25 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 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.

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, 2006, our operating health plans were located in California, Indiana, Michigan, New Mexico, Ohio, Texas, Utah, and Washington. Our Ohio HMO commenced operations in December 2005 and our Texas HMO commenced operations in September 2006. Effective December 31, 2006, the contract of our Indiana HMO expired without renewal. An overview of our health plans and their principal governmental program contracts with the relevant state authority as of December 31, 2006 is provided below:

State	Expiration Date	Contract Description or Covered Program
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	12-31-07	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	12-31-07	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	9-30-07	Medicaid contract with state of Michigan.
New Mexico	6-30-09	Medicaid Salud! Managed Care Program contract (including SCHIP) with New Mexico Human Services Department (HSD).
Ohio	6-30-07	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	6-30-07	Medicaid contract with Utah Department of Health.
Washington	12-31-07	Basic Health Plan and Basic Health Plus Programs contract with Washington State Health Care Authority (HCA).
Washington	12-31-07	Healthy Options Program (including Medicaid and SCHIP) contract with State of Washington Department of Social and Health Services.

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, but there can be no assurance that these contracts will continue to be renewed. For example, our Indiana HMO's contract with the state expired without being renewed effective December 31, 2006.

Our contracts with state and local governments determine the type and scope of health care services that we arrange for our members. Generally, our contracts require us to arrange for preventive care, office visits, inpatient and outpatient hospital and medical services, and 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, has the third largest enrollment of Medicaid beneficiaries among non-governmental health plans in the state, with 300,000 total members at December 31, 2006. 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.

Indiana. As of December 31, 2006, our Indiana HMO served 56,000 members. However, our Indiana HMO's contract with the state expired as of December 31, 2006, and that plan ceased serving members after December 31, 2006.

Michigan. Molina Healthcare of Michigan, Inc., our Michigan HMO, is the largest Medicaid managed care health plan in the state, with 228,000 members at December 31, 2006. It acquired Cape Health Plan effective May 15, 2006. Our Michigan HMO serves 40 counties throughout Michigan, including the Detroit metropolitan area.

New Mexico. As of December 31, 2006, our New Mexico HMO served 65,000 members. Our New Mexico HMO serves members in all of New Mexico's 33 counties.

Ohio. Our Ohio HMO became operational on December 1, 2005. As of December 31, 2006, our Ohio HMO served 76,000 members. Our Ohio HMO operates in 50 counties of the state. We expect our Ohio HMO membership to grow significantly in 2007.

Texas. Our Texas HMO began enrolling members in September 2006. As of December 31, 2006, our Texas HMO served 19,000 members. Our Texas HMO serves STAR and CHIP members in six 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. We expect our Texas HMO membership to grow in 2007.

Utah. Molina Healthcare of Utah, Inc., our Utah HMO, is the largest non-governmental Medicaid managed care health plan in Utah, serving 52,000 members (including 1,500 Medicare Advantage SNP members) as of December 31, 2006. Our Utah HMO serves Medicaid members in 25 of 29 counties in the state (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 281,000 members at December 31, 2006. We serve members in 33 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 (other than Indiana) as of December 31, 2006:

	California	Texas	Michigan	New Mexico	Ohio	Utah	Washington	Total
Primary care physicians	2,671	668	1,942	1,490	1,481	971	2,534	11,757
Specialists	6,675	1,821	4,349	6,849	4,861	804	5,693	31,052
Hospitals	81	24	49	54	83	32	83	406

Physicians. We contract with primary care physicians, medical groups, specialists, and independent practice associations. Primary care physicians provide office-based primary care services. Primary care physicians may

be paid under capitation or fee-for-service contracts and may receive additional compensation by providing certain preventive services. Our specialists care for patients for a specific episode or condition, 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 physicians, physician assistants, and nurse practitioners. These clinics are located in neighborhoods where our members reside, and provide us a first-hand opportunity to understand the special needs of our members. The clinics assist us in developing and implementing community education, disease management, and other programs. The clinics also give us direct clinic management experience that enables us to better understand the needs of our contracted providers.

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 expanded our corporate medical management efforts across all health plans during the second half of 2005 and throughout 2006.

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 now supported by a centralized corporate medical informatics function which utilizes third-party software and data warehousing tools to convert data into actionable information. We are continuing to develop a predictive modeling capability that will support a more proactive case and health management approach both for us and our affiliated physicians. We are also continuing to develop a provider profiling capability 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. 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 revamped our existing corporate website for enhanced usability and visual appeal. The most significant change made to the website is the addition of a secure ePortal. This feature 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, 2006, five of our seven HMOs were accredited by the NCQA. Our Ohio and Texas HMOs will undergo NCQA review as soon as they are eligible.

Claims Processing. Our Long Beach, California headquarters serves as the central processing center for all of our health plan claims.

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

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 seven operating health plans are licensed to operate as HMOs in each of California, Michigan, New Mexico, Ohio, Utah, Washington, and Texas. 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 states. The health plans generally must obtain approval from the state before declaring dividends in excess of certain thresholds. Each health plan must maintain its net worth at an amount determined by statute or regulation. Any acquisition of another plan's members must also be approved by the state, and our ability to invest in certain financial securities may be proscribed by statute.

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

Medicaid. Medicaid was established under the U.S. Social Security Act to provide medical assistance to the poor. Although both the 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 contracts' expiration (although our Indiana health plan was recently unsuccessful in obtaining such contract renewal). 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.

In addition, HIPAA regulations require the assignment of a unique national identifier for providers by May 2007. We anticipate being compliant by the effectiveness date.

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

Employees

As of December 31, 2006, we had approximately 2,000 employees, including physicians, nurses, and administrators. Our employee base is multicultural and reflects the diverse member base we serve. We believe we have good relations with our employees. None of our employees are represented by a union.

Item 1A: ***Risk Factors***

RISK FACTORS

Investing in our securities involves a high degree of risk. Before making an investment decision, you should carefully consider the risk factors described below, 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. 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 will depend on our ability to accurately predict and effectively manage medical costs.

Our profitability depends, to a significant degree, on our ability to accurately predict and effectively manage medical costs. Historically, our medical care cost ratio, meaning our medical care costs as a percentage of premium revenue, has fluctuated. 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, as was shown by our unexpected results in the second quarter of 2005. 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 or inflation. Many of these factors are beyond our control and could reduce our ability to accurately predict and effectively control 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 could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

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 relevant payment patterns, cost trends, product mix, seasonality, utilization of health care services, and other relevant factors. The estimation methods and the resulting reserves are continually monitored, reviewed, and updated, and adjustments, if deemed necessary, are reflected in the period known. Given the uncertainties inherent in such estimates, our actual claims liabilities for particular periods could differ significantly from the amounts estimated and reserved. As occurred in the second quarter of 2005, 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 claims incurred but not reported 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 claims incurred but not reported, our ability to take timely corrective actions may be limited, further exacerbating the extent of the negative impact on our results.

There are numerous risks associated with the rapid growth of our Ohio and Texas HMOs.

Membership at our Ohio and Texas HMOs is growing rapidly, and is expected to continue to grow rapidly throughout 2007. Such rapid growth will likely require a significant concentration of our Company energy and

resources, thereby potentially limiting our ability to pursue new requests for proposals or other new business opportunities.

The medical care ratio of our Ohio and Texas HMOs has been substantially higher than that historically experienced by the Company as a whole. The lack of experience of our new members in Ohio and Texas in accessing managed care, of our local providers in coordinating managed care services for their patients, and our lack of experience in operating in these states, may also contribute to a higher than average medical care ratio. In the event we are unable to lower the medical care ratio of our Ohio and Texas HMOs within a reasonable time period, or if either the Ohio or Texas HMO requires a disproportionate investment of corporate energy and resources or is otherwise unsuccessful, their poor performance could detrimentally impact the financial performance of the Company as a whole.

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 not be sufficient 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.

Reductions in Medicaid and SCHIP funding could substantially reduce our profitability.

Substantially all of our revenues currently come from state Medicaid and SCHIP premiums. Under these programs, subject to actuarial soundness, the government payor typically determines premium and reimbursement levels. If the government payor reduces premium or reimbursement levels or increases them by less than the amount by which our costs increase, unlike a commercial plan we are unable to make offsetting adjustments through supplemental premiums or changes in our benefit plan. For instance, it is possible for a state to mandate an increase in the rates payable to the providers with which we contract without granting a corresponding increase in the premiums paid to us, as we have sometimes experienced in the past. Thus, any premium reduction or insufficient premium increase could have a material adverse effect on our business, financial condition, or results of operations.

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

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.

If our government contracts are not renewed or are terminated, our 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. 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 rebid, 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.

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

Our business is extensively regulated by the federal government and the states in which we operate. The laws and regulations governing our operations are generally intended to benefit and protect health plan members

and providers rather than stockholders. The government agencies administering these laws and regulations have broad latitude 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.

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.

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

American citizenship or legal immigration status has always been a requirement for Medicaid eligibility. However, beneficiaries could assert their status by simply checking a box on a form. The United States Department of Health and Human Services has issued guidelines for states to implement a new requirement, effective July 1, 2006, that persons applying for Medicaid document their citizenship. The new 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 new 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. Current Medicaid beneficiaries should not lose benefits during the period in which they are undertaking a good-faith effort to provide documentation to the state.

As with other Medicaid program requirements, states must implement an effective process for assuring compliance with documentation of citizenship in order to obtain federal matching funds, and effective compliance will be part of Medicaid program integrity monitoring. In particular, audit processes will track the extent to which states rely 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 new, it is unclear what impact it will have on the enrollment levels of our various state HMOs. The new rule may result in the disenrollment of a material number of our members, thereby decreasing our premium revenues. As a result, this new proof of citizenship requirement could have a material adverse effect on our business, financial condition, or results of operations.

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. We regularly upgrade and expand our information systems capabilities. If we experience difficulties with the transition to or from information systems or are unable to properly implement, maintain, or expand our system, we could suffer from, among other things, operational disruptions, loss of members, difficulty in attracting new members, regulatory problems, and increases in administrative expenses.

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

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

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

- additional employees who are not familiar with our operations,

- new provider networks, which may operate on terms different from our existing networks,
- additional members, who may decide to transfer to other health care providers or health plans,
- disparate information, claims processing, and record keeping systems, and
- 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.

Also, we are generally required to obtain regulatory approval from one or more state agencies when making acquisitions. In the case of an acquisition of a business located in a state in which we do not already operate, we would be required to obtain the necessary licenses to operate in that state. In addition, although we may already operate in a state in which we acquire a new business, we will be required to obtain regulatory approval if, as a result of the acquisition, we will operate in an area of the state in which we did not operate previously. We may be unable to 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 or to sustain our pattern of growth.

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 2006, we had total premium revenue of $1,985 million, an increase of 70% in just two years. Continued rapid growth could place a significant strain on our management and on other resources. Our ability to manage our growth may depend on our ability to strengthen our management team and attract, train, and retain skilled employees, and our ability to implement and improve operational, financial, and management information systems on a timely basis. If we are unable to manage our growth effectively, our financial condition and results of operations could be materially and adversely affected. In addition, due to the initial substantial costs related to acquisitions, rapid growth could adversely affect our short-term profitability and liquidity.

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 or to support growth, 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 to themselves, 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 the 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 the 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 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 impact on our business, financial condition, and results of operations.

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 2006. If we were unable to continue to operate in any of those states or if our current operations in any portion of one of those states 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 would harm our business.

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

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

Our experience with Medicare members is limited.

Our business strategy includes increasing the number of our members who are dually eligible under both the Medicaid and Medicare programs. While we have extensive experience with Medicaid members, our experience with Medicare members is more limited. The Medicare population has many differing characteristics and behavior patterns from the Medicaid population with which we are familiar. If we are unable to adapt to the differing needs of our Medicare members, our business strategy may be unsuccessful.

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

In order to provide liquidity, we have a $180 million five-year senior secured credit facility that matures in March 2010. As of December 31, 2006, indebtedness of $45 million was outstanding 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, if at all. If we are unable to obtain financing on terms and within a time 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.

Negative publicity regarding the managed health care industry could adversely affect our ability to market and sell our products and services.

Managed health care companies have received and continue to receive negative publicity reflecting the public perception of the industry. The managed health care industry has also recently experienced significant merger and acquisition activity, giving rise to speculation and uncertainty regarding the status of companies in our industry. Our marketing efforts may be affected by the amount of negative publicity to which the managed health care industry has been subject, as well as by speculation and uncertainty relating to merger and acquisition activity among companies in our industry. Speculation, uncertainty, or negative publicity about us, our industry, or our business could adversely affect our ability to market our services, require changes to our services, or stimulate additional legislation, regulation, review of industry practices, or private litigation that could adversely affect us.

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.

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

The number of persons eligible to receive Medicaid benefits has historically increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. However, during such economic downturns, state and federal 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 principally operate through our health plan subsidiaries. These subsidiaries are subject to laws and regulations that limit the amount of dividends and distributions that they can pay to us without prior approval of, or notification to, state regulators. In California, our health plan may dividend, without notice to or approval of the California Department of Managed Health Care, amounts by which its tangible net equity exceeds 130% of the tangible net equity requirement. In Michigan, 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, 2006, 2005, and 2004 without approval of the regulatory authorities were approximately $6.9 million, $4.3 million, and $27.9 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 on amounts drawn under our credit facility.

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

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

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 eligibility,
- changes in government payment levels,
- a change in control of Congress from the Republican party to the Democratic party, or vice versa,
- changes in state mandatory programs,
- changes in expectations as to our future financial performance or changes in financial estimates, if any, of public market analysts,
- announcements relating to our business or the business of our competitors,
- conditions generally affecting the managed care industry or our provider networks,
- the success of our operating or acquisition strategy,
- the operating and stock price performance of other comparable companies,
- the termination of our Medicaid or SCHIP contracts with state or county agencies, or subcontracts with other Medicaid managed care organizations that contract with such state or county agencies,

- regulatory or legislative change, and
- general economic conditions, including inflation and unemployment rates.

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 54% 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 assumes that the membership of our Ohio HMO will grow during 2007 to approximately 160,000 members, an assumption which may prove to be inaccurate. 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.

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, and Section 21E of the Securities 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 42 facilities, including 18 of our 19 medical clinics in California. We 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*

Securities Class Action. Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired our common stock between November 3, 2004 and July 20, 2005. The class action complaints purported to allege claims for alleged violations of the Securities Exchange Act of 1934 arising out of our issuance and subsequent revision of earnings guidance for the 2005 fiscal year. The class action complaints were consolidated into a single consolidated action, Case No. CV 05-5460 GPS (SHx) (the "Class Action"), and a lead plaintiff was appointed. On December 11, 2006, Molina Healthcare, Inc., J. Mario Molina, John C. Molina, and Joseph W. White, the defendants in the Class Action, and PACE Industry Union-Management Pension Fund, the lead plaintiff, filed a Joint Stipulation of Voluntary Dismissal Pursuant to Federal Rule of Civil Procedure 41(a) (the "Dismissal Stipulation"). The Dismissal Stipulation provided for the immediate dismissal with prejudice of the Class Action against the defendants as to the lead plaintiff, thereby ending the Class Action. The defendants did not make any payment to the lead plaintiff or any other party in connection with the Dismissal Stipulation, and each party agreed to bear its own costs and attorneys' fees arising from the Class Action. The Dismissal Stipulation followed the District Court's Order on November 17, 2006, pursuant to which the District Court granted the defendants' motion to dismiss the lead plaintiff's consolidated complaint without prejudice. Under Federal Rule of Civil Procedure 41(a), the Dismissal Stipulation became immediately effective upon its filing with the court.

Derivative Action. On August 8, 2005, a shareholder derivative complaint was filed in the Superior Court of the State of California for the County of Los Angeles, Case No. BC 337912 (the "Derivative Action"). The Derivative Action purports to allege claims on behalf of Molina Healthcare, Inc. against certain current and former officers and directors for breach of fiduciary duty, breach of the duty of loyalty, gross negligence, and violation of California Corporations Code Section 25402, arising out of the Company's announcement of its guidance for the 2005 fiscal year. On February 7, 2006, the Superior Court ordered that the Derivative Action be stayed pending the outcome of the Class Action. As a result of the final disposition of the Class Action, the Los Angeles Superior Court has scheduled a hearing for April 27, 2007 on the Demurrer filed by Molina Healthcare. Discovery in the Derivative Action is stayed pending the court's ruling on the Demurrer. The Derivative Action is in the early stages, and no prediction can be made as to the outcome.

Arbitration with Tenet Hospital. In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital, or Tenet, seeking damages of approximately $4.5 million involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospital claimants and to increase its damage claim to approximately $8.0 million. The parties agreed to conduct the arbitration in two phases. The first phase of the arbitration, comprising approximately $3.0 million of the total demand, concluded in December 2005. At that time, Tenet was awarded approximately $1.7 million by the arbitrator. Our California HMO paid the award in January 2006. This amount is in addition to approximately $330,000 our California HMO had paid earlier in the fourth quarter of 2005 to settle a portion of the claims included in the first phase of the arbitration. At December 31, 2005, our California HMO had recorded $2.0 million of additional expense beyond the amount of $2.03 million referenced above in connection with this matter. The final phase of the arbitration was settled during the third quarter of 2006. In connection with that settlement, our California HMO paid Tenet $2.0 million. As a result, the Tenet matter is now resolved.

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. The proceeding is in the early stages, and no prediction can be made as to the outcome.

Antelope Valley. On May 1, 2006, Antelope Valley Healthcare District ("Antelope Valley") filed a complaint in Los Angeles County Superior Court against our California HMO, Case No. BC351590. To date, our California HMO has not been served with the complaint, and upon information and belief the complaint was filed by Antelope Valley at this stage in order to toll the applicable statute of limitations. The complaint alleges claims for breach of contract, breach of implied contract, quantum meruit, unfair business practice, and declaratory relief related to the payment of emergency room claims for Molina members who sought treatment at Antelope Valley facilities from January 2002 to the present. Antelope Valley alleges that the emergency room claims, which our California HMO paid in accordance with its Medicaid contract with the California Department of Health Services and Title 22 of the California Code of Regulations, Section 53855, were underpaid. The complaint seeks damages in the amount of $2.0 million, plus interest and attorney fees. An administrative hearing currently pending before a California Department of Health Services (DHS) hearing officer involves the same parties and the same general subject matter as the complaint, but the amount at issue in that hearing is considerably less than the damage amount alleged in the complaint. The parties are currently awaiting the ruling of the DHS hearing officer in the administrative matter. The Antelope Valley matter is in the early stages, and no prediction can be made either as to its outcome or the circumstances under which Antelope Valley would serve the complaint on our California HMO.

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. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to the New Mexico HMO, an indemnification escrow account was established and funded with $6.0 million in order to indemnify our New Mexico HMO against the costs of such litigation and any eventual liability or settlement costs. Currently, approximately $4.1 million 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., 48, 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., 42, 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 25 years in a variety of positions. Mr. Molina is a past president of the California Association of Primary Care Case Management Plans. He earned a Juris Doctorate from the University of Southern California School of Law. Mr. Molina is the brother of J. Mario Molina, M.D.

Mark L. Andrews, Esq., 49, 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, 56, was named as our Chief Operating Officer on November 7, 2005. She had formerly served as our Executive Vice President, Health Plan Operations since January 18, 2005. Ms. Bayer has 25 years of healthcare management experience, including staff model clinic administration, provider contracting, managed care operations, disease management, and home care. Prior to joining us, her professional experience included regional responsibility at FHP, Inc. and multi-state responsibility as Regional Vice-President at Maxicare; Partners National Health Plan, a joint venture of Aetna Life Insurance Company and Veterans Health Administration (VHA); and Lincoln National. She has also served as Executive Vice President of Managed Care at Matria Healthcare, President and Chief Operating Officer of Praxis Clinical Services, and as Western Division President of AccentCare. She holds a Juris Doctorate from Stanford University, a Master's degree in Public Health from the University of California, Berkeley, and a Bachelor's degree in Communications from Northwestern University. Ms. Bayer is a member of the board of directors of Apria Healthcare Group Inc.

PART II

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

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

Date Range	High	Low
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
2005		
First Quarter	$ 53.23	$ 42.15
Second Quarter	$ 47.25	$ 37.20
Third Quarter	$ 48.40	$ 20.00
Fourth Quarter	$ 28.31	$ 20.22

As of March 8, 2007, there were approximately 138 holders of record of our common stock.

We did not declare or pay any dividends in 2006, 2005, or 2004. 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, 2006)

Plan Category	Number of shares to be issued upon exercise of outstanding options, warrants and rights (a)	Weighted average exercise price of outstanding options, warrants and rights (b)	Number of shares remaining available for future issuance under equity compensation plans (excluding securities reflected in column (a)) (c)
Equity compensation plans approved by security holders	789,965(1)	$ 25.78	3,178,295(2)

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

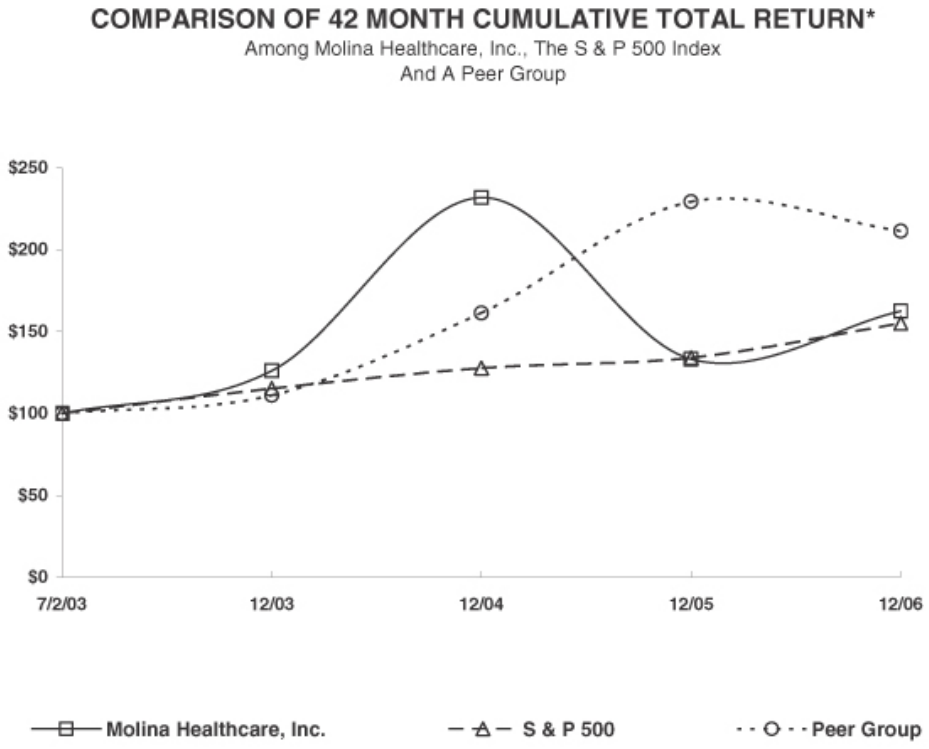
(2) Includes only shares issuable under the 2002 Equity Incentive Plan and the 2002 Employee Stock Purchase Plan. The number of shares available for issuance under the 2002 Equity Incentive Plan will automatically increase by the lesser of 400,000 shares or 2% of total outstanding capital stock on a fully diluted basis on January 1st of each year, unless the Board determines not to permit the automatic increase. The number of shares available for issuance under the 2002 Equity Incentive Plan increased in accordance with the terms of the Plan by 400,000 on each of January 1, 2007, January 1, 2006, January 1, 2005, and January 1, 2004, and is currently 3,200,000 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 of 1933, as amended, or the Securities Exchange Act of 1934, as amended, 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 42-month period from July 2, 2003 (the date of our initial public offering of common stock) to December 31, 2006. 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), United Health Group, Inc. (UNH), and WellPoint, Inc. (WLP).



* $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, 2006 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,				
	2006 (1)	2005	2004 (2)	2003	2002
Statements of Income Data:					
Revenue:					
Premium revenue	$ 1,985,109	$ 1,639,884	$ 1,171,038	$ 791,783	$ 642,179
Investment income	19,886	10,174	4,230	1,761	1,982
Total revenue	2,004,995	1,650,058	1,175,268	793,544	644,161
Expenses:					
Medical care costs	1,678,652	1,424,872	984,686	657,921	530,018
General and administrative expenses (including a charge for stock option settlements of $7,796 in 2002)	229,057	163,342	94,150	61,543	61,227
Loss contract charge	—	939	—	—	—
Depreciation and amortization	21,475	15,125	8,869	6,333	4,112
Total expenses	1,929,184	1,604,278	1,087,705	725,797	595,357
Operating income	75,811	45,780	87,563	67,747	48,804
Total other income (expense), net	(2,353)	(1,929)	122	(1,334)	(405)
Income before income taxes	73,458	43,851	87,685	66,413	48,399
Provision for income taxes	27,731	16,255	31,912	23,896	17,891
Net income	$ 45,727	$ 27,596	$ 55,773	$ 42,517	$ 30,508
Net income per share:					
Basic	$ 1.64	$ 1.00	$ 2.07	$ 1.91	$ 1.53
Diluted	$ 1.62	$ 0.98	$ 2.04	$ 1.88	$ 1.48
Cash dividends declared per share	—	—	—	—	—
Weighted average number of common shares outstanding	27,966,000	27,711,000	26,965,000	22,224,000	20,000,000
Weighted average number of common shares and potential dilutive common shares outstanding	28,164,000	28,023,000	27,342,000	22,629,000	20,609,000
Operating Statistics:					
Medical care ratio (3)	84.6%	86.9%	84.1%	83.1%	82.5%
General and administrative expense ratio (4)	11.4%	9.9%	8.0%	7.8%	9.5%
General and administrative expense ratio, excluding premium taxes	8.4%	7.1%	5.9%	6.6%	8.7%
Members (5)	1,077,000	893,000	788,000	564,000	489,000

	As of December 31,				
	2006 (1)	2005	2004 (2)	2003	2002
Balance Sheet Data:					
Cash and cash equivalents	$ 403,650	$ 249,203	$ 228,071	$ 141,850	$ 139,300
Total assets	864,475	659,927	533,859	344,585	204,966
Long-term debt (including current maturities)	45,000	—	1,894	—	3,350
Total liabilities	444,309	297,077	203,237	123,263	109,699
Stockholders' equity	420,166	362,850	330,622	221,322	95,267

(1) The balance sheet and operating results of the HCLB (Cape Health Plan) acquisition have been included since May 15, 2006, the effective date of acquisition.

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

(3) 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.

(4) General and administrative expense ratio represents such expenses as a percentage of total revenue.

(5) Number of members at end of period. Effective January 1, 2007, our Indiana HMO no longer had any membership as a result of the contract termination with the state.

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

Our fiscal year 2006 financial performance may be briefly summarized as follows:

- Earnings per diluted share of $1.62;
- Premium revenue of $1,985.1 million;
- Net income of $45.7 million;
- Medical care ratio of 84.6%;
- G&A expenses as a percentage of total revenue of 11.4%;
- Total membership at year-end of 1,077,000 members (includes Indiana membership).

In addition, our operational achievements during the year included:

- The start-up of our Ohio and Texas health plans;
- The Cape Health Plan acquisition in Michigan;
- The start-up of our Medicare Advantage Special Needs Plans, with total enrollment at December 31, 2006 of approximately 2,000 members; and
- The strengthening of our medical management.

Discussion

We generate revenues primarily from the premiums we receive from the states in which we operate. Premium revenue is primarily derived from Medicaid, SCHIP, and other government-sponsored programs for low-income individuals. Premium revenue includes per member per month fees received for providing medical services, fee for service revenue generated by our clinics in California, fee for service reimbursement for delivery of newborns on a per case basis (birth income), and in Utah reimbursement of health care expenditures plus an administrative fee. We also receive savings sharing revenue in Utah and California, where we receive additional incentive payments from those states if medical costs are less than prescribed amounts. Such fee-for-service revenue and savings sharing revenue is included in our financial statements with our premium revenue. Starting in 2006, our premium revenue also includes premiums generated from Medicare.

Premium revenue is fixed in advance of the periods covered and is not subject to significant accounting estimates. For the year ended December 31, 2006, we received approximately 87.5% of our premium revenue as a fixed amount per member per month, or PMPM, pursuant to our contracts with state Medicaid agencies and other managed care organizations with which we operate as a subcontractor. These premium revenues are recognized in the month members are entitled to receive health care services. The state Medicaid programs periodically adjust premium rates. The amount of these premiums may vary widely between states and among various government programs. PMPM premiums for SCHIP members are generally among the Company's lowest, with rates as low as approximately $70 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 $90 in California to a high of approximately $200 in Ohio. Among our Medicaid Aged, Blind and Disabled

(ABD) membership, PMPM premiums range from approximately $320 in California to over $1,000 in New Mexico. Medicare revenue is approximately $1,200 PMPM. Approximately 6.7% of our premium revenue in the year ended December 31, 2006 was realized under a Medicaid cost plus reimbursement agreement that our Utah plan has with that state. We also received approximately 5.7% of our premium revenue for the year ended December 31, 2006 in the form of birth income (one-time payments for the delivery of children) from the Medicaid programs in Indiana, Michigan, New Mexico, Ohio, Texas and Washington. Such payments are recognized as revenue in the month the birth occurs. Other revenues from savings sharing and fee-for-service clinic income contributed the remaining 0.1% of our premium revenue.

Membership growth has been the primary reason for our increasing revenues. We have increased our membership through both internal growth and acquisitions. The following table sets forth the approximate number of members by state in the periods presented:

	As of December 31,		
State	2006	2005	2004
California	300,000	321,000	253,000
Indiana (1)	56,000	24,000	—
Michigan	228,000	144,000	158,000
New Mexico	65,000	60,000	65,000
Ohio (2)	76,000	N/A	—
Texas (3)	19,000	N/A	—
Utah	52,000	59,000	49,000
Washington	281,000	285,000	263,000
Total	1,077,000	893,000	788,000

(1) Our Indiana HMO ceased serving members effective January 1, 2007. It currently has no members.
(2) Our Ohio HMO commenced operations in December 2005, serving less than 250 members as of December 31, 2005.
(3) Our Texas HMO commenced operations in September 2006.

The following table details member months (defined as the aggregation of each month's membership for the period) by state for the years ended December 31, 2006, 2005, and 2004:

State	2006	2005	2004
California	3,694,000	3,569,000	2,989,000
Indiana (1)	499,000	149,000	—
Michigan	2,365,000	1,811,000	1,272,000
New Mexico	726,000	734,000	391,000
Ohio (2)	442,000	—	—
Texas (3)	34,000	—	—
Utah	689,000	668,000	576,000
Washington	3,410,000	3,383,000	2,851,000
Total	11,859,000	10,314,000	8,079,000

(1) Our Indiana HMO ceased serving members effective January 1, 2007. It currently has no members.
(2) Our Ohio HMO commenced operations in December 2005, serving less than 250 members as of December 31, 2005.
(3) Our Texas HMO commenced operations in September 2006.

Our operating expenses include expenses related to the provision of medical care services and general and administrative, or G&A, costs. Our results of operations are impacted by our ability to effectively manage expenses related to health care services and to accurately predict costs incurred.

Expenses related to medical care services include two components: direct medical expenses and medically-related administrative costs. Direct medical expenses include payments to physicians, hospitals, and providers of ancillary medical services, such as pharmacy, laboratory, and radiology services. Medically-related administrative costs include expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, member services, and compliance. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2006, 2005, and 2004, medically-related administrative costs, included in “Medical services” in our Consolidated Statements of Income, constituted approximately 3% of premium revenue.

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 pay a fixed per member per month payment to the provider without regard to the frequency, extent, or nature of the medical services actually furnished. Under capitated contracts we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management, and other criteria. Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. All capitation expenses are recorded as “Medical services” in our Consolidated Statements of Income.

As noted above, many of our primary care physicians are paid on a capitation basis, while others are paid on a fee-for-service basis. Specialists and hospitals are paid for the most part on a fee-for-service basis. 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 fee-for-service (per diems, diagnostic-related groups, percent of billed charges, and case rates) and capitation. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided at discounted payment rates. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. For the year ended December 31, 2006, approximately 83.9% of our direct medical expenses were related to fees paid to providers on a fee-for-service basis, with the balance paid on a capitation basis.

Medical care costs and medical claims and benefits payable are based upon actual historical experience and estimates of medical expenses incurred but not reported, or IBNR. We estimate our IBNR monthly based on a number of factors, including prior claims experience, health care service utilization data, cost trends, product mix, seasonality, prior authorization of medical services, and other factors. As part of this review, we also consider uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership, and medical cost trends. We include loss adjustment expenses in the recorded claims liability. We continually review and update the estimation methods and the resulting reserves. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may not come to light until a substantial period of time has passed following the contract implementation, leading to potential misstatement of some costs in the period in which they are first recorded. Estimates are adjusted monthly as more information becomes available. Any adjustments to reserves are reflected in current operations. We employ our own actuaries and engage the service of independent actuaries as needed. We believe that our process for estimating IBNR is adequate, but all estimates are subject to uncertainties and our actual medical care costs have, in the past, exceeded such estimates. Our estimates of IBNR may be inadequate in the future, which would negatively affect our results of operations. Additionally, if we are unable to accurately estimate IBNR, our ability to take timely corrective actions may be affected, further exacerbating the extent of the negative impact on our results of operations.

G&A costs are largely comprised of wage and benefit costs related to our employee base and other administrative expenses. Some G&A services are provided locally, while others are delivered to our health plans from a centralized location. The major centralized functions are claims processing, information systems, finance and accounting services, and legal and regulatory services. Locally-provided functions include marketing (to the extent permitted by law and regulation), plan administration, and provider relations. Included in G&A expenses are premium taxes for the California HMO (beginning July 2005), the Michigan HMO, the New Mexico HMO

(beginning with its acquisition on July 1, 2004), the Ohio HMO, the Texas HMO (beginning September 2006), and the Washington HMO.

Results of Operations

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

	Year Ended December 31,		
	2006	2005	2004
Premium revenue	99.0%	99.4%	99.6%
Investment income	1.0%	0.6%	0.4%
Total revenue	100.0%	100.0%	100.0%
Medical care ratio	84.6%	86.9%	84.1%
General and administrative expense ratio, excluding premium taxes	8.4%	7.1%	5.9%
Premium taxes included in general and administrative expenses	3.0%	2.8%	2.1%
Total general and administrative expense ratio	11.4%	9.9%	8.0%
Operating income	3.8%	2.8%	7.5%
Net income	2.3%	1.7%	4.7%

Year Ended December 31, 2006 Compared to Year Ended December 31, 2005

Premium Revenue

Premium revenue for 2006 was $1,985.1 million, an increase of $345.2 million, or 21.1%, over premium revenue for the year ended December 31, 2005, of $1,639.9 million. Acquisitions in California (effective June 1, 2005) and Michigan (effective May 15, 2006) and the start-up operation in Ohio were the primary drivers of the increase in premium revenue.

The acquisition of Cape Health Plan in Michigan effective May 15, 2006 added $114.4 million in premium revenue in 2006. The Ohio health plan (which had less than $50,000 of premium revenue in 2005) contributed $94.8 million to premium revenue in 2006, and premium revenue from the now-terminated Indiana health plan contributed $59.6 million. Medicare Advantage revenue for all of 2006 was $27.2 million, of which $20.2 million came from our Utah health plan. We had no Medicare Advantage revenue in 2005. The now-terminated Indiana health plan contributed $59.6 million more in premium revenue in 2006 than in 2005.

Membership growth contributed $258.6 million to the increase in premium revenue. Year-end enrollment increased 20.6% to 1,077,000 members at December 31, 2006 (including subsequently discontinued Indiana membership of 56,000), from 893,000 members at December 31, 2005. Membership growth was primarily the result of our acquisition of Cape Health Plan in Michigan effective May 15, 2006 and the start-up of our Ohio, Texas, and Indiana HMOs. However, since the contract between our Indiana HMO and the State of Indiana expired on December 31, 2006, we no longer have any membership in Indiana effective January 1, 2007. Member months for the year ended December 31, 2006 increased by 15.0% to 11,859,000 from 10,314,000 for the year ended December 31, 2005. The remaining $86.6 million increase in premium revenue was attributable to increases in premium rates and proportionally greater increases in membership in those states with higher premium rates.

Investment Income

Investment income for 2006 was $19.9 million as 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

Medical care costs for 2006 were $1,678.7 million, as compared with $1,424.9 million for 2005. Medical care costs as a percentage of premium revenue (the medical care ratio, or MCR) decreased to 84.6% in 2006 as compared to 86.9% in 2005. The decrease in the medical care ratio during 2006 was due to improved medical care ratios reported in our Michigan (excluding Cape Health Plan), Washington, and New Mexico HMOs. Partially offsetting the improved medical care ratios in these states was a 207 basis points increase in the MCR in our California HMO in 2006 as compared to 2005 due to higher unit costs and limited premium rates. In addition, Cape Health Plan (acquired effective May 15, 2006) experienced a higher medical care ratio during 2006 than our consolidated average.

The medical care ratios for our start-up operations in Ohio, Texas, and Indiana were substantially higher than that 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 as 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. The Company anticipates significant growth in enrollment in the Ohio health plan in 2007 and projects a lower Ohio health plan medical care ratio as a result of re-contracting and lower costs in new regions of that state. Our Indiana health plan's Medicaid contract expired on December 31, 2006 and we do not believe the wind-up of our operations in Indiana will have a material impact on our future operating results. The Texas health plan did not have significant enrollment until December of 2006, and revenue and medical costs generated from the Texas health plan did not have a material impact on our consolidated results for either the fourth quarter of 2006 or the full year of 2006.

General and Administrative Expenses

G&A expenses for 2006 were $229.1 million as compared with $163.3 million for 2005. G&A expenses as a percentage of total revenue were 11.4% for 2006 as 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 HCLB (Cape Health Plan) in May 2006, the start-up Ohio HMO which commenced operations in December 2005 and the full year effect of premium taxes in California commencing July 1, 2005.

G&A excluding premium taxes (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 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. Effective January 1, 2006, we adopted SFAS 123(R), Share-Based Payment, which increased our G&A expenses by $3.2 million (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 by $2.1 million in 2006 due to acquisitions in California and Michigan. Depreciation expense increased by $4.3 million in 2006 due to investments in infrastructure, principally at our corporate offices.

Interest Expense

Interest expense increased to $2.4 million in 2006 from $1.5 million in 2005 due to increased borrowings 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 consists 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%, as compared to $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.

Year Ended December 31, 2005 Compared to Year Ended December 31, 2004

Premium Revenue

Premium revenue for 2005 was $1,639.9 million, up $468.9 million (40.0%) from $1,171.0 million for 2004.

Membership growth contributed $387.5 million to the increase in premium revenue. Year-end enrollment increased 13.3% to 893,000 members at December 31, 2005, from 788,000 members at the same date of the prior year. Membership growth was primarily the result of acquisitions in San Diego, California effective June 1, 2005, the start-up of our Indiana HMO effective April 1, 2005, and the full-year benefit of acquisitions made during 2004 in Washington, New Mexico, and Michigan. Member months for the year ended December 31, 2005 increased by 27.7% to 10,314,000 from 8,079,000 for the year ended December 31, 2004.

The remaining $81.4 million increase in premium revenue was attributable to increases in premium rates and proportionally greater increases in membership in those states with higher premium rates.

Investment Income

Investment income for 2005 increased to $10.2 million from $4.2 million for 2004 due to greater average invested balances and higher investment yields.

Medical Care Costs

Medical care costs for 2005 were $1,424.9 million, as compared with $984.7 million for 2004. The medical care ratio increased to 86.9% in 2005 as compared to 84.1% for 2004. The increase in the medical care ratio during 2005 resulted in sharply lower net income when compared to 2004. Among the factors increasing the medical care ratio in 2005 were a shift in utilization to higher cost hospitals; increased costs from catastrophic cases; increased maternity costs in Michigan and Washington; and increased outpatient costs.

Hospital costs for 2005 include $5.7 million of expense related to the settlement and anticipated settlement of certain claims made against us by various hospitals. These claims seek additional or first-time reimbursement for services ostensibly provided to our members that purportedly were not paid or were underpaid by us. The claims made by these hospitals involve issues of contract compliance, interpretation, payment methodology and intent. These claims extend to services provided over a number of years.

General and Administrative Expenses

G&A expenses for 2005 were $163.3 million as compared with $94.2 million for 2004. G&A expenses as a percentage of total revenue were 9.9% for 2005 as compared with 8.0% for 2004.

Premium taxes (which are included in G&A) increased to 2.8% of total revenue in 2005 from 2.1% of total revenue in 2004. Increased premium taxes were due to the inclusion of our New Mexico HMO in our

consolidated results for all of 2005 as compared to only the second half of 2004; as well as the implementation of a premium tax in California effective July 1, 2005.

G&A excluding premium taxes (Core G&A) increased to 7.1% of total revenue for 2005 from 5.9% of total revenue for 2004. The increase in Core G&A was due to investments in infrastructure, administrative expenses associated with our development of our Medicare Advantage Special Needs Plans and administrative costs associated with our Indiana, Ohio, and Texas start-ups.

Depreciation and Amortization

Depreciation and amortization expense for 2005 increased to $15.1 million from $8.9 million for 2004. Amortization expense increased by $3.4 million during 2005 due to increased amortization of acquisition costs. The remainder of the increase in depreciation and amortization expense was due to higher depreciation expense, principally as a result of increased investment in infrastructure at our corporate offices.

Interest Expense

Interest expense increased to $1.5 million for 2005 from $1.0 million for 2004 due to increased average debt balances during 2005.

Other Income (Expense)

Other expense recorded for the year ended December 31, 2005 of $0.4 million consists of a charge for the write off of costs associated with a registration statement filed during the second quarter of 2005.

Other income for 2004 includes a pretax gain of $1.2 million recognized upon the termination of certain Collateral Assignment Split-Dollar Insurance Agreements between our company and the Molina Siblings Trust, a related party, during the first quarter of 2004.

Provision for Income Taxes

Income tax expense totaled $16.3 million in 2005, resulting in an effective tax rate of 37.1%, as compared to $31.9 million in 2004, resulting in an effective tax rate of 36.4%.

Acquisitions

On May 18, 2006, the Company completed its acquisition of HCLB, Inc. (“HCLB”). HCLB is the parent company of Cape Health Plan, Inc. (“Cape”), a Michigan corporation based in Southfield, Michigan. Cape serves approximately 90,000 Medicaid members primarily in Southeast 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 HMO.

Liquidity and Capital Resources

We generate cash from premium revenue, savings sharing income, services provided on a fee-for-service basis at our clinics, and investment income. Our primary uses of cash include the payment of expenses related to medical care services, G&A expenses, and acquisitions. We generally receive premium revenue in advance of payment of claims for related health care services, with the exception of our Utah HMO. Additionally, because we generally receive premium revenue in advance of payment for the related medical care costs (with the exception of our Utah HMO), our cash has increased during periods when we experienced enrollment growth.

At December 31, 2006, we had working capital of $258.6 million as compared to $189.2 million at December 31, 2005. At December 31, 2006 and December 31, 2005, cash and cash equivalents were $403.7

million and $249.2 million, respectively. At December 31, 2006 and December 31, 2005, our investments, all classified as current assets, were $81.5 million and $103.4 million, respectively. At December 31, 2006, the parent company had cash and investments of $34.6 million.

Our subsidiaries are required to maintain minimum capital prescribed by the various jurisdictions in which we operate. As of December 31, 2006, all of our subsidiaries were in compliance with the minimum capital requirements. Barring any change in regulatory requirements, we believe that we will continue to be in compliance with these requirements at least through 2007. Although the rapid growth of our Ohio and Texas HMOs may require us to contribute substantial regulatory capital by the end of 2007 which is likely to exceed internally generated cash, we believe that our cash resources, internally generated funds, and amounts drawable under our credit facility together will be sufficient to support our operations, regulatory requirements, and capital expenditures for at least the next 12 months.

Our investment policies are designed to provide liquidity, preserve capital, and maximize total return on invested assets, all in a manner consistent with state requirements, which prescribe the types of instruments in which our subsidiaries may invest their funds. As of December 31, 2006, we invested a substantial portion of our cash in a portfolio of highly liquid money market securities. As of December 31, 2006, 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. Two professional portfolio managers operating under documented investment guidelines manage our investments. The average annualized portfolio yield for the years ended December 31, 2006, 2005, and 2004 was approximately 4.8%, 3.0%, and 1.4%, respectively.

Our restricted investments consist principally of certificates of deposit and treasury securities with maturities of up to 12 months. These investments are held to satisfy statutory deposit requirements at the various states in which we operate.

Net cash provided by operating activities was $102.3 million in 2006, as compared to $97.3 million in 2005, an increase of $5.0 million. The increase resulted from higher net income, increased deferred revenue at our Ohio HMO and the timing of income tax payments. Partially offsetting these increases was an increase in receivables from our Utah, California, and Ohio HMOs.

Net cash provided by investing activities was $3.9 million in 2006 as compared to cash used of $72.6 million in 2005. The decrease in cash used of $76.5 million in 2006 was driven by the acquisition of $5.8 million in net cash as a result of the Cape purchase in 2006 as compared to the payment of $40.9 million net cash as a result of purchase transactions in 2005.

Net cash provided by financing activities was $48.2 million in 2006 compared to cash used for financing activities of $3.6 million in 2005. The increase in 2006 was due to borrowings under our $180 million credit facility to fund capital infusions into our Ohio, Indiana, California, and Texas HMOs. At December 31, 2006, we owed $45.0 million under our $180.0 million credit facility.

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 million of securities, including common stock or debt securities. No securities have been issued under the shelf registration statement. We may publicly offer securities from time to time at prices and terms to be determined at the time of the offering.

Credit Facility

On March 9, 2005, we entered into an amended and restated five-year secured credit agreement for a $180.0 million revolving credit facility with a syndicate of lenders. The credit facility is intended to be used for working capital and general corporate purposes.

The credit facility has a term of five years and all amounts outstanding under the credit facility will be due and payable on March 8, 2010. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the credit facility to up to $200.0 million.

Borrowings under the credit facility are based, at our election, on the London interbank offering 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 0.5% 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 EBITDA. The applicable margins range between 1.00% and 1.75% for LIBOR loans and between 0% and 0.75% for base rate loans. The commitment fee ranges between 0.375% and 0.500%. 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.

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 HMO subsidiaries.

The credit agreement 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, and investments. The credit agreement also requires us to maintain certain fixed charge coverage ratios. At December 31, 2006, we were in compliance with all financial covenants in the credit agreement.

Regulatory Capital and Dividend Restrictions

At December 31, 2006, our principal operations were conducted through the seven HMOs operating in California, Michigan, New Mexico, Ohio, Texas, Utah, and Washington. The HMOs are subject to state laws that, among other things, may require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment, and amount of dividends and other distributions that may be paid to us as their sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries, after intercompany eliminations, which may not be transferable to us in the form of loans, advances, or cash dividends was $236.8 million at December 31, 2006, and $155.9 million at December 31, 2005.

The National Association of Insurance Commissioners has adopted rules effective December 31, 1998, which, if implemented by the states, set new minimum capitalization requirements for insurance companies, HMOs, and other entities bearing risk for health care coverage. The requirements take the form of risk-based capital rules. These HMO rules, which may vary from state to state, have been adopted in Michigan, New Mexico, Indiana, Ohio, Texas, Utah and Washington. California has not adopted risk-based capital requirements for HMOs and has not formally given notice of its intention to do so. The National Association of Insurance Commissioners' HMO rules, if adopted by California, may increase the minimum capital required for that state.

As of December 31, 2006, our HMOs had aggregate statutory capital and surplus of approximately $243.6 million, compared with the required minimum aggregate statutory capital and surplus of approximately $150.7 million. All of our HMOs were in compliance with the minimum capital requirements.

Critical Accounting Policies

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

Our medical care costs include amounts that have actually 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 also record reserves for estimated referral claims related to medical groups under contract with us that are financially troubled or insolvent and that may not be able to honor their obligations for the payment of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses are not expected to be significant. In applying this policy, we use judgment to determine the appropriate assumptions for determining the required estimates. The most important part in estimating our medical care costs, however, 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 are not paid at the reporting date are collectively referred to as medical costs that are “Incurred But Not Reported”, or IBNR. We estimate these medical claims liabilities using actuarial methods based upon historical claims payment data. We adjust that data to account for changes in payment patterns, cost trends, changes in product mix, seasonality, changes in utilization of health care services, information provided by our providers; and other relevant factors. In assessing the adequacy of accruals for medical claims liabilities, we consider our historical experience, the terms of existing contracts, our knowledge of trends in the industry, information provided by our customers, and information available from other sources, as appropriate. The estimation methods and the resulting reserves are frequently reviewed and updated, and adjustments, if necessary, are reflected in the period known.

While we believe our current estimates are adequate, we have in the past been required to make a significant adjustment to these estimates and it is possible that we will be required to make significant adjustments or revisions to these estimates in the future.

The most significant estimates involved in determining our IBNR liability concern the determination of claims payment completion factors and trended per member per month cost estimates.

For the fifth month of service prior to the reporting date and earlier, we estimate our outstanding claims liability based upon actual claims paid, adjusted for estimated completion factors. Completion factors seek to measure the cumulative percentage of claims expense that will have been paid for a given month of service as of the reporting date based on historical payment patterns.

The following table reflects the change in our estimate of claims liability as of December 31, 2006 that would have resulted had we changed our completion factors for the fifth through the twelfth months preceding December 31, 2006 by the percentages indicated. A reduction in the completion factor results in an increase in medical claims liabilities. Our Utah HMO is excluded from these calculations, as the majority of the Utah business is conducted under a cost reimbursement contract. Our acquisition of Cape Health Plan, effective May 15, 2006, is excluded from these calculations because our statements of income only includes Cape Health Plan since the acquisition date. Dollar amounts are in thousands.

(Decrease) Increase in Estimated Completion Factors	Increase (Decrease) in Medical Claims and Benefits Payable
(3)%	$ 18,777
(2)%	12,518
(1)%	6,259
1%	(6,259)
2%	(12,518)
3%	(18,777)

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 upon trended per member per month (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, 2006 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, as the majority of the Utah business is conducted under a cost reimbursement contract. Cape Health Plan, which was acquired on May 15, 2006, is included in these calculations. Dollar amounts are in thousands.

(Decrease) Increase in Trended Per member Per Month Cost Estimates	(Decrease) Increase in Medical Claims and Benefits Payable
(3)%	$(11,256)
(2)%	(7,504)
(1)%	(3,752)
1%	3,752
2%	7,504
3%	11,256

Assuming a hypothetical 1% change in completion factors from those used in our calculation of IBNR at December 31, 2006, net income for the year ended December 31, 2006 would increase or decrease by approximately $3.9 million, or $0.14 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, 2006, net income for the year ended December 31, 2006 would increase or decrease by approximately $2.3 million, or $0.08 per diluted share, net of tax.

Commitments and Contingencies

We lease office space and equipment under various operating leases. As of December 31, 2006, our lease obligations for the next five years and thereafter are as follows: $13.1 million in 2007, $13.0 million in 2008, $12.1 million in 2009, $10.9 million in 2010, $10.1 million in 2011, and an aggregate of $43.8 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 the “Commitments and Contingencies” section of our consolidated financial statements appearing elsewhere in this report and the notes thereto. We have in the past made certain advances and loans to related parties, which are discussed in the consolidated financial statements appearing elsewhere in this report and the notes thereto.

Contractual Obligations

In the table below, we set forth our contractual obligations as of December 31, 2006. Some of the figures we include in this table are based on management’s estimates and assumptions about these obligations, including their duration, the possibility of renewal, anticipated actions by third parties, and other factors. Because these estimates and assumptions are necessarily subjective, the contractual obligations we will actually pay in future periods may vary from those reflected in the table. Amounts are in thousands.

	2007	2008–2009	2010–2011	2012 and Beyond
Long-term debt	$ —	$ —	$45,000	$ —
Operating lease obligations	13,137	25,035	21,018	43,830
Purchase commitments	8,031	5,510	1,365	36
Total contractual obligations	$21,168	$30,545	$67,383	$ 43,866

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. Concentration of credit risk with respect to accounts receivable is limited due to payors consisting principally of the governments of each state in which our HMO subsidiaries operate.

As of December 31, 2006, we had cash and cash equivalents of $403.7 million, investments of $81.5 million, and restricted investments of $20.2 million. The cash equivalents consist of highly liquid securities with original maturities of up to three months that are readily convertible into known amounts of cash. As of December 31, 2006, 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.

Inflation

We use various strategies to mitigate the negative effects of health care cost inflation. Specifically, our health plans try to control medical and hospital costs through contracts with independent providers of health care services. Through these contracted providers, our health plans emphasize preventive health care and appropriate use of specialty and hospital services. While we currently believe our strategies 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.

Compliance Costs

Our health plans are regulated by both state and federal government agencies. Regulation of managed care products and health care services is an evolving area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules occur frequently. Compliance with such laws and rules may lead to additional costs related to the implementation of additional systems, procedures and programs that we have not yet identified.

MOLINA HEALTHCARE, INC.

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

INDEX TO FINANCIAL STATEMENTS

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, 2006 and 2005, and the related consolidated statements of income, stockholders' equity and cash flows for each of the three years in the period ended December 31, 2006. 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, 2006 and 2005, and the consolidated results of its operations and its cash flows for each of the three years in the period ended December 31, 2006, in conformity with U.S. generally accepted accounting principles.

As discussed in Note 2 and Note 11 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), the effectiveness of Molina Healthcare, Inc.'s internal control over financial reporting as of December 31, 2006, 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 9, 2007 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 9, 2007

MOLINA HEALTHCARE, INC.

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

	December 31, 2006	December 31, 2005
ASSETS		
Current assets:		
Cash and cash equivalents	$403,650	$249,203
Investments	81,481	103,437
Receivables	110,835	70,532
Income tax receivable	7,960	3,014
Deferred income taxes	313	2,339
Prepaid and other current assets	9,263	10,321
Total current assets	613,502	438,846
Property and equipment, net	41,903	31,794
Intangible assets, net	85,480	81,655
Goodwill	57,659	43,259
Restricted investments	20,154	18,242
Receivable for ceded life and annuity contracts	32,923	38,113
Other assets	12,854	8,018
Total assets	$864,475	$659,927
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims and benefits payable	$290,048	$217,354
Accounts payable and accrued liabilities	46,725	31,257
Deferred revenue	18,120	803
Net liability for termination of commercial operations	—	200
Total current liabilities	354,893	249,614
Long-term debt, less current maturities	45,000	—
Deferred income taxes	6,700	4,796
Liability for ceded life and annuity contracts	32,923	38,113
Other long-term liabilities	4,793	4,554
Total liabilities	444,309	297,077
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding: 28,119,026 shares at December 31, 2006 and 27,792,360 shares at December 31, 2005	28	28
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	173,990	162,693
Accumulated other comprehensive loss	(337)	(629)
Retained earnings	266,875	221,148
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	420,166	362,850
Total liabilities and stockholders' equity	$864,475	$659,927

See accompanying notes.

MOLINA HEALTHCARE, INC.

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

	Year ended December 31,		
	2006	2005	2004
Revenue:			
Premium revenue	$ 1,985,109	$ 1,639,884	$ 1,171,038
Investment income	19,886	10,174	4,230
Total revenue	2,004,995	1,650,058	1,175,268
Expenses:			
Medical care costs:			
Medical services	351,022	271,769	222,168
Hospital and specialty services	1,125,600	983,513	643,074
Pharmacy	202,030	169,590	119,444
Total medical care costs	1,678,652	1,424,872	984,686
General and administrative expenses	229,057	163,342	94,150
Loss contract charge	—	939	—
Depreciation and amortization	21,475	15,125	8,869
Total expenses	1,929,184	1,604,278	1,087,705
Operating income	75,811	45,780	87,563
Other income (expense):			
Interest expense	(2,353)	(1,529)	(1,049)
Other, net	—	(400)	1,171
Total other income (expense)	(2,353)	(1,929)	122
Income before income taxes	73,458	43,851	87,685
Provision for income taxes	27,731	16,255	31,912
Net income	$ 45,727	$ 27,596	$ 55,773
Net income per share:			
Basic	$ 1.64	$ 1.00	$ 2.07
Diluted	$ 1.62	$ 0.98	$ 2.04
Weighted average shares outstanding:			
Basic	27,966,000	27,711,000	26,965,000
Diluted	28,164,000	28,023,000	27,342,000

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(dollars in thousands)

	Common Stock		Additional Paid-in Capital	Accumulated Other Comprehensive Income (Loss)	Retained Earnings	Treasury Stock	Total
	Outstanding	Amount					
Balance at January 1, 2004	25,373,785	25	103,854	54	137,779	(20,390)	221,322
Comprehensive income:							
Net income	—	—	—	—	55,773	—	55,773
Other comprehensive loss, net of tax:							
Change in unrealized loss on investments	—	—	—	(288)	—	—	(288)
Total comprehensive income	—	—	—	(288)	55,773	—	55,485
Issuance of shares	1,800,000	2	47,280	—	—	—	47,282
Stock options exercised, employee stock grants and employee stock purchases	428,658	1	2,678	—	—	—	2,679
Tax benefit for exercise of employee stock options	—	—	3,854	—	—	—	3,854
Balance at December 31, 2004	27,602,443	28	157,666	(234)	193,552	(20,390)	330,622
Comprehensive income:							
Net income	—	—	—	—	27,596	—	27,596
Other comprehensive loss, net of tax:							
Change in 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:							
Change in unrealized loss 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

See accompanying notes.

MOLINA HEALTHCARE, INC.

CONSOLIDATED STATEMENTS OF CASH FLOWS
(dollars in thousands)

	Year ended December 31,		
	2006	2005	2004
Operating activities			
Net income	$ 45,727	$ 27,596	$ 55,773
Adjustments to reconcile net income to net cash provided by operating activities:			
Depreciation and amortization	21,475	15,125	8,869
Amortization of capitalized credit facility fee	885	718	628
Deferred income taxes	(399)	1,705	2,175
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	—	1,872	3,854
Loss on disposal of property and equipment	—	297	—
Stock-based compensation	5,505	1,283	179
Changes in operating assets and liabilities, net of effects of acquisitions:			
Receivables	(38,847)	(5,102)	(3,641)
Prepaid and other current assets	1,369	(1,866)	(2,049)
Medical claims and benefits payable	51,550	57,144	23,121
Deferred revenue	10,443	803	(687)
Accounts payable and accrued liabilities	5,188	6,665	5,196
Income taxes payable and receivable	(579)	(8,982)	(2,369)
Net cash provided by operating activities	102,317	97,258	91,049
Investing activities			
Purchases of equipment	(20,297)	(13,960)	(10,765)
Purchases of investments	(148,795)	(63,774)	(440,208)
Sales and maturities of investments	171,225	48,227	450,039
Increase in restricted cash	(912)	(1,706)	(1,062)
Other long-term liabilities	239	488	644
Advances to related parties and other assets	(3,334)	(983)	3,099
Cash paid in purchase transactions, net of cash acquired and received in divestiture transaction	5,820	(40,866)	(51,766)
Net cash provided by (used in) investing activities	3,946	(72,574)	(50,019)
Financing activities			
Issuance of common stock	—	—	47,282
Payment of credit facility fees	(459)	(3,530)	—
Borrowings under credit facility	50,000	3,100	—
Repayments of debt acquired in acquisition	—	—	(5,819)
Repayments of amounts borrowed under credit facility	(5,000)	(3,100)	—
Issuance (repayment) of mortgage note	—	(1,302)	1,302
Principal payments on capital lease obligations	—	(592)	(74)
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	1,227	—	—
Proceeds from exercise of stock options and employee stock purchases	2,416	1,872	2,500
Net cash provided by (used in) financing activities	48,184	(3,552)	45,191
Net increase in cash and cash equivalents	154,447	21,132	86,221
Cash and cash equivalents at beginning of year	249,203	228,071	141,850
Cash and cash equivalents at end of year	$ 403,650	$ 249,203	$ 228,071
Supplemental cash flow information			
Cash paid during the year for:			
Income taxes	$ 27,354	$ 21,684	$ 25,385
Interest	$ 2,260	$ 1,620	$ 416
Schedule of non-cash investing and financing activities:			
Change in unrealized gain (loss) on investments	$ 474	$ (640)	$ (461)
Deferred income taxes	(182)	245	173
Net unrealized gain (loss) on investments	$ 292	$ (395)	$ (288)
Accrual of software license fees	$ 2,375	$ —	$ —
Accrual of equipment	$ 945	$ —	$ —
Value of stock issued for employee compensation earned in the previous year	$ 2,149	$ —	$ —
Details of acquisitions:			
Fair value of assets acquired, net of assets sold	$ 86,024	$ 43,265	$ 165,651
Less cash acquired in purchase and divestiture transaction	(49,820)	(2,249)	(56,770)
Liabilities assumed in purchase and divestiture transaction	(42,024)	(150)	(57,115)
Net cash (acquired) paid in purchase transactions and cash received in divestiture transaction	$ (5,820)	$ 40,866	$ 51,766

See accompanying notes.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS
(dollars in thousands, except per share data)
December 31, 2006

1. The Reporting Entity

Molina Healthcare, Inc. is a multi-state managed care organization that arranges for the delivery of health care services to persons eligible for Medicaid and other programs for low-income families and individuals. 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 were founded in 1980 as a provider organization serving the Medicaid population through a network of primary care clinics in California. In 1994, we began operating as a health maintenance organization (HMO). We operate our HMO business through subsidiaries in California (California HMO), Michigan (Michigan HMO), Ohio (Ohio HMO), New Mexico (New Mexico HMO), Texas (Texas HMO), Utah (Utah HMO), and Washington (Washington HMO). Our Texas HMO began serving members in September 2006. As a result of our Indiana HMO's not being selected for contract negotiations to provide services in 2007 under the Hoosier Healthwise Medicaid program, its Medicaid contract with the State of Indiana expired on December 31, 2006, and our Indiana HMO is currently winding up its operations.

On May 18, 2006, we completed our acquisition of HCLB, Inc. ("HCLB"). HCLB is the parent company of Cape Health Plan, Inc. ("Cape"), a Michigan corporation based in Southfield, Michigan. At the time of the acquisition, Cape served approximately 90,000 Medicaid members primarily in Southeast Michigan. 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 HMO.

2. Significant Accounting Policies

Principles of Consolidation

The consolidated financial statements include the accounts of Molina Healthcare, Inc. and all majority-owned subsidiaries. All significant 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.

Premium Revenue

Premium revenue is primarily derived from Medicaid programs and other programs for low-income individuals. Premium revenue includes per member per month fees received for providing medical services, fee for service revenue generated by our clinics in California, fee for service reimbursement for delivery of newborns

on a per case basis (birth income), and (in Utah) reimbursement of health care expenditures plus an administrative fee and savings sharing revenue. Starting in 2006, our premium revenue also includes premiums generated from Medicare.

Prepaid health care premiums are reported as revenue in the month in which enrollees are entitled to receive health care. A portion of the premiums is subject to possible retroactive adjustments which have not been significant, although there can be no certainty that such adjustments will not be significant in the future. We estimate the savings sharing revenue based upon claims experience reported by our Utah HMO and we record birth income during the month when services are rendered.

During each of the three years in the period ended December 31, 2006, our birth income was approximately 6% of total premium revenue. Savings sharing revenue recognized by our Utah HMO was $1,569; $1,767 and $2,142 for the years ended December 31, 2006, 2005 and 2004, respectively (see Receivables). Revenue earned by our California medical clinics and by our New Mexico HMO for performing certain administrative services for the state contributed less than 1% of total revenue for the years ended December 31, 2006, 2005 and 2004.

Medical Care Costs

We arrange to provide comprehensive medical care to our members through a network of contracted hospitals, physician groups and other health care providers that includes our clinics. Expenses related to medical care services include two components: direct medical expenses and medically-related administrative costs. Direct medical expenses include payments to physicians, hospitals, and providers of ancillary medical services, such as pharmacy, laboratory, and radiology services. Medically-related administrative costs include expenses relating to health education, quality assurance, case management, disease management, 24-hour on-call nurses, member services, and compliance. Salary and benefit costs are a substantial portion of these expenses. For the years ended December 31, 2006, 2005, and 2004, medically-related administrative costs, classified as “Medical services” in our Consolidated Statements of Income, constituted approximately 3% of premium revenue.

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 pay a fixed per member per month payment to the provider without regard to the frequency, extent or nature of the medical services actually furnished. Under capitated contracts we remain liable for the provision of certain health care services. Certain of our capitated contracts also contain incentive programs based on service delivery, quality of care, utilization management and other criteria. Capitation payments are fixed in advance of periods covered and are not subject to significant accounting estimates. These payments are expensed in the period the providers are obligated to provide services. All capitation expenses are recorded as “Medical services” in our Consolidated Statements of Income.

As noted above, many of our primary care physicians are paid on a capitation basis, while others are paid on a fee-for-service basis. Specialists and hospitals are paid for the most part on a fee-for-service basis. 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 fee-for-service (per diems, diagnostic-related groups, percent of billed charges and case rates) and capitation. Under fee-for-service arrangements, we retain the financial responsibility for medical care provided at discounted payment rates. Expenses related to fee-for-service contracts are recorded in the period in which the related services are dispensed. For the year ended December 31, 2006, approximately 83.9% of our direct medical expenses were related to fees paid to providers on a fee-for-service basis, with the balance paid on a capitation basis.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Medical care costs and medical claims and benefits payable are based upon actual historical experience and estimates of medical expenses incurred but not reported, or IBNR. We estimate our IBNR monthly based on a number of factors, including prior claims experience, health care service utilization data, cost trends, product mix, seasonality, prior authorization of medical services and other factors. We also consider uncertainties related to fluctuations in provider billing patterns, claims payment patterns, membership, and medical cost trends. We include loss adjustment expenses in the recorded claims liability. We continually review and update the estimation methods and the resulting reserves. Many of our medical contracts are complex in nature and may be subject to differing interpretations regarding amounts due for the provision of various services. Such differing interpretations may not come to light until a substantial period of time has passed following the contract implementation, leading to potential misstatement of some costs in the period in which they are first recorded. Estimates are adjusted monthly as more information becomes available. Any adjustments to reserves are reflected in current operations. We employ our own actuaries and engage the service of independent actuaries as needed. We believe that our process for estimating IBNR is adequate, but all estimates are subject to uncertainties and our actual medical care costs have, in the past, exceeded such estimates. Our estimates of IBNR may be inadequate in the future, which would negatively affect our results of operations.

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

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

	Year ended December 31,		
	2006	2005	2004
Balances as of January 1	$ 217,354	$ 160,210	$105,540
Medical claims and benefits payable from business acquired during the period	21,144	—	—
Components of medical care costs related to:			
Current year	1,716,256	1,424,406	990,007
Prior years	(37,604)	466	(5,321)
Total medical care costs	1,678,652	1,424,872	984,686
Payments for medical care costs related to:			
Current year	1,443,843	1,216,593	839,663
Prior years	183,259	151,135	90,353
Total paid	1,627,102	1,367,728	930,016
Balances as of December 31	$ 290,048	$ 217,354	$160,210

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, 2006 or 2005.

Premium Deficiency Reserves on Loss Contracts

We assess the profitability of our contracts for providing medical care services to our members and identify those contracts where current operating results or forecasts indicate probable future losses. Anticipated future premiums are compared to anticipated medical care costs, including the cost of processing claims. If the anticipated future costs exceed the premiums, a loss contract accrual is recognized. No such accrual was required as of December 31, 2006 or 2005 other than that the accrual of additional loss contract charge in 2005 for the New Mexico Transition Services Agreement which was entered into as a result of our acquisition of HCH on July 1, 2004.

Cash and Cash Equivalents

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

Investments

We account for our investments in marketable securities in accordance with Statement of Financial Accounting Standards (SFAS) No. 115, *Accounting for Certain Investments in Debt and Equity Securities.* Realized gains and losses and unrealized losses judged to be other than temporary with respect to available-for-sale and held-to-maturity securities are included in the determination of net income. All unrealized losses at December 31, 2006 and 2005 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. Fair values of securities are based on quoted prices in active markets.

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

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Our investments consisted of the following:

	December 31, 2006			
	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
U.S. Treasury and agency securities	$ 71,374	$ 24	$ 441	$ 70,957
Municipal securities	8,515	—	10	8,505
Corporate bonds	2,020	—	1	2,019
Total investment securities	$ 81,909	$ 24	$ 452	$ 81,481

	December 31, 2005			
	Cost or Amortized Cost	Gross Unrealized		Estimated Fair Value
		Gains	Losses	
U.S. Treasury and agency securities	$ 88,290	$ —	$ 1,010	$ 87,280
Municipal securities	9,653	24	22	9,655
Corporate bonds	6,508	3	9	6,502
Total investment securities	$ 104,451	$ 27	$ 1,041	$ 103,437

The contractual maturities of our investments as of December 31, 2006 are summarized below.

	Amortized Cost	Estimated Fair Value
Due in one year or less	$ 44,916	$ 44,676
Due one year through five years	30,536	30,372
Due after five years through ten years	707	683
Due after ten years	5,750	5,750
Total debt securities	$ 81,909	$ 81,481

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 $12,583, $4,689 and $29,303 for the years ended December 31, 2006, 2005 and 2004, respectively. Net realized investment losses for the years ended December 31, 2006, 2005 and 2004 were $151, $220 and $19, respectively.

Unrealized losses at December 31, 2006 and 2005 have been determined to be temporary in nature. The decline in market value for these securities is the result of rising interest rates rather than a deterioration of the credit worthiness of the issuers. So long as we hold these securities to maturity, we are unlikely to experience losses. In the event that we dispose of these securities before maturity, we expect that realized losses, if any, will be immaterial. Also, the disclosures required under EITF 03-1, *The Meaning of Other-Than-Temporary Impairment and Its Application to Certain Investments*, have not been included because our unrealized losses are immaterial at December 31, 2006 and 2005.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

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. Accounts receivable by operating subsidiary are comprised of the following:

	December 31,	
	2006	2005
California HMO	$ 32,404	$ 19,952
Utah HMO	46,570	32,929
Ohio HMO	11,611	—
Washington HMO	7,447	7,486
Other HMOs	12,803	10,165
Total receivables	$ 110,835	$ 70,532

Substantially all receivables due our California HMO at December 31, 2006 and 2005 were collected in January of 2007 and 2006, respectively.

Our agreement with the State of Utah calls for the reimbursement of our Utah HMO of medical costs incurred in serving our members plus an administrative fee of 9% of medical costs and all or a portion of any cost savings realized, as defined in the agreement. Our Utah health plan bills the State of Utah monthly for actual paid health care claims plus administrative fees. Our receivable balance from the State of Utah includes: 1) amounts billed to the state for actual paid health care claims plus administrative fees; 2) amounts estimated to be due under the savings sharing provision of the agreement; 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 a result of increased claims volume from our Utah members, all three components of the receivables were higher in 2006 as compared to 2005.

We have estimated the amount we believe that we will recover under our savings sharing plan with the State of Utah based on the information we have to date, and our interpretation of the provisions of our contract with the state. The ultimate amount of savings sharing that we will realize may be subject to negotiation with the state, and the state may not agree with our interpretation of the contract language. When additional information is known, or a settlement is reached with the state, we will adjust the amount of savings sharing recorded in our financial statements.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Restricted Investments

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

	December 31, 2006	December 31, 2005
California	$ 301	$ 300
Utah	550	550
Michigan	2,000	1,000
New Mexico	8,571	8,128
Indiana	536	514
Washington	151	150
Ohio	1,742	400
Texas	1,559	1,511
Phoenix National Insurance Company	4,744	5,689
Total	$ 20,154	$ 18,242

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 specific purposes as required by each state.

Property and Equipment

Property and equipment are stated at historical cost. Replacements and major improvements are capitalized, and repairs and maintenance are charged to expense as incurred. Software developed for internal use is capitalized in accordance with the provision of SOP 98-1. 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.

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 five and fifteen years). We performed the required impairment tests of goodwill and indefinite lived intangible assets in 2006, 2005 and 2004 and no impairment was identified in these periods.

Long-Lived Asset Impairment

Situations may arise where the carrying value of a long-lived asset may exceed the 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. We have determined that no long-lived assets were impaired at December 31, 2006 or 2005.

Receivable / Liability for Ceded Life and Annuity Contracts

As of June 30, 2006, we reported 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. Prior period amounts have been reclassified to conform to the 2006 presentation. The reclassification has no effect on our earnings, working capital or stockholders' equity as previously reported.

Income Taxes

Income taxes are accounted for under the asset and liability method in accordance with SFAS No. 109, *"Accounting for Income Taxes."* Deferred tax assets and liabilities are determined based on temporary differences between the financial reporting and the tax basis of assets and liabilities and operating loss and tax credit carry forwards. Deferred tax assets and liabilities are measured by applying enacted tax rates and laws and are released to taxable income in the years in which the temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax rates is recognized in income in the period that includes the enactment date. Valuation allowances are provided against deferred tax assets when it is more likely than not that some portion or all of the deferred tax asset will not be realized. Loss contingencies resulting from tax audits or certain tax positions are accrued when the potential loss can be reasonably estimated and where occurrence is probable.

The loss contingency amounts are released upon closure of the examination. In the event new reserve amounts are necessary we will provide a new reserve for specific issues for the tax year in which the issue arises. Such reserves were not significant at December 31, 2006 or 2005.

Taxes Based on Premiums

Our California HMO (beginning July 1, 2005), Michigan HMO, New Mexico HMO (beginning July 1, 2004), Ohio HMO, Texas HMO and Washington HMO are assessed a tax based upon premium revenue collected. Premium tax expense totaled $60,777, $46,301, and $24,333 in 2006, 2005, and 2004, respectively, and is included in general and administrative expenses.

Professional Liability Insurance

We carry medical malpractice insurance for health care services rendered through our clinics in California. Claims-made coverage under this insurance is $1,000 per occurrence with an annual aggregate limit of $3,000 for years ended December 31, 2006 and 2005. 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 aggregate for each policy year.

Stock-Based Compensation

At December 31, 2006, we had two stock-based employee compensation plans, both of which are described more fully in Note 11. Through December 31, 2005, we accounted for the plans under the recognition and measurement principles (the intrinsic-value method) prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations. Compensation cost for stock options was reflected in net income and was measured as the excess of the market price of our stock at the date of grant over the amount an employee must pay to acquire the stock. At December 31, 2005, we had adopted the disclosure provisions required by SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure*.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The recognition and measurement of stock grants is the same under APB Opinion No. 25 and SFAS No. 123. The related expenses for the fair value of stock grants were charged to general and administrative expenses and are included in the "net income, as reported" amounts in the pro forma net income table below.

In December 2004, the FASB issued Statement of Financial Accounting Standards (SFAS) No. 123 (revised 2004) (SFAS 123(R)), "Share-Based Payment". SFAS 123(R) is a revision of SFAS No. 123, "Accounting for Stock Based Compensation", and supersedes APB 25. Among other items, SFAS 123(R) eliminates the use of APB 25 and the intrinsic value method of accounting, and requires companies to recognize the cost of employee services received in exchange for awards of equity instruments, based on the grant date fair value of those awards, in the financial statements. The effective date of SFAS 123(R) is the first reporting period beginning after December 31, 2005, which is first quarter 2006 for calendar year companies, although early adoption is allowed. SFAS 123(R) permits companies to adopt its requirements using either a "modified prospective" method, or a "modified retrospective" method. Under the "modified prospective" method, compensation cost is recognized in the financial statements beginning with the effective date, based on the requirements of SFAS 123(R) for all share-based payments granted, modified or settled after that date, and based on the requirements of SFAS 123 for all unvested awards granted prior to the effective date of SFAS 123(R). Under the "modified retrospective" method, the requirements are the same as under the "modified prospective" method, but entities are also permitted to restate financial statements of previous periods based on pro forma disclosures made in accordance with SFAS 123.

As of January 1, 2006, we adopted SFAS 123(R) using the modified prospective method, which requires measurement of compensation cost for all stock-based awards at fair value on date of grant and recognition of compensation over the service period for awards expected to vest. The fair value of restricted stock is determined based on the number of shares granted and the quoted price of our common stock, and the fair value of stock options is determined using the Black-Scholes valuation model, which is consistent with our valuation techniques previously utilized for options in footnote disclosures required under SFAS No. 123, *Accounting for Stock Based Compensation*, as amended by SFAS No. 148, *Accounting for Stock-Based Compensation—Transition and Disclosure.*

In addition, for awards granted prior to January 1, 2006, the unvested portion of the awards have been recognized in periods subsequent to the adoption date based on the grant date fair value determined for pro forma disclosure purposes under SFAS 123. Compensation expense in connection with restricted stock awards and option grants is recognized on a straight-line basis over the vesting periods. Our adoption of SFAS 123 (R) reduced income before income taxes and net income for the year ended December 31, 2006 by approximately $3,248 and $2,021, respectively, or $0.07 per basic and diluted share.

Prior to the adoption of SFAS 123(R), cash retained as a result of tax deductions relating to stock-based compensation was presented in operating cash flows. SFAS 123(R) requires tax benefits relating to excess stock-based compensation deductions be presented as financing cash inflows. Tax benefits resulting from stock-based compensation deductions in excess of amounts reported for financial reporting purposes were $1.2 million, $1.9 million, and $3.9 million for the years ended December 31, 2006, 2005, and 2004, respectively.

In November 2005, the FASB issued Staff Position (FSP) 123(R)-3, "Transition Election Related to Accounting for the Tax Effects of Share-Based Payment Awards." This pronouncement provides an alternative transition method of calculating the excess tax benefits available to absorb any tax deficiencies recognized subsequent to the adoption of SFAS No. 123(R). The company has elected to adopt the alternative transition method.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The following table illustrates the effect on net income and earnings per share if we had applied the fair value recognition provisions to stock-based employee compensation permitted by SFAS No. 148 with the following weighted-average assumptions: a risk-free interest rate of 4.11% in 2005 and 4.15% in 2004; expected stock price volatility of 53.2% in 2005 and 51.2% in 2004; dividend yield of 0% and expected option lives of 60 months for 2005 and 2004.

	Year ended December 31,	
	2005	2004
Net income, as reported	$27,596	$55,773
Reconciling items (net of related tax effects):		
Add: Stock-based employee compensation expense determined under the intrinsic-value based method for stock option awards	—	—
Deduct: Stock-based employee compensation expense determined under the fair-value based method for stock option and employee stock purchase plan awards	(1,048)	(976)
Net adjustment	(1,048)	(976)
Net income, as adjusted	$26,548	$54,797
Earnings per share:		
Basic—as reported	$ 1.00	$ 2.07
Basic—as adjusted	$ 0.96	$ 2.03
Diluted—as reported	$ 0.98	$ 2.04
Diluted—as adjusted	$ 0.95	$ 2.00

Earnings Per Share

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

	Year ended December 31,		
	2006	2005	2004
Shares outstanding at the beginning of the year	27,792,000	27,602,000	25,374,000
Weighted-average number of shares issued	174,000	109,000	1,591,000
Denominator for basic earnings per share	27,966,000	27,711,000	26,965,000
Dilutive effect of employee stock options and stock grants (1)	198,000	312,000	377,000
Denominator for diluted earnings per share	28,164,000	28,023,000	27,342,000

(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.

Concentrations of Credit Risk

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

We invest a substantial portion of our cash in the CADRE Affinity Fund and CADRE Reserve Fund (CADRE Funds), a portfolio of highly liquid money market securities. The CADRE Funds are a series of funds

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

Our investments and a portion of our cash equivalents are managed by two professional portfolio managers operating under documented investment guidelines. Our investments consist solely of investment grade debt securities with a maximum maturity of 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. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization. The carrying value of advances to related parties and all long-term obligations approximates their fair value based on borrowing rates currently available to the company for instruments with similar terms and remaining maturities.

Risks and Uncertainties

Our profitability depends in large part on accurately predicting and effectively managing medical care costs. We continually review our 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 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, 2006, we operated in seven 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.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

New Accounting Pronouncements

In May 2005, the FASB issued Statement No. 154 (SFAS No. 154), *Accounting Changes and Error Corrections*, which replaced APB Opinion No. 20, *Accounting Changes*, and FASB Statement No. 3, *Reporting Changes in Interim Financial Statements*. SFAS No. 154 requires retrospective application to prior periods' financial statements of voluntary changes in accounting principles and changes required by a new accounting standard when the standard does not include specific transition provisions. Previous guidance required most voluntary changes in accounting principle to be recognized by including in net income of the period in which the change was made the cumulative effect of changing to the new accounting principle. SFAS No. 154 carries forward existing guidance regarding the reporting of the correction of an error and a change in accounting estimate. SFAS No. 154 is effective for accounting changes and corrections of errors made in fiscal years beginning after December 15, 2005. Adoption of SFAS No. 154 as of January 1, 2006 did not have a material effect on our consolidated financial statements.

In June 2006, the EITF reached a consensus on EITF Issue No. 06-03 ("EITF 06-03"), "How Taxes Collected from Customers and Remitted to Governmental Authorities Should Be Presented in the Income Statement (That Is, Gross versus Net Presentation)" EITF 06-03"). EITF 06-03 provides that the presentation of taxes assessed by a governmental authority that is directly imposed on a revenue-producing transaction between a seller and a customer on either a gross basis (included in revenues and costs) or on a net basis (excluded from revenues) is an accounting policy decision that should be disclosed. The provisions of EITF 06-03 are effective for fiscal years beginning after December 15, 2006. We are currently evaluating the effect that the adoption of EITF 06-03 will have on our consolidated financial statements. We currently report such taxes on a gross basis.

In July 2006, FASB released Interpretation No. 48, "Accounting for Uncertainty in Income Taxes—an Interpretation of FASB Statement No. 109" (FIN 48), which clarifies the accounting and disclosure for uncertainty in income taxes recognized in financial statements. FIN 48 prescribes a comprehensive accounting model for recognizing, measuring, presenting and disclosing in the financial statements uncertain tax positions that the Company has taken or expects to take on a tax return. FIN 48 is effective for fiscal years beginning after December 15, 2006. We are in the process of evaluating the impact of the adoption on our consolidated financial statements.

On September 15, 2006, the FASB issued SFAS No. 157, "Fair Value Measurements" (SFAS No. 157). SFAS No. 157 addresses how companies should measure fair value when they are required to use a fair value measure for recognition and disclosure purposes under generally accepted accounting principles. SFAS No. 157 will require the fair value of an asset or liability to be based on a market based measure which will reflect the credit risk of the company. SFAS No. 157 will also require expanded disclosure requirements which will include the methods and assumptions used to measure fair value and the effect of fair value measures on earnings. SFAS No. 157 will be applied prospectively and will be effective for fiscal years beginning after November 15, 2007. We are currently assessing the impact SFAS No. 157 will have on our consolidated financial statements.

In September 2006, the SEC staff issued Staff Accounting Bulletin No. 108, "Considering the Effects of Prior Year Misstatements when Quantifying Misstatements in Current Year Financial Statements" (SAB 108). SAB 108 was issued to provide interpretive guidance on how the effects of the carryover or reversal of prior year misstatements should be considered in quantifying a current year misstatement. We adopted the provisions of SAB 108 effective December 31, 2006. The adoption of SAB 108 did not have a material impact on our consolidated financial statements.

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.

Reclassifications

Certain prior year amounts have been reclassified to conform to the current year presentation. As of June 30, 2006, we reported 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. Prior period amounts totaling $38,113 have been reclassified to conform to the 2006 presentation. The reclassification has no effect on our earnings, working capital or stockholders' equity as previously reported.

3. Acquisitions

Michigan HMO

On May 18, 2006, the Company completed its acquisition of HCLB, Inc. ("HCLB"). HCLB is the parent company of Cape Health Plan, Inc. ("Cape"), a Michigan corporation based in Southfield, Michigan. Cape serves approximately 90,000 Medicaid members primarily in Southeast 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 HMO.

In accordance with FAS 141, the purchase price was allocated to the fair value of HCLB 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. Based upon our current valuation, the fair values of HCLB assets acquired and liabilities assumed at the date of the merger are summarized as follows:

Current assets	$ 55,313
Property and equipment	408
Other non-current assets	1,003
Goodwill and intangible assets	28,024
Total assets acquired	$ 84,748
Current liabilities	(36,917)
Other long-term liabilities	(3,831)
Total liabilities assumed	(40,748)
	$ 44,000

Of the $28,024 of acquired goodwill and intangible assets, $9,900 was assigned to the member list with a five year life, $3,484 was assigned to provider network with a ten year life and the remaining $14,640 was assigned to non-tax deductible goodwill which is not subject to amortization.

4. Goodwill and Intangible Assets

Under SFAS No. 142, *Goodwill and Other Intangible Assets*, goodwill and indefinite lived assets are no longer amortized, but are subject to impairment tests on an annual basis or more frequently if impairment indicators exist. Under the guidance of SFAS No. 142, we used a discounted cash flow methodology to assess the fair values of our reporting units at December 31, 2006 and 2005. 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, 2006, 2005 and 2004.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Other intangible are comprised of the costs of acquired payor contracts, provider contracts and insurance licenses. These assets are being amortized over their useful lives ranging from 5 to 15 years. Amortization on intangible assets recognized for the years ended December 31, 2006, 2005, and 2004 was $9,539, $7,431, and $4,043, respectively. We estimate our intangible asset amortization will be $10,463 in 2007, $9,972 in 2008, $8,676 in both 2009 and 2010, and $7,439 in 2011. The following table sets forth balances of identified intangible assets, by major class, for the periods indicated:

	Cost	Accumulated Amortization	Net Balance
		(Amounts in thousands)	
Intangible assets:			
Contract rights and licenses	$ 103,282	$ 24,748	$ 78,534
Provider network	8,013	1,067	6,946
Balance at December 31, 2006	$ 111,295	$ 25,815	$ 85,480
Intangible assets:			
Contract rights	$ 93,403	$ 15,902	$ 77,501
Provider network	4,529	375	4,154
Balance at December 31, 2005	$ 97,932	$ 16,277	$ 81,655

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

Balance as of December 31, 2005	$ 43,259
Goodwill related to acquisition of HCLB, Inc in 2006	14,640
Adjustment to goodwill related to acquisition of Health Care Horizon, Inc. in 2004 and Phoenix National Insurance Company in 2005	(240)
Balance at December 31, 2006	$ 57,659

5. Property and Equipment

A summary of property and equipment is as follows:

	December 31,	
	2006	2005
Land	$ 3,000	$ 3,000
Building and improvements	18,665	15,474
Furniture, equipment and automobiles	32,933	24,873
Capitalized computer software costs	20,571	10,206
	75,169	53,553
Less: accumulated depreciation and amortization on building and improvements, furniture, equipment and automobiles	(25,670)	(18,416)
Less: accumulated amortization on capitalized computer software costs	(7,596)	(3,343)
	(33,266)	(21,759)
Property and equipment, net	$ 41,903	$ 31,794

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Depreciation expense recognized for building and improvements, furniture, equipment and automobiles was $7,676, $5,909 and $4,001 for the years ended December 31, 2006, 2005, and 2004, respectively. Amortization expense recognized for capitalized computer software costs was $4,261, $1,785 and $825 for the years ended December 31, 2006, 2005 and 2004, respectively.

6. Related Party Transactions

We lease two medical clinics from the Molina Family Trust. These leases have five five-year renewal options. In May 2001, we entered into a similar agreement with the Molina Siblings Trust for the lease of another medical clinic, which we also use as a backup data center. In December 2004, we purchased this clinic from the Molina Siblings Trust for $1,850. Rental expense for these leases totaled $97, $96, and $367 for the years ended December 31, 2006, 2005, and 2004, respectively. At December 31, 2006, minimum future lease payments for the two remaining leased clinics consisted of the following:

Year ending December 31,	
2007	$107
2008	107
2009	107
2010	35
Total minimum lease payments	$356

During the second quarter of 2005, we made an equity investment of approximately $1,600 (included in other assets) in a medical service provider that provides certain vision services to our members. Upon the achievement by the medical service provider of certain benchmarks prior to December 31, 2006, we were obligated to invest an additional $1,900. At December 31, 2006, the provider had not attained those benchmarks. No additional investments were made during 2006. We account for this investment under the equity method of accounting as we have an ownership interest in the investee in excess of 20%. At December 31, 2006, we carried this investment at $1,375 as a result of write downs to reflect our pro rata share of the provider's losses. The investment was reduced by $221 in 2006 and $4 in 2005. Medical service fees paid to this provider totaled $7,862 and $3,440 in 2006 and 2005, respectively.

Effective March 1, 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 $170 for the year ended December 31, 2006.

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 $357 and $375 for the years ended December 31, 2006 and 2005, respectively. We believe that the claims submitted to us by Pacific Hospital were reimbursed at prevailing market rates.

Effective June 1, 2006, the Company entered into an additional agreement with Pacific Hospital as part of a capitation arrangement. Under this arrangement, Pacific Hospital will receive a fixed fee from us based on member type. For the year ended December 31, 2006, approximately $1,652 was paid to Pacific Hospital for capitation services. We believe that this agreement with Pacific Hospital is based on prevailing market rates for similar services.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

We were a party to Collateral Assignment Split-Dollar Insurance Agreements with the Molina Siblings Trust. We agreed to make premium payments towards the life insurance policies held by the Molina Siblings Trust on the life of Mary R. Molina, a former employee and director and a current shareholder, in exchange for services from Mrs. Molina. We were not an insured under the policies, but were entitled to receive repayment of all premium advances from the Molina Siblings Trust upon the earlier of Mrs. Molina's death or cancellation of the policies. Advances through December 31, 2003 of $3,349 were discounted based on the insured's remaining actuarial life, using discount rates commensurate with instruments of similar terms or risk characteristics (4%). Such receivables were secured by the cash surrender values of the policies. The discounted receivable of $2,188 was included in advances to related parties and other assets. On March 2, 2004, the Collateral Assignment Split-Dollar Insurance Agreements were terminated when the Molina Siblings Trust repaid to us the advances. Upon such termination, we recognized a pretax gain of $1,161. The gain of $1,161 represented the recovery of the discounts previously recorded and was recorded as Other Income in the Consolidated Statements of Income.

Mr. Harvey Fein, our Vice President of Internal Audit, serves on the board of directors of CADRE Funds, the professional portfolio manager of our invested cash and cash equivalents. Mr. Fein has no direct management control over the Company's funds invested by CADRE Funds.

7. Long-Term Debt

On March 9, 2005, we entered into an amended and restated five-year senior secured credit agreement for a $180,000 revolving credit facility with a syndicate of lenders. The credit facility will be used for working capital and general corporate purposes. This credit facility replaced the $75,000 facility that we entered into on March 19, 2003. We incurred approximately $3,047 in related fees, which were capitalized as deferred financing cost (in other assets) to be amortized over the term of the new credit facility.

The credit facility has a term of five years and all amounts outstanding under the credit facility will be due and payable on March 8, 2010. Subject to obtaining commitments from existing or new lenders and satisfaction of other specified conditions, we may increase the credit facility to up to $200,000.

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 will equal the higher of Bank of America's prime rate or 0.5% 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 EBITDA. The applicable margins range between 1.00% and 1.75% for LIBOR loans and between 0% and 0.75% for base rate loans. The commitment fee ranges between 0.375% and 0.500%. 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.

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 HMO subsidiaries.

The amended credit agreement 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 fixed charge coverage ratio. The credit agreement also requires us to maintain a ratio of total consolidated debt to total consolidated EBITDA of not more than 2.00 to 1.00 at any time. At December 31, 2006, we were in compliance with all financial covenants in the credit agreement.

At December 31, 2006 and 2005, amounts outstanding under the credit facility were $45,000 and $0, respectively.

In December 2004, we issued a mortgage note in the amount of $1,302 in connection with the purchase of a medical clinic from a related party (see Note 6. Related Party Transactions). In December 2005, we repaid the note in full.

8. Income Taxes

The provision for income taxes was as follows:

	Year ended December 31,		
	2006	2005	2004
Current:			
Federal	$ 24,987	$ 13,906	$ 28,635
State	3,143	879	1,102
Total current	28,130	14,785	29,737
Deferred:			
Federal	(471)	1,404	1,822
State	(578)	66	353
Total deferred	(1,049)	1,470	2,175
Change in valuation allowance	650	—	—
Total provision for income taxes	$ 27,731	$ 16,255	$ 31,912

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

	Year ended December 31,		
	2006	2005	2004
Taxes on income at statutory federal tax rate	$ 25,710	$ 15,348	$ 30,691
State income taxes, net of federal benefit	2,097	614	946
Other	(76)	293	275
Reported income tax expense	$ 27,731	$ 16,255	$ 31,912

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 (Credits).

During 2006, 2005, and 2004, tax benefits related to stock option exercises were $1,227, $1,872 and $3,854, respectively. Such benefits were recorded as a reduction of income taxes payable and an increase in additional paid-in capital.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Deferred tax assets and liabilities are classified as current or noncurrent according to the classification of the related asset or liability. Significant components of the Company's deferred tax assets and liabilities as of December 31, 2006 and 2005 are as follows:

	December 31	
	2006	2005
Accrued expenses	$ 1,388	$ 1,072
Reserve liabilities	425	158
State taxes	1,005	93
Prepaid expenses	(2,396)	—
Net operating losses	27	75
Other, net	(130)	941
Valuation allowance	(6)	—
Deferred tax asset, net of valuation allowance —current	313	2,339
Net operating losses	819	587
State taxes	437	421
Depreciation and amortization	(9,656)	(6,822)
Deferred compensation	2,329	1,113
Other accrued medical costs	98	97
Other, net	(83)	(192)
Valuation allowance	(644)	—
Deferred tax liability—long term	(6,700)	(4,796)
Net deferred income tax liabilities	$(6,387)	$(2,457)

At December 31, 2006, we had federal and state net operating loss carryforwards of $577 and $7,578, 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, 2006, $650 of deferred tax assets did not satisfy the recognition criteria set forth in SFAS No. 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 2006, $4,147 of deferred tax liabilities were established for certain acquired intangible assets in connection with the purchase of all of the outstanding stock of HCLB (Cape Health Plan). 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.

9. 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 $2,540, $1,633 and $1,387 in the years ended December 31, 2006, 2005, and 2004, respectively.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

10. 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 related parties) consist of the following approximate amounts:

Year ending December 31,	
2007	$ 13,137
2008	12,966
2009	12,069
2010	10,883
2011	10,135
Thereafter	43,830
Total minimum lease payments	$ 103,020

Rental expense related to these leases totaled $12,193, $9,505 and $7,416 for the years ended December 31, 2006, 2005, and 2004, respectively.

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 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

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.

Securities Class Action. Beginning on July 27, 2005, a series of securities class action complaints were filed in the United States District Court for the Central District of California on behalf of persons who acquired our common stock between November 3, 2004 and July 20, 2005. The class action complaints purported to allege

claims for alleged violations of the Securities Exchange Act of 1934 arising out of our issuance and subsequent revision of earnings guidance for the 2005 fiscal year. The class action complaints were consolidated into a single consolidated action, Case No. CV 05-5460 GPS (SHx) (the "Class Action"), and a lead plaintiff was appointed. On December 11, 2006, Molina Healthcare, Inc., J. Mario Molina, John C. Molina, and Joseph W. White, the defendants in the Class Action, and PACE Industry Union-Management Pension Fund, the lead plaintiff, filed a Joint Stipulation of Voluntary Dismissal Pursuant to Federal Rule of Civil Procedure 41(a) (the "Dismissal Stipulation"). The Dismissal Stipulation provided for the immediate dismissal with prejudice of the Class Action against the defendants as to the lead plaintiff, thereby ending the Class Action. The defendants did not make any payment to the lead plaintiff or any other party in connection with the Dismissal Stipulation, and each party agreed to bear its own costs and attorneys' fees arising from the Class Action. The Dismissal Stipulation followed the District Court's Order on November 17, 2006, pursuant to which the District Court granted the defendants' motion to dismiss the lead plaintiff's consolidated complaint without prejudice. Under Federal Rule of Civil Procedure 41(a), the Dismissal Stipulation became immediately effective upon its filing with the court.

Derivative Action. On August 8, 2005, a shareholder derivative complaint was filed in the Superior Court of the State of California for the County of Los Angeles, Case No. BC 337912 (the "Derivative Action"). The Derivative Action purports to allege claims on behalf of Molina Healthcare, Inc. against certain current and former officers and directors for breach of fiduciary duty, breach of the duty of loyalty, gross negligence, and violation of California Corporations Code Section 25402, arising out of the Company's announcement of its guidance for the 2005 fiscal year. On February 7, 2006, the Superior Court ordered that the Derivative Action be stayed pending the outcome of the Class Action. As a result of the final disposition of the Class Action, the Los Angeles Superior Court has scheduled a hearing for April 27, 2007 on the Demurrer filed by Molina Healthcare. Discovery in the Derivative Action is stayed pending the court's ruling on the Demurrer. The Derivative Action is in the early stages, and no prediction can be made as to the outcome.

Arbitration with Tenet Hospital. In July 2004, our California HMO received a demand for arbitration from USC/Tenet Hospital, or Tenet, seeking damages of approximately $4,500 involving certain disputed medical claims. In September 2004, Tenet amended its demand to join additional Tenet hospital claimants and to increase its damage claim to approximately $8,000. The parties agreed to conduct the arbitration in two phases. The first phase of the arbitration, comprising approximately $3,000 of the total demand, concluded in December 2005. At that time, Tenet was awarded approximately $1,700 by the arbitrator. Our California HMO paid the award in January 2006. This amount is in addition to approximately $330 our California HMO had paid earlier in the fourth quarter of 2005 to settle a portion of the claims included in the first phase of the arbitration. At December 31, 2005, our California HMO had recorded $2,000 of additional expense beyond the amount of $2,030 referenced above in connection with this matter. The final phase of the arbitration was settled during the third quarter of 2006. In connection with that settlement, our California HMO paid Tenet $2,000. As a result, the Tenet matter is now resolved.

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. The proceeding is in the early stages, and no prediction can be made as to the outcome.

Antelope Valley. On May 1, 2006, Antelope Valley Healthcare District ("Antelope Valley") filed a complaint in Los Angeles County Superior Court against our California HMO, Case No. BC351590. To date, our

California HMO has not been served with the complaint, and upon information and belief the complaint was filed by Antelope Valley at this stage in order to toll the applicable statute of limitations. The complaint alleges claims for breach of contract, breach of implied contract, quantum meruit, unfair business practice, and declaratory relief related to the payment of emergency room claims for Molina members who sought treatment at Antelope Valley facilities from January 2002 to the present. Antelope Valley alleges that the emergency room claims, which our California HMO paid in accordance with its Medicaid contract with the California Department of Health Services and Title 22 of the California Code of Regulations, Section 53855, were underpaid. The complaint seeks damages in the amount of $2,001, plus interest and attorney fees. An administrative hearing currently pending before a California Department of Health Services (DHS) hearing officer involves the same parties and the same general subject matter as the complaint, but the amount at issue in that hearing is considerably less than the damage amount alleged in the complaint. The parties are currently awaiting the ruling of the DHS hearing officer in the administrative matter. The Antelope Valley matter is in the early stages, and no prediction can be made either as to its outcome or the circumstances under which Antelope Valley would serve the complaint on our California HMO.

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. Under the terms of the stock purchase agreement pursuant to which we acquired Health Care Horizons, Inc., the parent company to the New Mexico HMO, an indemnification escrow account was established and funded with $6,000 in order to indemnify our 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.

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 in order 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 HMO subsidiaries operating in California, Michigan, New Mexico, Ohio, Texas, Washington and Utah. Our Indiana HMO no longer has any membership effective January 1, 2007 as a result of contract terminations with the state. Our HMOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us as the sole stockholder. To the extent the subsidiaries must comply with these regulations, they may not have the financial flexibility to transfer funds to us. The net assets in these subsidiaries (after intercompany eliminations), which may not be transferable to us in the form of loans, advances or cash dividends was $236,800 at December 31, 2006 and $155,900 at December 31, 2005. 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, Indiana, 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, 2006, our HMOs had aggregate statutory capital and surplus of approximately $243,622, compared with the required minimum aggregate statutory capital and surplus of approximately $150,700. All of our HMOs were in compliance with the minimum capital requirements at December 31, 2006. We have the ability and commitment to provide additional capital to each of our HMOs when necessary to ensure that statutory capital and surplus continue to meet regulatory requirements.

11. Stock Plans

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

Stock options are granted with an exercise price equal to the fair value of shares at the grant date. Our vesting requirements for stock options vary from immediate vesting to up to three years vesting in equal annual installments. Restricted stock awards are granted with a fair value equal to the market price of our common stock

on the date of grant. Our vesting provisions for restricted stock awards vary from immediate vesting to up to five years vesting in equal annual installments. The stock option shares carry a maximum term of up to ten years from the grant date. Compensation expense is recorded on a straight-line basis over the vesting period.

Through December 31, 2005, we accounted for stock-based compensation under the recognition and measurement principles (the intrinsic-value method) prescribed in Accounting Principles Board (APB) Opinion No. 25, *Accounting for Stock Issued to Employees*, and related interpretations. Pro forma information regarding net income (loss) and earnings (loss) per share, as presented in Note 2, "Significant Accounting Policies," is required by SFAS No. 123, as amended by SFAS No. 148, and has been determined as if we had accounted for our employee stock options under the fair value method of that Statement upon its initial effective date. The fair value for these options was estimated at the date of grant using a minimum value option-pricing model for grants made prior to our initial public offering in July 2003 and a Black-Scholes option-pricing model for grants made subsequent to our initial public offering.

Effective January 1, 2006, we adopted SFAS 123(R) using the modified prospective method. During the year ended December 31, 2006, we issued options to purchase 347,202 shares at a market value of $10,056 on the grant date. Also during the year ended December 31, 2006, we awarded stock grants for 65,376 shares with a market value at the date of grant of $2,249. During 2006, we recognized $5,505 in compensation expense in connection with stock and stock option grants issued in 2006 and for all unvested awards granted prior to the effective date of SFAS 123(R).

During the year ended December 31, 2005, we issued options to purchase 125,600 shares at a market value of $2,695 on the grant date. Also during the year ended December 31, 2005, we awarded stock grants for 77,930 shares with a market value at the date of grant of $3,395. During 2005, we recognized $1,283 in compensation expense in connection with stock grants issued in 2005 and 2004.

During the year ended December 31, 2004, we issued options to purchase 302,200 shares at a market value of $3,960 on the grant date. Also during the year ended December 31, 2004, we awarded stock grants for 51,000 shares with a market value at the date of grant of $1,908. During 2004, we recognized $179 in compensation expense in connection with stock grants issued in 2004.

In July 2002, we adopted the 2002 Employee Stock Purchase Plan (Purchase Plan) which provides for the issuance of up to 600,000 common shares. The Purchase Plan was effective upon the effectiveness of our initial public offering of common stock in July of 2003. Beginning January 1, 2004, and each year thereafter, shares eligible for issuance automatically increase by 1% of total outstanding capital stock, but in no event shall the total number of shares of common stock reserved for issuance exceed 2.2 million shares. During each six-month offering period, eligible employees may purchase common shares at 85% of the lower of the fair value of a share of common stock on either the first or last trading day of the offering period. Each eligible employee is limited to a maximum purchase of $25 (as measured by the fair value of the stock acquired) per year through payroll deductions. Shares issued pursuant to the Purchase Plan during the years ended December 31, 2006, 2005 and 2004 were 44,412; 36,213 and 37,050, respectively.

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

	Year ended December 31,		
	2006	2005	2004
Stock options and Purchase Plan	$2,020	$ —	$ —
Stock grants	1,404	795	112
Total stock-based compensation expense	$3,424	$795	$ 112

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

The fair value of each option grant is estimated on the date of the grant using the Black-Scholes option-pricing model based on the following weighted-average assumptions:

	Year ended December 31,		
	2006	2005	2004
Risk-free interest rate	4.54%	4.11%	4.15%
Expected volatility	53.1%	53.2%	51.2%
Expected option life (in years)	6	5	5
Expected dividend yield	0%	0%	0%

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 Staff Accounting Bulletin No. 107. There were no material changes made to the methodology used to determine the assumptions during 2006.

Stock option activity for the year ended December 31, 2006 is as follows:

	Number of Options	Weighted Average Exercise Price	Weighted Average Remaining Contractual Term (Years)	Aggregate Intrinsic Value
Stock options outstanding at December 31, 2005	651,047	$ 20.99		
Granted	347,202	28.96		
Exercised	(158,869)	9.77		
Forfeited	(49,415)	36.48		
Stock options outstanding at December 31, 2006	789,965	$ 25.78	7.65	$ 6,589
Stock options exercisable at December 31, 2006	326,653	$ 18.99	6.15	$ 4,898

	Options Outstanding			Options Exercisable	
Range of Exercise Prices	Number Outstanding at December 31, 2006	Weighted Average Remaining Contractual Life (Years)	Weighted Average Exercise Price	Number Exercisable at December 31, 2006	Weighted Average Exercise Price
$2.00 – $4.50	124,922	4.37	$ 3.98	124,922	$ 3.98
$16.98 – $25.33	211,804	6.99	24.01	144,810	23.43
$27.49 – $28.66	308,764	9.08	28.62	3,333	27.49
$29.17 – $48.35	144,475	8.41	41.14	53,588	41.44
$2.00 – $48.35	789,965	7.65	$ 25.78	326,653	$ 18.99

As of December 31, 2006, the aggregate intrinsic value of our outstanding stock options was $6,589 with a weighted average remaining contractual term of 7.65 years. The weighted-average fair value of options granted for the years ended December 31, 2006, 2005 and 2004 were $16.01, $21.45 and $13.10, respectively. The total intrinsic value of stock options exercised during the years ended December 31, 2006, 2005 and 2004 amounted to $3,812, $6,182 and $11,705, respectively. The total fair value of restricted shares vested during the years ended December 31, 2006, 2005 and 2004 was $1,993, $723 and $30, respectively.

Non-vested restricted stock activity for the year ended December 31, 2006 is summarized below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2005	100,497	$ 41.71
Granted	65,376	34.33
Vested	(55,440)	37.35
Forfeited	(8,675)	44.48
Non-vested balance as of December 31, 2006	101,758	$ 39.10

As of December 31, 2006, there was $7,300 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans. That cost is expected to be recognized over a weighted-average period of two years.

12. Quarterly Results of Operations (Unaudited)

The following is a summary of the quarterly results of operations for the years ended December 31, 2006 and 2005.

	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

	For the quarter ended			
	March 31, 2005	June 30, 2005	September 30, 2005	December 31, 2005
Premium revenue	$ 392,187	$ 401,915	$ 425,943	$ 419,839
Operating income (loss) (a)	24,094	(6,773)	10,881	17,578
Income (loss) before income taxes	23,805	(7,591)	10,300	17,337
Net income (loss)	14,759	(4,706)	6,811	10,732
Net income (loss) per share:				
Basic	$ 0.53	$ (0.17)	$ 0.25	$ 0.39
Diluted	$ 0.53	$ (0.17)	$ 0.24	$ 0.38

(a) During the second quarter of 2005, we experienced a sharp and unexpected increase in claims expense. Approximately $13.4 million of the increase in claims expense was for adverse out-of-period claims development, substantially all of which related to the first quarter of 2005. The effect of this item was to reduce second quarter earnings per diluted share by $0.30.

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

13. Condensed Financial Information of Registrant

Following are the condensed balance sheets of the Registrant as of December 31, 2006 and 2005, and the statements of income and cash flows for each of the three years in the period ended December 31, 2006.

Condensed Balance Sheets

	December 31, 2006	December 31, 2005
Assets		
Current assets:		
Cash and cash equivalents	$ 17,398	$ 2,736
Investments	17,215	25,723
Deferred income taxes	39	80
Due from affiliates	9,592	15,276
Income tax receivable	—	4,973
Prepaid and other current assets	6,739	7,298
Total current assets	50,983	56,086
Property and equipment, net	30,134	21,232
Investment in subsidiaries	391,694	292,074
Deferred income taxes	1,683	—
Advances to related parties and other assets	12,350	7,463
Total assets	$486,844	$376,855
Liabilities and stockholders' equity		
Current liabilities:		
Accounts payable and accrued liabilities	$ 17,826	$ 10,196
Total current liabilities	17,826	10,196
Deferred income taxes, long-term	—	295
Long-term debt, less current maturities	45,000	—
Other long-term liabilities	3,852	3,514
Total liabilities	66,678	14,005
Stockholders' equity:		
Common stock, $0.001 par value; 80,000,000 shares authorized; issued and outstanding:—28,119,026 shares at December 31, 2006 and 27,792,360 shares at December 31, 2005	28	28
Preferred stock, $0.001 par value; 20,000,000 shares authorized, no shares issued and outstanding	—	—
Paid-in capital	173,990	162,693
Accumulated other comprehensive loss, net of tax	(337)	(629)
Retained earnings	266,875	221,148
Treasury stock (1,201,174 shares, at cost)	(20,390)	(20,390)
Total stockholders' equity	420,166	362,850
Total liabilities and stockholders' equity	$486,844	$376,855

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Condensed Statements of Operations

	Year ended December 31,		
	2006	2005	2004
Revenue:			
Management fees	$120,036	$81,694	$52,039
Other operating revenue	144	139	134
Investment income	1,361	1,436	1,753
Total revenue	121,541	83,269	53,926
Expenses:			
Medical care costs	20,764	16,455	12,063
General and administrative expenses	91,347	61,111	32,569
Depreciation and amortization	10,162	6,169	3,681
Total expenses	122,273	83,735	48,313
Operating income (loss)	(732)	(466)	5,613
Other income (expense):			
Interest expense	(2,239)	(1,426)	(1,013)
Other, net	—	—	544
Total other expense	(2,239)	(1,426)	(469)
Income (loss) before income taxes and equity in net income of subsidiaries	(2,971)	(1,892)	5,144
Income tax (benefit) expense	(610)	502	931
Net income (loss) before equity in net income of subsidiaries	(2,361)	(2,394)	4,213
Equity in net income of subsidiaries	48,088	29,990	51,560
Net income	$ 45,727	$27,596	$55,773

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Condensed Statements of Cash Flows

	Year ended December 31,		
	2006	2005	2004
Operating activities			
Cash provided by operating activities	$ 24,205	$ 6,709	$ 11,492
Investing activities			
Net dividends from and capital contributions to subsidiaries	(51,260)	1,110	(21,694)
Purchases of investments	(20,613)	(17,772)	(383,246)
Sales and maturities of investments	29,181	42,119	417,681
Cash paid in purchase transactions	—	(10,827)	(76,403)
Purchases of equipment	(17,723)	(11,960)	(9,429)
Changes in amounts due to and due from affiliates	5,684	(7,482)	272
Change in other assets and liabilities	(2,996)	(451)	2,625
Net cash used in investing activities	(57,727)	(5,263)	(70,194)
Financing activities			
Issuance of common stock	—	—	47,282
Issuance (repayment) of mortgage note	—	(1,302)	1,302
Payment of credit facility fees	(459)	(3,530)	—
Borrowings under credit facility	50,000	3,100	—
Repayments under facility	(5,000)	(3,100)	—
Tax benefit from exercise of employee stock options recorded as additional paid-in capital	1,227	—	—
Proceeds from exercise of stock options and employee stock purchases	2,416	1,872	2,500
Net cash provided by financing activities	48,184	(2,960)	51,084
Net (decrease) increase in cash and cash equivalents	14,662	(1,514)	(7,618)
Cash and cash equivalents at beginning of year	2,736	4,250	11,868
Cash and cash equivalents at end of year	$ 17,398	$ 2,736	$ 4,250
Supplemental cash flow information			
Cash (received) paid during the year for:			
Income taxes	$ (7,721)	$ 5,918	$ (1,520)
Interest	2,154	1,520	1,013
Schedule of non-cash investing and financing activities:			
Change in unrealized gain (loss) on investments	$ 60	$ (73)	$ (147)
Deferred income taxes	(40)	46	33
Net unrealized gain (loss) on investments	$ 20	$ (27)	$ (114)
Accrual of software license fees	$ 2,375	$ —	$ —
Accrual of equipment	$ 945	$ —	$ —
Value of stock issued for employee compensation earned in the previous year	$ 2,178	$ —	$ —

MOLINA HEALTHCARE, INC.

NOTES TO CONSOLIDATED FINANCIAL STATEMENTS—(Continued)

Notes to Condensed Financial Information of Registrant

Note A—Basis of Presentation

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

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

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

Note B—Transactions with Subsidiaries

The Registrant provides certain centralized medical and administrative services to its subsidiaries pursuant to administrative services agreements, including medical affairs and quality management, health education, credentialing, management, financial, legal, information systems and human resources services. Fees are based on the fair market value of services rendered and are recorded as operating revenue. Payment is subordinated to the subsidiaries' ability to comply with minimum capital and other restrictive financial requirements of the states in which they operate. Charges in 2006, 2005, and 2004 for these services totaled $120,036, $81,694 and $52,039, 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 2006, 2005, and 2004, the Registrant received dividends from its subsidiaries totaling $22,500, $29,000, and $4,850, respectively. Such amounts have been recorded as a reduction to the investments in the respective subsidiaries.

During 2006, 2005, and 2004, the Registrant made capital contributions to certain subsidiaries totaling $73,760, $27,890, and $26,544 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

During the second quarter of 2005 the Registrant made an equity investment of approximately $1,600 (included in other assets) in a medical service provider that provides certain vision services to our members. Upon the achievement by the medical service provider of certain benchmarks prior to December 31, 2006, the Registrant was obligated to invest an additional $1,900. At December 31, 2006, the provider had not attained

those benchmarks. No additional investments were made during 2006. The Registrant accounts for this investment under the equity method of accounting as it has an ownership interest in the investee in excess of 20%. At December 31, 2006, the Registrant carried this investment at $1,375 as a result of write downs to reflect its pro rata share of the provider's losses. The investment was reduced by $221 in 2006 and $4 in 2005. Medical service fees paid to this provider by subsidiaries of the Registrant totaled $7,862 and $3,440 in 2006 and 2005, respectively.

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, its 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 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 $170 for the year ended December 31, 2006.

The Registrants's California HMO subsidiary 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, our Executive Vice President, Research and Development. Amounts paid under the terms of that agreement were $357.4 and $374.6 for the years ended December 31, 2006 and 2005, respectively. We believe that the claims submitted to us by Pacific Hospital were reimbursed at prevailing market rates.

Effective June 1, 2006, the Registrant's California HMO subsidiary entered into an additional agreement with Pacific Hospital as part of a capitation arrangement. Under this arrangement, Pacific Hospital will receive a fixed fee from us based on member type. For the year ended December 31, 2006, approximately $1,652 was paid to Pacific Hospital for capitation services. We believe that this agreement with Pacific Hospital is based on prevailing market rates for similar services.

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

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

In December 2004, the Registrant issued a mortgage note in the amount of $1,302 in connection with the purchase of a medical clinic from a related party, the Molina Siblings Trust. This facility also serves as the Registrant's backup data center. Total purchase price for the facility was $1,850. In December 2005, the Registrant repaid the note in full.

Mr. Harvey Fein, the Registrant's Vice President of Internal Audit, serves on the board of directors of CADRE Funds, the professional portfolio manager of our invested cash and cash equivalents. Mr. Fein has no direct management control over the Company's funds invested by CADRE Funds.

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. 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 Securities Exchange Act of 1934 (the "Exchange Act")). Based on this evaluation, our Chief Executive Officer and our Chief Financial Officer have concluded that our disclosure controls and procedures are effective as of the end of the period covered by this report to ensure that information required to be disclosed in the reports that we file or 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, 2006 that have materially affected, or are reasonably likely to materially affect, our internal controls over financial reporting.

Management's Report on Internal Control over Financial Reporting: Our management is responsible for establishing and maintaining adequate internal control over financial reporting as defined in Rules 13a-15(f) and 15d-15(f) under 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. Our management assessed the effectiveness of our internal control over financial reporting as of December 31, 2006. 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, we believe that, as of December 31, 2006, the company's internal control over financial reporting is effective based on the COSO criteria.

Management's assessment of the effectiveness of internal control over financial reporting as of December 31, 2006 has been audited by Ernst & Young LLP; the independent registered public accounting firm who also audited the company's consolidated financial statements. Ernst & Young LLP's attestation report on management's assessment of the company's internal control over financial reporting appears on the page immediately following.

REPORT OF INDEPENDENT REGISTERED PUBLIC ACCOUNTING FIRM

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

We have audited management's assessment, included in the accompanying Management's Report on Internal Control over Financial Reporting that Molina Healthcare, Inc. (the company) maintained effective internal control over financial reporting as of December 31, 2006, based on criteria established in Internal Control—Integrated Framework issued by the Committee of Sponsoring Organizations of the Treadway Commission (the COSO criteria). The company's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting. Our responsibility is to express an opinion on management's assessment and an opinion on the effectiveness of the company's internal control over financial reporting based on our audit.

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

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

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

In our opinion, management's assessment that the company maintained effective internal control over financial reporting as of December 31, 2006, is fairly stated, in all material respects, based on the COSO criteria. Also, in our opinion, the company maintained, in all material respects, effective internal control over financial reporting as of December 31, 2006, 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, 2006 and 2005, and the related consolidated statements of income, stockholders' equity, and cash flows for each of the three years in the period ended December 31, 2006 of Molina Healthcare, Inc. and our report dated March 9, 2007 expressed an unqualified opinion thereon.

/s/ ERNST & YOUNG LLP

Los Angeles, California
March 9, 2007

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

None.

PART III

Item 10. ***Directors, Executive Officers of the Registrant and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2007 Annual Meeting of Stockholders under “Election of 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 1 of Part I of this Annual Report on Form 10-K under the caption “Executive Officers,” and will also appear in our Proxy Statement. 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 2007 Annual Meeting of Stockholders under “Information About Corporate Governance—Director Candidates”, “Information About Corporate Governance—Board and Committee Meetings” and “Information About Corporate Governance—Audit Committee.” These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2007 Annual Meeting of Stockholders under “Information About Executive Compensation.” This portion of the Proxy Statement is incorporated herein by reference. The sections entitled “Compensation Committee Report” in our 2007 Proxy Statement are 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 and our equity compensation plans will appear in our Proxy Statement for our 2007 Annual Meeting of Stockholders under “Information About Stock Ownership” and “Equity Compensation Plan Information.” These portions of the Proxy Statement are 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 2007 Annual Meeting of Stockholders under “Related Party Transactions.” This portion of our Proxy Statement is 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 2007 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 43 through 79 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, 2006 and 2005
Consolidated Statements of Operations—Years ended December 31, 2006, 2005, and 2004
Consolidated Statements of Stockholders' Equity—Years ended December 31, 2006, 2005, and 2004
Consolidated Statements of Cash Flows—Years ended December 31, 2006, 2005, and 2004
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 14th day of March, 2007.

MOLINA HEALTHCARE, INC.

By: /S/ JOSEPH M. MOLINA, M.D.
Joseph M. Molina, M.D.
Chief Executive Officer
(Principal Executive Officer)

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

Signature	Title	Date
/S/ JOSEPH M. MOLINA, M.D. **Joseph M. Molina, M.D.**	Director, Chairman of the Board, Chief Executive Officer and President (Principal Executive Officer)	March 14, 2007
/S/ JOHN C. MOLINA, J.D. **John C. Molina, J.D.**	Director, Executive Vice President, Financial Affairs, Chief Financial Officer and Treasurer (Principal Financial Officer)	March 14, 2007
/S/ JOSEPH W. WHITE, CPA, MBA **Joseph W. White, CPA, MBA**	Vice President, Accounting (Principal Accounting Officer)	March 14, 2007
/S/ JOHN P. SZABO **John P. Szabo**	Director	March 14, 2007
/S/ CHARLES Z. FEDAK, CPA, MBA **Charles Z. Fedak, CPA, MBA**	Director	March 14, 2007
/S/ SALLY K. RICHARDSON **Sally K. Richardson**	Director	March 14, 2007
/S/ RONNA ROMNEY **Ronna Romney**	Director	March 14, 2007
/S/ FRANK E. MURRAY, M.D. **Frank E. Murray, M.D.**	Director	March 14, 2007
/S/ STEVEN ORLANDO, CPA **Steven Orlando, CPA**	Director	March 14, 2007
/S/ WAYNE LOWELL, CPA, MBA **Wayne Lowell, CPA, MBA**	Director	March 14, 2007

Table of Contents

INDEX TO EXHIBITS

Number	Description	Method of Filing
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.
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 herewith.
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	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	Form of Indemnification Agreement	Filed herewith.

Number	Description	Method of Filing
10.15	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.
10.15.1	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.
10.15.2	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.
10.15.3	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.
10.16	Two Plan Model Medi-Cal contract for Riverside and San Bernardino Counties (Inland Empire) with California Department of Health Services	Filed herewith.
10.17	Medi-Cal contract for San Diego Geographic Managed Care Program with California Department of Health Services	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.18	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.
10.19	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.
10.20	Medicaid Managed Care Services Agreement between Molina Healthcare of New Mexico, Inc. and State of New Mexico Human Services Department	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 9, 2005.
10.21	Ohio Medicaid Medical Assistance Provider Agreement for CFC Eligible Population with Ohio Department of Job and Family Services	Filed herewith.
10.22	Ohio Medicaid Medical Assistance Provider Agreement for Aged, Blind & Disabled with Ohio Department of Job and Family Services	Filed herewith.
10.23	Medicaid Contract with Texas Health & Human Services Commission	Filed herewith.
10.24	Utah Medicaid Contract with Utah Department of Health	Filed as Exhibit 10.1 to registrant's Form 10-Q filed August 8, 2006.
10.25	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.

Table of Contents

Number	Description	Method of Filing
10.26	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 filed May 10, 2006.
10.27	Common form of Medicare Advantage Special Needs Plan Contract for California, Michigan, Utah, and Washington health plans.	Filed herewith.
10.28	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.
10.28.1	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.
10.28.2	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.
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.

Exhibit 10.3

MOLINA HEALTHCARE, INC.

Notice of Grant of Stock Option

_____ (the "*Grantee*") has been granted an option (the "*Option*") to purchase certain shares of Molina Healthcare, Inc. common stock, par value $0.001 per share (the "*Stock*"), pursuant to the Molina Healthcare, Inc. 2002 Equity Incentive Plan (the "*Plan*"). For purposes of this Option and the Stock Option Agreement incorporated herein by reference (the "*Option Agreement*"), the following terms shall have the following meanings:

Grant Date:

Number of Option Shares:

Exercise Price (per share):

Expiration Date:

Tax Status of Option: **Non-Qualified Stock Option**

Vested Shares: Except as provided in the Option Agreement and provided that the Grantee's Service Relationship has not terminated prior to any applicable date set forth below, the number of Vested Shares as of each date set forth below shall be:

Vesting Date	Vested Shares
Initial Vesting Date:	
Plus:	
On each of the _____ and _____ anniversary of the Grant Date thereafter until all Option Shares are Vested Shares	

The Grantee acknowledges that the Option is governed by this Notice and by the provisions of the Plan and the Option Agreement, both of which are attached to and made a part of this document. The Grantee acknowledges receipt of a copy of the Plan and the Option Agreement, represents that the Grantee has read and is familiar with their provisions and hereby accepts the Option subject to all of their terms and conditions. This Notice shall have no force or effect unless it is duly executed and delivered by the Company. The Company has caused this Agreement to be signed and delivered as of the date set forth above.

MOLINA HEALTHCARE, INC.

/s/ Mark L. Andrews
Mark L. Andrews
Chief Legal Officer, General Counsel

ATTACHMENTS: Molina Healthcare, Inc. 2002 Stock Equity Incentive Plan, as amended through the Grant Date, and Stock Option Agreement

Stock Option Agreement Under The
Molina Healthcare, Inc. 2002 Equity Incentive Plan

Pursuant to the Molina Healthcare, Inc. 2002 Equity Incentive Plan (the "*Plan*"), Molina Healthcare, Inc., a Delaware corporation (together with its successors, the "*Company*"), hereby grants to the Grantee named in the Notice of Grant of Stock Option attached hereto (the "*Notice*") an option to purchase on such dates as specified herein, all or any part of the number of shares of Stock indicated in the Notice (the "*Option Shares*," and such shares once issued shall be referred to as the "*Issued Shares*," each as adjusted pursuant to Section 5 hereof), at the Exercise Price specified in the Notice, subject to the terms and conditions set forth in this Option Agreement, the Notice and the Plan. All capitalized terms used herein and not otherwise defined shall have the respective meanings set forth in the Notice and the Plan (as applicable).

If this Option is designated as an Incentive Stock Option in the Notice, this Option is intended to qualify as an "*incentive stock option*" as defined in Section 422(b) of the Code. To the extent that any portion of this Option does not so qualify as an Incentive Stock Option or, if this Option is designated as a Non-Qualified Stock Option in the Notice, it shall be deemed a Non-Qualified Stock Option. The Grantee should consult with the Grantee's own tax advisor regarding the tax effects of this Option (and any requirements necessary to obtain favorable income tax treatment under Section 422 of the Code, including, but not limited to, the holding period requirements).

1. Vesting and Exercisability.

(a) No portion of this Option may be exercised until such portion shall have vested.

(b) Except as set forth below, this Option shall be exercisable at any time on and after the Initial Vesting Date and prior to the Expiration Date or earlier termination of the Option as provided herein and in the Plan, in an amount not to exceed the number of Vested Shares (determined at the time of exercise) less the number of shares previously acquired upon exercise of this Option. In no event shall this Option be exercisable for more than the Number of Option Shares.

(c) In the event that the Grantee's Service Relationship terminates, this Option may thereafter be exercised, to the extent it was vested and exercisable on the date of such termination, until the date specified in Section l (d) hereof. Any portion of this Option that is not vested on the date of termination of the Service Relationship shall immediately expire and be null and void.

(d) Subject to the provisions of Section 6 hereof, once any portion of this Option becomes vested and exercisable, it shall continue to be exercisable by the Grantee or his or her representatives and legatees as contemplated herein at any time or times prior to the earliest of: (i) the date which is: (A) twelve (12) months following the date on which the Grantee's Service Relationship terminates due to death or Disability, or (B) three (3) months following the date on which the Grantee's Service Relationship terminates if the termination is

due to any other reason, or (ii) the Expiration Date; provided that, if the Grantee's Service Relationship is terminated for "*Cause*" (as hereinafter defined), this Option shall terminate immediately and be null and void effective as of the date of the action or inaction by the Grantee that provided the Company "Cause" to terminate his or her employment. For purposes hereof, "*Cause*" shall mean, unless otherwise defined in Grantee's employment agreement: (i) any material breach by the Grantee of any agreement to which the Grantee and the Company (or any Subsidiary) are parties, including, but not limited to, any agreement containing covenants not to compete and covenants relating to the protection of confidential information and proprietary rights of the Company (or any Subsidiary), which breach is not cured pursuant to the terms of such agreements, (ii) any act (other than retirement) or omission to act by the Grantee which would reasonably be likely to have the effect of injuring the reputation, business or business relationships of the Company (or any Subsidiary) or on the Grantee's ability to perform services for the Company (or any Subsidiary), (iii) the Grantee's conviction (including any pleas of guilty or nolo contendre) of any crime (other than ordinary traffic violations) which impairs the Grantee's ability to perform his or her duties, (iv) any material misconduct or willful and deliberate non-performance of duties by the Grantee in connection with the business or affairs of the Company (or any Subsidiary), (v) the Grantee's theft, dishonesty, misrepresentation or falsification of the Company's (or any Subsidiary's) documents or records, (vi) the Grantee's improper use or disclosure of the Company's (or any Subsidiary's) confidential or proprietary information, or (vii) the Grantee's use of the facilities or premises of the Company (or any Subsidiary) to conduct unlawful or unauthorized activities or transactions.

(e) If designated as an Incentive Stock Option in the Notice, the Grantee understands that in order to obtain the benefits of an incentive stock option under Section 422 of the Code, subject to any amendments thereof, no sale or other disposition may be made of Issued Shares within the one (1)-year period after the day of issuance of such Issued Shares to him or her (i.e., the exercise date), nor within the two (2)-year period after the grant of this Option and further that this Option must be exercised, if and to the extent permitted hereunder, within three (3) months after termination of employment (or twelve (12) months in the case of Disability). If the Grantee disposes of any such Issued Shares (whether by sale, gift, transfer or otherwise) within either of these periods, he or she agrees to notify the Company within thirty (30) days after such disposition. The Grantee also agrees to provide the Company with any information concerning any such dispositions required by the Company for tax purposes. Further, to the extent that the aggregate Fair Market Value (determined as of the time that the applicable option is granted) of the shares of Stock with respect to which all Incentive Stock Options held by the Grantee are exercisable for the first time during any calendar year (under all option plans of the Company, its Parent and/or its Subsidiaries) exceeds one hundred thousand dollars ($100,000), such Incentive Stock Options shall constitute Non-Qualified Stock Options. For purposes of this Section 1(e), Incentive Stock Options shall be taken into account in the order in which they were granted. If pursuant to the above, an Incentive Stock Option is treated as an Incentive Stock Option in part and a Non-Qualified Stock Option in part, the Grantee may designate which portion of the Stock Option the Grantee is exercising. In the absence of such designation, the Grantee shall be deemed to have exercised the Incentive Stock Option portion of the Stock Option first.

2. Exercise of Option.

(a) The Grantee may exercise this Option only by delivering an Option exercise notice (an "*Exercise Notice*") in substantially the form of Appendix A attached hereto to the Company's General Counsel or, if none, the Chief Executive Officer, indicating his or her election to purchase some or all of the Option Shares which have vested at the time of delivery of such Exercise Notice (which amount shall be specified in the Exercise Notice), accompanied by payment in full of the aggregate Exercise Price; provided that, such exercise shall in no event be effective before receipt by such officer of the Exercise Notice and the aggregate Exercise Price. Payment of the aggregate Exercise Price for the Option Shares elected to be purchased by the Grantee may be made by one or more of the following methods:

(i) in cash, by certified or bank check, or other instrument acceptable to the Committee in U.S. funds payable to the order of the Company in an amount equal to the aggregate Exercise Price of such Option Shares;

(ii) if permitted by the Committee in its sole and absolute discretion, (y) through the delivery (or attestation to ownership) of shares of Stock with an aggregate Fair Market Value (as of the date such shares are delivered or attested to) equal to the aggregate Exercise Price and that have been purchased by the Grantee on the open market or that have been held by the Grantee for at least six (6) months and are not subject to restrictions under any plan of the Company, or (z) by the Grantee delivering to the Company a properly executed Exercise Notice together with irrevocable instructions to a broker to promptly deliver to the Company cash or a check payable and acceptable to the Company in an amount equal to the aggregate Exercise Price; provided that, in the event the Grantee chooses such payment procedure, the Grantee and the broker shall comply with such procedures and enter into such agreements of indemnity and other agreements as the Committee shall prescribe as a condition of such payment procedure; or

(iii) a combination of the payment methods set forth in clauses (i) and (ii) above.

(b) Certificates for the Option Shares so purchased will be issued and delivered to the Grantee upon compliance to the satisfaction of the Committee with all requirements under applicable laws, regulations or rules in connection with such issuance. Until the Grantee shall have complied with the requirements hereof and of the Plan, including the withholding requirements set forth in Section 7 hereof, the Company shall be under no obligation to issue the Option Shares. The determination of the Committee as to such compliance shall be final and binding on the Grantee. The Grantee shall not be deemed to be the holder of, or to have any of the rights of a holder with respect to, any Issued Shares unless and until this Option shall have been exercised pursuant to the terms hereof and the Company shall have issued and delivered such Issued Shares to the Grantee (as evidenced by an appropriate entry on the books of the Company or of a duly authorized transfer agent of the Company.) Thereupon, the Grantee shall have full dividend and other ownership rights with respect to such Issued Shares, subject to the terms of this Option Agreement and the Plan.

(c) The Company shall not be required to issue fractional shares upon the exercise of this Option.

3. Subject to Plan.

This Option is subject to all of the terms and conditions set forth in the Plan. Notwithstanding anything in this Option Agreement or the Notice to the contrary, to the extent of any conflict between the terms of the Plan, this Option Agreement and the Notice, the terms of the Plan shall control.

4. Transferability.

This Option is personal to the Grantee and is not transferable by the Grantee in any manner other than by will or by the laws of descent and distribution; provided that, if this Option is designated as a Non-Qualified Stock Option, this Option may also be transferred by the Grantee, without consideration for the transfer, to members of his or her immediate family, to trusts for the benefit of such family members, to partnerships in which such family members are the only partners or to limited liability companies in which such family members are the only members (each a "*Permitted Transferee*"); provided that, the transferee agrees in writing with the Company to be bound by all of the terms and conditions of the Plan and this Option Agreement. This Option may be exercised during the Grantee's lifetime only by the Grantee (or by the Grantee's legal representative or guardian in the event of the Grantee's incapacity) or by a Permitted Transferee pursuant to this Section 4. The Grantee may elect to designate a beneficiary by providing written notice of the name of such beneficiary to the Company and may revoke or change such designation at any time by filing written notice of revocation or change with the Company. Any such beneficiary may exercise the Grantee's Option in the event of the Grantee's death to the extent permitted herein. If the Grantee does not designate a beneficiary or if the designated beneficiary predeceases the Grantee, the executor of the Grantee may exercise this Option to the extent permitted herein in the event of the Grantee's death.

5. Adjustment Upon Changes in Capitalization.

If, as a result of any reorganization, recapitalization, reclassification, stock dividend, stock split, reverse stock split or other similar change in the Company's capital stock, the outstanding shares of Stock are increased or decreased or are exchanged for a different number or kind of shares or other securities of the Company, or additional shares or new or different shares or other securities of the Company or other non-cash assets are distributed with respect to such shares of Stock or other securities, or, if, as a result of any merger, consolidation or sale of all or substantially all of the assets of the Company, the outstanding shares of Stock are converted into or exchanged for a different number or kind of shares or other securities of the Company or any successor entity (or parent or subsidiary thereof), the Committee in its sole discretion shall make an appropriate or proportionate adjustment in the number and kind of shares or other securities subject to this Option and the Exercise Price, without changing the aggregate Exercise Price (i.e., the Exercise Price multiplied by the number of shares or other securities subject to this Option shall be the same both before and after any adjustment pursuant to this Section 5); provided that, the adjusted Exercise Price may not be less than the par value of

the Stock. After any such adjustment, all references herein to Stock or common stock shall be deemed to refer to the security that is subject to acquisition upon exercise of this Option. The adjustment by the Committee shall be final, binding and conclusive. No fractional shares of Stock shall be issued under the Plan resulting from any such adjustment, but the Committee in its discretion may either make a cash payment in lieu of fractional shares or round any resulting fractional share down to the nearest whole number.

6. Certain Transactions.

Upon the effectiveness of a Transaction (as defined in the Plan), unless provision is made in connection with the Transaction for the assumption of a Grantee's outstanding Award granted hereunder, or the substitution of such Award with a new Award of the successor entity or parent thereof, with appropriate adjustment as to the number and kind of shares and, if appropriate, the per share exercise and/or repurchase prices, as provided in Section 10(a) of the Plan (the "Assumption"), such Award shall terminate and, if such Award is a Stock Option, the Grantee shall be permitted to exercise such Stock Option to the extent that it is then vested and exercisable (after giving effect to the acceleration of vesting provided for in connection with the Transaction, if any) for a period of at least ten (10) days prior to the date of such termination; provided that, the exercise of the portion of such Stock Option that becomes vested and exercisable in connection with the Transaction, if any, shall be subject to and conditioned upon the effectiveness of the Transaction. In addition, if no Awards are assumed or substituted for in an Assumption, this Plan shall terminate upon the effectiveness of such Transaction. In the Committee's sole and absolute discretion, Award agreements may contain additional terms and conditions, not inconsistent with the foregoing, that will apply in the event a Transaction occurs.

7. Withholding Taxes.

(a) Payment by Grantee. The Grantee shall, no later than the date as of which the exercise of this Option (or, if applicable, the issuance, in whole or in part, of any Issued Shares, the operation of any law, regulation or rule providing for the imputation of interest related to this Option or the lapsing of any restriction with respect to any Issued Shares) gives rise to taxable income and subjects the Company to a tax withholding obligation, authorize the Company to withhold from payroll and any other amounts payable to the Grantee or pay to the Company or make arrangements satisfactory to the Committee for payment of any federal, state, foreign and local taxes required by law to be withheld with respect to such income.

(b) Payment in Stock. Subject to approval by the Committee, the Grantee may elect to have the minimum tax withholding obligation satisfied, in whole or in part, by: (i) authorizing the Company to withhold from shares of Stock to be issued a number of shares of Stock with an aggregate Fair Market Value (as of the date the withholding is effected) that would satisfy the withholding amount due, or (ii) transferring to the Company shares of Stock owned by the Grantee with an aggregate Fair Market Value (as of the date the withholding is effected) that would satisfy the withholding amount due. The Fair Market Value of any shares of Stock withheld or tendered to satisfy any such tax withholding obligation shall not exceed the amount determined by the applicable minimum statutory withholding rates.

8. Compliance with Legal Requirements.

The grant of this Option and the issuance of shares of Stock upon exercise of this Option shall be subject to compliance with all applicable requirements of federal, state and foreign law with respect to such securities. This Option may not be exercised if the issuance of shares of Stock upon exercise would constitute a violation of any applicable federal, state or foreign securities laws or other law or regulations or the requirements of any stock exchange or market system upon which the Stock may then be listed. In addition, this Option may not be exercised unless: (a) a registration statement under the Act shall at the time of exercise of this Option be in effect with respect to the shares issuable upon exercise, or (b) the shares issuable upon exercise of this Option may be issued in accordance with the terms of an applicable exemption from the registration requirements of the Act. The inability of the Company to obtain from any regulatory body having jurisdiction the authority, if any, deemed by the Company's legal counsel to be necessary to the lawful issuance and sale of any shares hereunder shall relieve the Company of any liability in respect of the failure to issue or sell such shares as to which such requisite authority shall not have been obtained. As a condition to the exercise of this Option, the Company may require the Grantee to satisfy any qualifications that may be necessary or appropriate, to evidence compliance with any applicable law or regulation and to make any representation or warranty with respect thereto as may be requested by the Company.

9. Lock-up Provision.

The Grantee and each Permitted Transferee agrees that, if the Company proposes to offer for sale any shares of Stock pursuant to a secondary offering and if requested by the Company and any underwriter engaged by the Company for a reasonable period of time specified by the Company or such underwriter following the effective date of the registration statement filed with respect to such offering, the Grantee will not, directly or indirectly, offer, sell, pledge, contract to sell (including any short sale), grant any option to purchase, or otherwise dispose of any securities of the Company held by him or her (except for any securities sold pursuant to such registration statement) or enter into any "*Hedging Transaction*" (as defined below) relating to any securities of the Company held by him or her (including, without limitation, pursuant to Rule 144 under the Act or any successor or similar exemptive rule hereinafter in effect). Notwithstanding the foregoing, such period of time shall not exceed ninety (90) days. For purposes of this Section 9 "*Hedging Transaction*" means any short sale (whether or not against the box) or any purchase, sale or grant of any right (including, without limitation, any put or call option) with respect to any security (other than a broad-based market basket or index) that includes, relates to or derives any significant part of its value from the Stock.

10. Personal Data.

By signing the Notice, the Grantee acknowledges and understands that in order to perform its requirements under this Option and the Plan, the Company may process personal data about the Grantee, which may or may not be sensitive personal data. Such data includes, but is not limited to, the information provided in this Option, the Notice and any other correspondence received in connection with this Option and any changes thereto, other appropriate personal and financial data about the Grantee and information about the Grantee's participation in the Plan, including the timing and extent to which this Option is exercised from time to time. Further, the Grantee hereby authorizes the Company to process any such personal data, whether or not sensitive, and to transfer any such personal data outside the country in which Grantee works or is employed, including to the United States. Grantee acknowledges that the legal persons for whom the Grantee's personal data are intended include the Company and any of its Subsidiaries, the outside plan administrator as selected by the Company from time to time and any other person or entity that the Company may find appropriate in its administration of the Plan. The Company hereby informs the Grantee of his or her right to access and correction of his or her personal data by contacting the Company's local Human Resources representative.

11. Miscellaneous Provisions.

(a) Administration. All questions of interpretation concerning this Option Agreement shall be determined by the Committee. All determinations by the Committee shall be final and binding upon all persons having an interest in this Option.

(b) Employment Rights. The grant of this Option does not confer upon the Grantee any right to continued employment or service with the Company or any Subsidiary or interfere in any way with the right of the Company or any Subsidiary to terminate the Grantee's employment or service at any time. Payments you receive pursuant to this Option Agreement shall not be considered to be part of your compensation for purposes of determining benefits under any other employee benefit plan or arrangement provided by the Company or any subsidiary or affiliate thereto.

(c) Equitable Relief. The parties hereto agree and declare that legal remedies may be inadequate to enforce the provisions of this Option Agreement and that equitable relief, including specific performance and injunctive relief, may be used to enforce the provisions of this Option Agreement.

(d) Change and Modifications. The Committee may terminate or amend the Plan or this Option at any time; provided, that, except as provided in Section 3(c) of the Plan in connection with a Transaction, no such termination or amendment may adversely affect this Option without the consent of the Grantee unless such termination or amendment is necessary to comply with any applicable law, rule or regulation or, to the extent that this Option is designated as an Incentive Stock Option, is required to enable this Option to continue to qualify as an Incentive Stock Option.

(e) Governing Law. This Option Agreement shall be governed by and construed in accordance with the laws of the State of California without regard to conflict of laws principles thereof.

(f) Headings. The headings used herein are intended only for convenience in finding the subject matter and do not constitute part of the text of this Option Agreement and shall not be considered in the interpretation of this Option Agreement.

(g) Integrated Agreement. This Option Agreement, the Notice and the Plan constitute the entire understanding and agreement between the Grantee and the Company with respect to the subject matter contained herein and supersedes any prior agreements, understandings, restrictions, representations or warranties among the Grantee and the Company with respect to such subject matter except as provided for herein. To the extent contemplated herein, the provisions of this Option Agreement shall survive any exercise of this Option and shall remain in full force and effect.

(h) Saving Clause. If any provision of this Option Agreement shall be determined to be illegal or unenforceable, such determination shall in no manner affect the legality or enforceability of any other provision hereof.

(i) Notices. All notices, requests, consents and other communications shall be in writing and be deemed given when delivered personally, by telex or facsimile transmission, or two (2) days after deposit in the mail if mailed by first class registered or certified mail, postage prepaid, or one (1) business day after deposit with a nationally recognized overnight carrier. Notices to the Company or the Grantee shall be addressed to such address or addresses as may have been furnished by such party in writing to the other.

(j) Benefit and Binding Effect. This Option Agreement shall be binding upon and shall inure to the benefit of the parties hereto, their respective successors, permitted assigns, and legal representatives. The Company has the right to assign this Option Agreement and such assignee shall become entitled to all the rights of the Company hereunder to the extent of such assignment.

Appendix A
STOCK OPTION EXERCISE NOTICE

Molina Healthcare, Inc.
2277 Fair Oaks Boulevard, Suite 440
Sacramento, California 95825
Attention: Executive Vice President/General Counsel

Date:_____

Pursuant to the terms of the Notice of Grant of Stock Option dated _____, ____ and the Stock Option Agreement granted pursuant to the Molina Healthcare, Inc. 2002 Equity Incentive Plan and entered into by Molina Healthcare, Inc. and _____ on such date, I hereby *[Circle One]* partially/fully exercise such Option by including herein payment in the amount of $_____ representing the purchase price for _____ shares of common stock, all of which have vested in accordance with the Notice of Grant of Stock Option. I hereby authorize payroll withholding or otherwise will make adequate provision for federal, state, foreign and local tax withholding obligations of the Company, if any, that arise in connection with the Option.

I acknowledge that the shares are being acquired in accordance with and subject to the terms, provisions and conditions of the Plan, the Notice of Grant of Stock Option and the Option Agreement, copies of which I have received and carefully read and understand, including the Company's right of first refusal set forth therein, to all of which I hereby expressly assent.

I hereby represent that I am purchasing the shares of common stock for my own account and not with a view to any sale or distribution thereof. I acknowledge that any sale of shares that might be made in reliance on Rule 144 may only be made in limited amounts in accordance with the terms and conditions of such rule and that a copy of Rule 144 will be delivered to me upon my request. Finally, I agree that, if the Option is designated as an "*incentive stock option*" in the Notice of Grant of Stock Option, that I will promptly notify the Chief Financial Officer of the Company if I transfer any of the shares acquired pursuant to the option within one (1) year from the date of exercise of all or part of the Option or within two (2) years of the date of grant of the Option.

Sincerely yours,

_____
Name:

Address: _____
_____

Exhibit 10.14

INDEMNIFICATION AGREEMENT

THIS AGREEMENT is made and entered into effective as of the __th day of _____, 200_ by and between MOLINA HEALTHCARE, INC., a Delaware corporation (the "Corporation"), and _____, a director of the Corporation (the "Indemnitee").

RECITALS:

WHEREAS, Section 145 ("Section 145") of the Delaware General Corporation Law ("DGCL") empowers the Corporation to indemnify its directors, officers, employees and agents if certain enumerated conditions are met;

WHEREAS, the Corporation's Certificate of Incorporation ("Certificate of Incorporation") and Bylaws ("Bylaws") require the Corporation to indemnify its directors and officers to the fullest extent permitted by the DGCL;

WHEREAS, Section 145, the Certificate of Incorporation and the Bylaws each permit contracts between the Corporation and its directors, officers, employees and other agents with respect to indemnification of such persons;

WHEREAS, the Board of Directors has determined that contractual indemnification, as set forth herein, is reasonable and prudent and promotes the best interests of the Corporation and its stockholders; and

WHEREAS, to induce Indemnitee to serve or continue to serve as an officer and/or director of the Corporation, the Corporation has agreed to enter into this Agreement with Indemnitee.

NOW, THEREFORE, for good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties incorporate the above recitals in their agreement and further agree as follows:

1. **DEFINITIONS.**

For purposes of this Agreement, the following definitions shall apply:

(a) The term "Action, Suit or Proceeding" shall be broadly construed and shall include, without limitation, the investigation, preparation, prosecution, defense, settlement, mediation, arbitration and appeal of, and the giving of

testimony in, as a party, witness or otherwise, any actual, threatened, potential, pending or completed action, suit or proceeding, of any kind or description, whether civil, criminal, legislative, regulatory, administrative or investigative, in any locale, whether in this country or otherwise, including any claim or defense therein, and any other matter or thing relating thereto, or potentially relating thereto, including investigation, discovery and other proceedings of any kind or description undertaken before or after the commencement of any such Action, Suit or Proceeding.

(b) The term "Affiliate" shall be broadly construed to mean any natural or other person that directly, or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with the person specified.

(c) The term "Corporation" shall include Molina Healthcare, Inc., a Delaware corporation ("Molina Delaware") and, without limitation, and in addition to Molina Delaware, any constituent corporation (including any constituent of a constituent) absorbed by Molina Delaware in a consolidation or merger which, if its separate existence had continued, would have had power and authority to indemnify its directors, officers, and employees or agents, so that any person who is or was a director, officer, employee or agent of such constituent corporation, or is or was serving at the request of such constituent corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust, employee benefit plan or other Enterprise, shall stand in the same position under the provisions of this Agreement with respect to Molina Delaware as he or she would have stood with respect to such constituent corporation if its separate existence had continued.

(d) The term "Expenses" shall be broadly construed and shall include, without limitation, all direct and indirect costs of any type or nature whatsoever, actually and reasonably incurred by Indemnitee in connection with any Action, Suit or Proceeding including without limitation fees and costs of any type or nature incurred by Indemnitee in connection with (i) the investigation, defense or appeal of any Action, Suit or Proceeding; (ii) the assertion in any Action, Suit or Proceeding of claims, affirmative defenses, counter-claims, cross-claims and third-party claims; and (iii) the filing of an Action, Suit or Proceeding seeking to establish or enforce Indemnitee's right to indemnification under this Agreement or otherwise. Without limiting the generality of the foregoing, the term "Expenses" shall include counsel fees and disbursements and costs routinely charged by

counsel; the fees and costs of consulting and testifying expert witnesses; the cost of purchasing appeal bonds; all other like or unlike out-of-pocket costs reasonably incurred in connection with any such Action, Suit or Proceeding; and reasonable compensation for time spent by Indemnitee for which Indemnitee is not otherwise compensated by the Corporation or any third-party, provided that the rate of compensation and estimated time involved is approved by the Board, which approval shall not be unreasonably withheld.

(e) The term "Independent Legal Counsel" shall mean and refer to a law firm selected as follows: If Indemnitee and the Corporation are unable to agree in writing on the selection of the Independent Legal Counsel, such counsel shall be selected by lot from among the ten (10) law firms which, according to publicly available sources, have the most lawyers practicing in offices located in Los Angeles County, California and in New York County, New York (excluding firms that, in any of their offices, have acted as counsel for the Corporation, or Indemnitee or any other party to the Action, Suit or Proceeding or any Affiliate of any such person). The Corporation shall contact such counsel in order of their selection by lot, requesting each such firm to accept engagement to make the determination required hereunder until one of such firms accepts such engagement. The fees and costs of Independent Legal Counsel shall be paid by the Corporation.

(f) The term "Judgments, Fines and Amounts Paid in Settlement" shall be broadly construed and shall include, without limitation, all direct and indirect payments of any type or nature whatsoever in any Action, Suit or Proceeding, whether based on Indemnitee's affirmative acts or omissions to act, and shall include, without limitation, all penalties and amounts required to be forfeited or reimbursed to the Corporation as well as any penalties or excise taxes assessed on a person with respect to an employee benefit plan.

(g) The term "other Enterprises" shall include, without limitation, employee benefit plans.

(h) The term "serving at the request of the Corporation" shall be broadly construed to include, without limitation, any service as a director, officer, employee or agent of the Corporation which imposes duties on, or involves the rendering of services by, such director, officer, employee, or agent with respect to another Enterprise, including, without limitation, employee benefit plans.

2. **INDEMNITY.**

(a) To the fullest extent not prohibited by Delaware law, the Corporation shall indemnify and hold harmless the Indemnitee who was or is a witness or party, or is threatened to be made a witness or party, to any threatened, pending or completed Action, Suit or Proceeding (other than an action by or in the right of the Corporation) by reason of the fact that the Indemnitee is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other Enterprise, against Expenses and against Judgments, Fines and Amounts Paid in Settlement actually and reasonably incurred by the Indemnitee in connection with such Action, Suit or Proceeding if Indemnitee acted in good faith and in a manner Indemnitee reasonably believed to be in or not opposed to the best interests of the Corporation, and, with respect to any criminal action or proceeding, had no reasonable cause to believe Indemnitee's conduct was unlawful. The termination of any Action, Suit or Proceeding by judgment, order, settlement, conviction, or upon a plea of *nolo contendere* or its equivalent, shall not, of itself, create a presumption that the person did not act in good faith and in a manner which Indemnitee reasonably believed to be in or not opposed to the best interests of the Corporation, and, with respect to any criminal action or proceeding, had reasonable cause to believe that Indemnitee's conduct was unlawful.

(b) To the fullest extent not prohibited by Delaware law, the Corporation shall indemnify and hold harmless the Indemnitee who was or is a witness or party or is threatened to be made a witness or a party to any threatened, pending or completed action or suit by or in the right of the Corporation to procure a judgment in its favor by reason of the fact that the Indemnitee is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other Enterprise against Expenses actually and reasonably incurred by the Indemnitee in connection with the investigation, defense or settlement of such action or suit if the Indemnitee acted in good faith and in a manner the Indemnitee reasonably believed to be in or not opposed to the best interests of the Corporation and except that no indemnification shall be made in respect of any claim, issue or matter as to which such person shall have been adjudged to be liable to the Corporation unless and only to the extent that the Court of Chancery or, at Indemnitee's option, the court in which such action or suit was

brought shall determine upon application that, despite the adjudication of liability but in view of all the circumstances of the case, such person is fairly and reasonably entitled to indemnity for such Expenses which the Court of Chancery or, at Indemnitee's option, such other court shall deem proper.

3. **SUCCESSFUL DEFENSE.**

(a) To the extent that Indemnitee has been successful on the merits or otherwise in defense of any Action, Suit or Proceeding referred to in subsections (a) and (b) of Section 2 hereof, or in defense of any claim, issue or matter therein, such person (a "Successful Indemnitee") shall be indemnified against Expenses actually and reasonably incurred by such person in connection therewith.

(b) Without limiting the generality of sub-part (a) of this Section 3, for the purposes of this Agreement, Indemnitee shall be deemed to have been a Successful Indemnitee if any Action, Suit or Proceeding, or any claim, issue or matter therein, is disposed of, on the merits or otherwise (including a disposition without prejudice), in a manner whereby Indemnitee avoids or escapes from an adverse judgment or other detriment, for whatever reason, including without limitation, any such disposition in which no Amounts Paid in Settlement were paid by Indemnitee even if Amounts Paid in Settlement are or were paid by others to induce a third-party to dismiss Indemnitee from any Action, Suit or Proceeding.

4. **PROCEDURE FOR ENGAGING COUNSEL.**

(a) Within three (3) days after actual receipt of process in an Action, Suit or Proceeding hereunder, Indemnitee shall give written notice thereof to the Corporation (the "Section 4(a) Notice"); *provided, however,* Indemnitee's failure to timely submit a Section 4(a) Notice, or to request indemnification with respect to any Action, Suit or Proceeding, shall not relieve the Corporation of any liability it may have to Indemnitee except if and to the extent the Corporation establishes by clear and convincing evidence that it suffered actual prejudice in the defense of any such Action, Suit or Proceeding by reason thereof.

(b) After receipt of a Section 4(a) Notice, the Corporation, at its election, may assume the defense of the Action, Suit or Proceeding with counsel reasonably acceptable to Indemnitee by delivering written notice to Indemnitee of its election to do so (the "Assumption Notice"); *provided, however,* the Assumption Notice, if sent, (i) shall set forth with reasonable particularity the prior relationship, if any, between such counsel and the Corporation and its Affiliates, and (ii) shall be delivered to Indemnitee within a reasonable time before the expiration of the time period allotted by law to Indemnitee to move, answer or otherwise plead in response to the process identified in the Section 4(a) Notice.

(c) If Indemnitee accepts and approves counsel identified in the Assumption Notice, the Corporation shall not be liable to Indemnitee under this Agreement for fees or expenses of counsel subsequently incurred by Indemnitee in regard to the Action, Suit or Proceeding.

(d) Anything herein or elsewhere to the contrary notwithstanding,

(i) Indemnitee shall have the right to employ counsel of its choice in any such Action, Suit or Proceeding at Indemnitee's sole cost and expense;

(ii) Indemnitee shall have the right to employ counsel of its choice and control the defense of an Action, Suit or Proceeding if: (a) Indemnitee is authorized in writing by the Corporation to do so, or (b) either Indemnitee or counsel selected by the Corporation shall reasonably conclude that there is or may be a material conflict of interest or position on any significant issue in the Action, Suit or Proceeding, or (c) the Corporation does not employ counsel for Indemnitee in such Action, Suit or Proceeding, or (d) the Action, Suit or Proceeding is brought by or in the right of the Corporation to procure a judgment in its favor by reason of the fact that the Indemnitee is or was a director, officer, employee or agent of the Corporation, or is or was serving at the request of the Corporation as a director, officer, employee or agent of another corporation, partnership, joint venture, trust or other Enterprise;

(iii) without limiting Indemnitee's rights under sub-part (ii) above, if counsel identified by the Corporation in the Assumption Notice or otherwise selected by the Corporation, after being accepted and approved by Indemnitee, subsequently, at any time and for any reason, is no longer acceptable to Indemnitee, Indemnitee shall be entitled to replace such counsel and to select

counsel of its choice ("Substitute Counsel"); *provided*, *however,* (1) the added Expense, if any, attributable to Indemnitee's engagement of Substitute Counsel ("Added Expense") shall not be presumed to have been reasonable pursuant to Section 6(c) and (h) hereof, and (2) Indemnitee has the continuing right to replace Substitute Counsel but the Added Expense of doing so shall be borne by Indemnitee.

5. **ADVANCEMENT OF EXPENSES**.

(a) Expenses incurred by or on behalf of Indemnitee in investigating, defending or settling a threatened or pending Action, Suit or Proceeding shall be advanced by the Corporation within twenty (20) days after receipt by the Corporation of (i) a statement or statements in writing from Indemnitee requesting such advance (the "Section 5(a) Request"), and (ii) a written undertaking by or on behalf of Indemnitee to repay such advance if and to the extent it ultimately shall be determined hereunder that Indemnitee is not entitled to be indemnified by the Corporation. Such undertaking shall be accepted without reference to the financial ability of Indemnitee to make such repayment and such advances shall be unsecured and interest-free. Subject to sub-part (b) of this Section 5, the Section 5(a) Request shall state with reasonable particularity the nature of the Expenses to be advanced by the Corporation and shall be accompanied by reasonable supporting documentation.

(b) Any dispute of any kind or description as to advancement of Expenses hereunder, including without limitation disputes as to the reasonableness of the Expense item, or the adequacy of Indemnitee's description of the Expense(s) covered by the Section 5(a) Request, or the adequacy of the documentation provided by Indemnitee in support of the Section 5(a) Request, shall not delay the advancement of Expenses by the Corporation hereunder nor shall it extend the twenty (20) day time period in which Expenses shall be advanced.

(c) If, when, and to the extent it is determined in an "Enforcement Action," as that term is defined in Section 6(g) hereof, that (i) Indemnitee was not permitted to be indemnified hereunder, or (ii) an Expense advance was not reasonable, in whole or in part, the Corporation shall be reimbursed by Indemnitee for any such Expense advance; *provided*, *however*, no such reimbursement shall be made and the Corporation shall continue to advance Expenses hereunder, until a final judicial determination is made in the Enforcement Action as to which all rights of appeal therefrom have been exhausted or lapsed, which judicial determination then, and only then, shall be conclusive and binding on the parties.

6. **DETERMINING WHETHER INDEMNIFICATION IS PROPER.**

(a) If Indemnitee, at any time, seeks indemnification hereunder but does not assert that it is a Successful Indemnitee under Section 3 hereof, (i) indemnification, nevertheless, shall be made to Indemnitee, and (ii) Expenses shall be advanced and the prior advance(s) of Expenses confirmed, unless a determination ("Section 6(a) Determination") is made by the Corporation, on and subject to the terms of sub-part (b) hereof, that indemnification is not proper in the circumstances because Indemnitee did not meet the applicable standard of conduct set forth in Sections 2(a) and (b) hereof. A Section 6(a) Determination sustaining Indemnitee's claim for indemnification and advancement of Expenses shall be final and binding on the Corporation.

(b) The Section 6(a) Determination shall be made, at the option of Indemnitee, (1) by a majority vote of the directors who are not parties to such Action, Suit or Proceeding, even though less than a quorum, or (2) by a committee of such directors designated by majority vote of such directors, even though less than a quorum, or (3) if there are no such directors, or if such directors so direct, by Independent Legal Counsel in a written opinion. The Corporation and Indemnitee, by mutual agreement, may elect to have the Section 6(a) Determination made by the stockholders by a majority vote of a quorum of the outstanding shares of stock of all classes entitled to vote on the matter, voting as a single class, which quorum shall consist of stockholders who are not at that time parties to the Action, Suit or Proceeding in question.

(c) The body or person, natural or otherwise, selected by Indemnitee to make the Section 6(a) Determination shall presume that Indemnitee is entitled to indemnification under this Agreement and to the advancement of Expenses upon submission of a request for indemnification pursuant to this Section 6. Such presumption shall form the basis for a determination that Indemnitee is entitled to indemnification and advancement of Expenses unless the Corporation adduces clear and convincing evidence overcoming that presumption.

(d) To secure a Section 6(a) Determination, or to resolve any dispute as to whether Indemnitee is a Successful Indemnitee under Section 3 hereof, Indemnitee shall submit written notice to the Corporation (the "Indemnity Notice"), including

therein such documentation and information as reasonably is available to Indemnitee to enable the Corporation to determine, pursuant to Section 6(b) hereof, whether and, if so, to what extent Indemnitee is entitled to indemnification and advancement of Expenses. Promptly after the Indemnity Notice is submitted, the Corporation shall give notice thereof to the Board of Directors.

(e) Within ten (10) business days of the giving of the Indemnity Notice, the Corporation shall give written notice to Indemnitee of any reasonable request it may have for additional documentation or information it may seek to obtain from Indemnitee and, within ten (10) business days thereafter, Indemnitee shall provide such information or documents as are reasonably available to it.

(f) Within forty-five (45) days after an Indemnity Notice is submitted to it (the "Forty-Five Day Period"), the Corporation shall determine whether to grant Indemnitee's request for indemnification, utilizing the procedure specified by Indemnitee pursuant to sub-part (b) of this Section 6.

(g) If, within the Forty-Five Day Period, the Corporation fails or refuses to provide indemnification or advance Expenses to the full extent sought by Indemnitee, as requested, Indemnitee's rights under this Agreement shall be enforceable in court pursuant to Section 6(k) hereof. In any such action against the Corporation ("Enforcement Action"), it shall be a *prima facie* affirmative defense to claims asserted by Indemnitee (a "Section 145 Defense") that Indemnitee (i) did not meet the standard of conduct set forth in Section 2 (a) or (b) hereof, or (ii) was not a Successful Indemnitee under Section 3 hereof, if Indemnitee's assertion that it was a Successful Indemnitee is disputed by the Corporation.

(h) In any Enforcement Action, (i) the Corporation shall have the burden of pleading with particularity the alleged factual basis for each Section 145 Defense or any other defense asserted by it (each such defense must include, among other things, a detailed statement of the time and place of any statement, act or omission by Indemnitee or others which allegedly supports such defense); (ii) the Corporation shall have the burden of proving each such Section 145 Defense or any other defense by clear and convincing evidence; and (iii) the Indemnitee shall be presumed to be entitled to indemnification hereunder. Such presumption shall be used as a basis for granting judgment to Indemnitee, on motion or otherwise, unless the Corporation overcomes such presumption by clear and convincing evidence.

(i) Anything herein or elsewhere to the contrary notwithstanding, not less than ten (10) days before the Corporation asserts a Section 145 Defense, the parties shall meet and confer in an effort to informally resolve their differences relating to any such defense.

(j) Neither of the following shall constitute or support a Section 145 Defense, nor shall they create a presumption that Indemnitee is not entitled to indemnity hereunder: (i) the failure of the Corporation (including its Board of Directors or one of its committees, its Independent Legal Counsel, and its stockholders) to make a determination that indemnification is proper in the circumstances; or (ii) an actual determination by the Corporation (including its Board of Directors or one of its committees, its Independent Legal Counsel, and its stockholders) that indemnification is not proper in the circumstances.

(k) The Court of Chancery is hereby vested with exclusive original jurisdiction to hear and determine any and all Enforcement Actions as well as any action brought by the Corporation relating, in whole or in part, to the advancement of Expenses or the payment of indemnification under this Agreement or under the Certificate of Incorporation or any Bylaw, agreement, vote of stockholders or disinterested directors, or otherwise. Pursuant to this exclusive grant of original jurisdiction, the Court of Chancery may summarily determine the Corporation's obligation to advance Expenses (including attorneys' fees); *provided*, *however*, at the Indemnitee's sole option, an Enforcement Action or any other Action, Suit or Proceeding brought by Indemnitee arising out of or based on this Agreement may be brought by Indemnitee in any court of competent jurisdiction in the County of Los Angeles, State of California.

(l) Anything herein or elsewhere to the contrary notwithstanding, the Expenses incurred by Indemnitee in regard to any Enforcement Action or other Action, Suit or Proceeding concerning the interpretation or enforcement of Indemnitee's rights hereunder, or to obtain indemnification or advances of Expenses, shall be indemnified by the Corporation unless a court having original jurisdiction, as provided in Section 6(k), determines that each of the material assertions made by Indemnitee in any such Enforcement Action or other Action, Suit or Proceeding was not made in good faith or was frivolous.

7. **INSURANCE AND SUBROGATION**.

(a) The Corporation covenants and agrees that, as long as Indemnitee shall be entitled to indemnity under the terms of this Agreement, including Section 11(g) hereof, the Corporation, subject only to sub-part (b) of this Section 7, shall obtain and maintain in full force and effect directors' and officers' liability insurance ("D&O Insurance") in reasonable amounts from established and reputable insurers covering Indemnitee against any liability asserted against or incurred by Indemnitee or on Indemnitee's behalf in any indemnified capacity whether or not the Corporation would have the power to indemnify Indemnitee against such liability under this Agreement. In all such D&O Insurance policies, Indemnitee shall be named as an insured in a manner that grants Indemnitee the same rights and benefits as are granted to the most favorably insured of the Corporation's officers or directors.

(b) Notwithstanding sub-part (a) of this Section 7, if the Corporation gives reasonable prior written notice to Indemnitee of the termination of D&O Insurance coverage, the Corporation shall be relieved of its duty to obtain and maintain D&O Insurance in future periods, if the Corporation in good faith determines that such insurance is not reasonably available in such future periods, or the premium costs for such insurance are disproportionate to the amount of coverage available, or the available coverage is so limited by exclusions that it provides an insufficient benefit, or Indemnitee is covered by similar insurance maintained by a subsidiary of the Corporation.

(c) If the Corporation has D&O Insurance in effect at the time it receives a Section 6(a) Notice, the Corporation shall give due and prompt notice of the commencement of such Action, Suit or Proceeding to the insurer(s) in accordance with the procedures set forth in the applicable policy. The Corporation shall thereafter take all necessary or desirable action to cause each insurer to pay, on behalf of the Indemnitee, all amounts payable as a result of such Action, Suit or Proceeding in accordance with the terms of the applicable policy.

(d) In the event of payments by the Corporation under this Agreement, the Corporation shall be subrogated to the extent of such payment to all of the rights of recovery of Indemnitee with respect to any such D&O Insurance policy. The Indemnitee shall execute all papers reasonably required and take all action reasonably necessary to secure such subrogation rights, including execution of

such documents as are necessary to enable the Corporation to bring suit to enforce such rights in accordance with the terms of any such insurance policy. The Corporation shall pay or reimburse all expenses actually and reasonably incurred by Indemnitee in connection with such subrogation.

(e) Anything herein or elsewhere to the contrary notwithstanding, the Corporation shall not be liable to make any indemnity payment if and to the extent that Indemnitee has otherwise actually received such payment under any insurance policy, contract, agreement.

8. **LIMITATION ON INDEMNIFICATION.**

(a) Anything herein or elsewhere to the contrary notwithstanding, the Corporation shall not be obligated to provide indemnification as follows:

(i) To indemnify Indemnitee or advance Expenses to Indemnitee with respect to an Action, Suit or Proceeding filed by Indemnitee, unless (a) such Action, Suit or Proceeding was authorized or consented to by the Board of Directors of the Corporation, or (b) Indemnitee was successful in establishing Indemnitee's rights regarding the interpretation or enforcement of this Agreement in such Action, Suit or Proceeding, in whole or in part, or (c) the court in such Action, Suit or Proceeding shall determine that, despite Indemnitee's failure to establish their right to indemnification, Indemnitee is entitled to indemnity for such expenses; *provided, however*, that nothing in this Section 8(a)(i) limits Indemnitee's rights under Section 6(l) hereof with respect to an Enforcement Action or other Action, Suit or Proceeding filed by Indemnitee to enforce or interpret this Agreement.

(ii) To indemnify Indemnitee on account of any proceeding with respect to which final judgment is rendered against Indemnitee for payment or an accounting of profits arising from the purchase or sale by Indemnitee of securities in violation of Section 16(b) of the Securities Exchange Act of 1934, as amended.

9. **SETTLEMENT.**

(a) The Corporation shall have no obligation to indemnify Indemnitee under this Agreement for amounts paid in settlement of any Action, Suit or Proceeding effected without the Corporation's prior written consent, which shall not be unreasonably withheld.

(b) The Corporation shall not, in any manner, settle or compromise any Action, Suit or Proceeding of any kind or description that would impose any fine, payment or other obligation on Indemnitee without Indemnitee's prior written consent, which shall not be unreasonably withheld.

10. **CONTRIBUTION.**

In order to provide for just and equitable contribution in circumstances in which the indemnification provided for herein is held by a court of competent jurisdiction, as provided in Section 6(k) hereof, to be unavailable to Indemnitee in whole or in part, it is agreed that, in such event, the Corporation shall, to the fullest extent permitted by Delaware law, contribute to the payment of Indemnitee's Expenses and Judgments, Fines and Amounts Paid in Settlement with respect to any Action, Suit or Proceeding in an amount that is just and equitable in the circumstances, taking into account, among other things, contributions by other directors and officers of the Corporation or others pursuant to indemnification agreements or otherwise; provided, that, without limiting the generality of the foregoing, such contribution shall not be required where such holding by the court is due to (i) the failure of Indemnitee to meet the standard of conduct set forth in Section 145, or (ii) any limitation on indemnification set forth in Section 8 hereof.

11. **GENERAL PROVISIONS**.

(a) **Savings Clause.** If any provision or provisions of this Agreement shall be invalidated on any ground by a court of competent jurisdiction, as provided in Section 6(k) hereof, then the Corporation shall nevertheless indemnify Indemnitee as to all Expenses and all Judgments, Fines and Amounts Paid in Settlement with respect to any Action, Suit or Proceeding, including an action by or in the right of the Corporation, to the full extent permitted by any applicable portion of this Agreement that shall not have been invalidated and to the full extent permitted by Delaware law.

(b) **Limitation of Actions.** No Action, Suit, or Proceeding may be brought by or in the right of the Corporation or its assignees or Affiliates against Indemnitee or Indemnitee's spouse, heirs, executors, or personal or legal representatives, nor may any claim or cause of action be asserted in any such Action, Suit, or Proceeding, after the expiration of two years after the applicable statute of limitations commences to run with respect to Indemnitee's act or omission that allegedly gave rise to the Action, Suit, Proceeding or claim or cause of action; *provided*, *however*, that, if any shorter period of limitations is otherwise applicable to any such Action, Suit, Proceeding or claim or cause of action, the shorter period shall govern.

(c) **Form and Delivery of Notices, etc.** Any notice, request or other communication required or permitted to be given to the parties under this Agreement shall be in writing and shall be effective when, but only when, delivered in person or sent by telecopy or overnight delivery to the parties at the following addresses (or at such other addresses for a party as shall be specified by like notice):

If to the Corporation:

Corporate Secretary
Molina Healthcare, Inc.
2277 Fair Oaks Blvd., Suite 440
Sacramento, CA 95825
FACSIMILE 916-646-4572

With a copy to:

Chief Executive Officer
Molina Healthcare, Inc.
One Golden Shore Drive
Long Beach, CA 90802
FACSIMILE: 562-495-7770

If to Indemnitee:

_____

_____

_____

FACSIMILE: - -

(d) **Service of Process.** Notwithstanding any agreement or provision of law to the contrary, initial process in any Action, Suit or Proceeding to enforce this Agreement may be served by giving notice thereof in the manner specified in sub-part (c) of this Section 11.

(e) **Venue.** The Corporation, having consented, on and subject to the terms of Section 6(k) hereof, to the exclusive original jurisdiction of the Delaware Chancery Court, agrees not to (i) raise any defense that such court is an inconvenient forum or any similar defense or claim, or (ii) remove any Enforcement Action or any other Action, Suit or Proceeding to construe or apply this Agreement from the Delaware Chancery Court to a federal court.

(f) **Subsequent Legislation.** If the DGCL is amended after execution and delivery of this Agreement to expand the scope of indemnification permitted to directors or officers, then the Corporation shall indemnify Indemnitee to the fullest extent permitted by the DGCL, as so amended.

(g) **Nonexclusivity.** The indemnification provisions and provisions for advancement of Expenses set forth in this Agreement are not, and shall not be deemed to be, exclusive of any other rights which Indemnitee may have under any provision of law, the Corporation's Certificate of Incorporation or Bylaws, in any court in which a proceeding is brought, or the vote of the Corporation's stockholders or disinterested directors, or other agreements or otherwise; *provided*, *however,* no amendment or alteration of the Corporation's Certificate of Incorporation or Bylaws or any other agreement shall adversely affect the rights of Indemnitee under this Agreement.

(h) **Continuing and Future Rights.** All covenants, agreements, undertakings and obligations of the Corporation contained herein or referred to herein shall continue in effect during the period in which Indemnitee is a director,

officer, employee or other agent of the Corporation or is or was serving at the request of the Corporation as a director, officer, employee or other agent of another corporation, partnership, joint venture, trust, employee benefit plan or other Enterprise and shall continue thereafter so long as Indemnitee shall be subject to any claim or potential, or threatened, or pending or completed Action, Suit or Proceeding by reason of the fact that Indemnitee was serving in any of the indemnified capacities referred to herein.

(i) **Representations and Warranties of the Corporation.** The Corporation hereby represents and warrants to Indemnitee as follows:

(1) **Authority.** The Corporation has all necessary corporate power and authority to enter into, and be bound by the terms of, this Agreement, and the execution, delivery and performance of the undertakings contemplated by this Agreement have been duly and validly authorized by the Corporation by all necessary corporate action;

(2) **Enforceability.** This Agreement, when executed and delivered by the Corporation, shall be a legal, valid and binding obligation of the Corporation, enforceable against the Corporation in accordance with its terms, except as such enforceability may be limited by applicable bankruptcy, insolvency, moratorium, reorganization or similar laws affecting the enforcement of creditors' rights generally or general equitable principles, and to the extent limited by applicable federal or state securities laws.

(3) **Estoppel.** To the fullest extent permitted by law, the Corporation shall be precluded and estopped from asserting in any judicial or other proceeding that the provisions, procedures and presumptions of this Agreement are not valid, binding and enforceable in accordance with their terms, which constitute a final and binding stipulation under which the Corporation is and shall be irrevocably bound in any court of competent jurisdiction or other tribunal in which proceedings relating to this Agreement shall be commenced, continued or appealed on and subject to the terms of Section 6(k) hereof.

(j) **Equitable Relief.** The duties and obligations of the Corporation hereunder are unique and special, and the failure of the Corporation to comply with the provisions of this Agreement will cause irreparable and irremediable injury to Indemnitee, for which a remedy at law will be inadequate. As a result, in addition

to any other right or remedy hereunder which Indemnitee may have at law or in equity with respect to breach of this Agreement, Indemnitee shall be entitled to injunctive or mandatory relief directing specific performance by the Corporation of its obligations under this Agreement.

(k) **Interpretation of Agreement.** This Agreement shall be interpreted and enforced so as to provide indemnification to Indemnitee to the fullest extent now or hereafter permitted by Delaware law.

(l) **Governing Law.** This Agreement shall be governed by the laws of the State of Delaware without regard to its conflict of law rules.

(m) **Other Laws.** If, despite sub-part (l) of this Section 11, a court of competent jurisdiction, as determined by Section 6(k) hereof, shall make a final determination that the provisions of the law of any jurisdiction other than the State of Delaware govern indemnification by the Corporation of its officers and directors, then the indemnification provided under this Agreement shall in all instances be enforceable to the fullest extent permitted under such law, notwithstanding any provision of this Agreement to the contrary.

(n) **Entire Agreement.** This Agreement constitutes the entire agreement between the parties hereto with respect to the matters covered hereby, and any other prior or contemporaneous oral or written understandings or agreements with respect to the matters covered hereby are expressly superceded by this Agreement.

(o) **Modification and Waiver.** No supplement, modification or amendment of this Agreement shall be binding unless executed in writing by both of the parties hereto. No waiver of any of the provisions of this Agreement shall be deemed or shall constitute a waiver of any other provision hereof (whether or not similar) nor shall such waiver constitute a continuing waiver.

(p) **Successor and Assigns.** All of the terms and provisions of this Agreement shall be binding upon, shall inure to the benefit of and shall be enforceable by the parties hereto and their respective successors, assigns, heirs, executors, administrators and legal representatives. The Corporation shall require and cause any direct or indirect successor (whether by purchase, merger, consolidation or otherwise) of the Corporation, by written agreement in form and substance reasonably satisfactory to Indemnitee, expressly to assume and agree to perform this Agreement in the same manner and to the same extent that the Corporation would be required to perform as if no such succession had taken place.

(q) **Employment Rights**. Nothing in this Agreement is intended to create in Indemnitee any right to employment or continued employment.

(r) **Counterparts.** This Agreement may be executed in two or more counterparts, each of which shall be deemed to be an original and all of which together shall be deemed to be one and the same instrument, notwithstanding that both parties are not signatories to the original or same counterpart.

(s) **Headings.** The section and subsection headings contained in this Agreement are for reference purposes only and shall not affect in any way the meaning or interpretation of this Agreement.

[signature page follows]

IN WITNESS WHEREOF, the parties have executed this Agreement effective as of the date first written above.

INDEMNITEE

_____

_____

MOLINA HEALTHCARE, INC.

By: _____

Title: _____

Exhibit 10.16

STATE OF CALIFORNIA
STANDARD AGREEMENT
STD 213 (DHS Rev 7/06)

REGISTRATION NUMBER	AGREEMENT NUMBER
42601106149146	06-55498

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

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

California Department of Health Services

CONTRACTOR'S NAME (Also referred to as Contractor)

Molina Healthcare of California

2 The term of this Agreement is: August 1, 2006 through March 31, 2009

3 The maximum amount of this Agreement is: $453,626,000
Four Hundred Fifty-Three Million, Six Hundred Twenty-Six Thousand Dollars

4 The parties agree to comply with the terms and conditions of the following exhibits, which are by this reference made a part of this Agreement.

Exhibit A – Scope of Work	2 pages
Exhibit A, Attachments 1 through 18 (See Exhibit A, Table of Contents)	Various pages
Exhibit B – Budget Detail and Payment Provisions	13 pages
Exhibit B, Attachment 1 – Capitation Rate Worksheet	18 pages
Exhibit C * – General Terms and Conditions	GTC 306
Exhibit D (F) – Special Terms and Conditions (Attached hereto as part of this agreement)	26 pages
Notwithstanding provisions 2, 3, 4, 5, 6, 7, 10, 11, 12, 14, 15, 16, 22, 25, 28, 29, & 30 which do not apply to this agreement	
Exhibit E – Additional Provisions	2 pages
Exhibit E, Attachment 1 - Definitions	16 pages
Exhibit E, Attachment 2 – Program Terms and Conditions	27 pages
Exhibit E, Attachment 3 – Duties of the State	7 pages
Exhibit E, Attachment 4 – Innovative Activities List	12 pages
Exhibit F – Contractor's Release	1 page
Exhibit G – Health Insurance Portability and Accountability Act (HIPAA)	6 pages

See Exhibit E, Provision 1 for additional incorporated exhibits

Items shown above with an Asterisk (*), are hereby incorporated by reference and made part of this agreement as if attached hereto
These documents can be viewed at *http://www.ols.dgs.ca.gov/Standard+Language*

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

CONTRACTOR

California Department of General Services Use Only

CONTRACTOR'S NAME *(if other than an individual state whether a corporation partnership etc)*

Molina Healthcare of California
BY *(Authorized Signature)* DATE SIGNED *(Do not type)*
10/24/06

/s/ Stephen T. O'Dell
PRINTED NAME AND TITLE OF PERSON SIGNING
Stephen T. O'Dell, President

Address

One Golden Shore
Long Beach, CA 90802

STATE OF CALIFORNIA

AGENCY NAME

California Department of Health Services
BY *(Authorized Signature)* DATE SIGNED *(Do not type)*
11-2-06

/s/ Jayna Qucrin
Jayna Qucrin,
Chief CMU Policy & Procedures
PRINTED NAME AND TITLE OF PERSON SIGNING

☒ Exempt per: W&I Code 14087.4

Allan Chinn, Chief, Contracts and Purchasing Services Section

ADDRESS

1501 Capitol Avenue, Suite 71 2101, MS 1403, P.O. Box 997413
Sacramento, CA 95899-7413

Exhibit A
Scope of Work

Table of Contents

Exhibit A
Scope of Work

1. Service Overview

Contractor agrees to provide to the California Department of Health Services (CDHS) the services described herein.

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

2. Service Location

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

3. Service Hours

The services shall be provided on a 24-hour, seven (7) days a week basis.

4. Project Representatives

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

California Department of Health Services	**Contractor**
Medi-Cal Managed Care Division	Stephen T. O'Dell, President
Attention: Chief, Plan Management Branch	Telephone: (562) 491-7019
Telephone: (916) 449-5100	Fax: (562) 499-6170
Fax: (916) 449-5090	E-mail: steve.o'dell@molinahealthcare.com

B. Direct all inquiries to:

California Department of Health Services	**Contractor**
Medi-Cal Managed Care Division	Stephen T. O'Dell, President
Attention: Contracting Officer	One Golden Shore
1501 Capitol Avenue, Suite 71.4001	Long Beach, CA 90802
MS 4407, P.O. Box Number 997413	Telephone: (562) 491-7019
Sacramento, CA 95899-7413	Fax: (562) 499-6170
Telephone: (916) 449-5000	E-mail: steve.o'dell@molinahealthcare.com
Fax: (916) 449-5005	

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

ORGANIZATION AND ADMINISTRATION OF THE PLAN

1. Legal Capacity

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

2. Key Personnel (Disclosure Form)

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

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

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

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

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

3. Conflict Of Interest – Current And Former State Employees

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

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

4. Contract Performance

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

A. The organization has an accountable governing body.

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

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

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

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

5. Medical Decisions

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

6. Medical Director

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

A. Ensuring that medical decisions are:

1) Rendered by qualified medical personnel.

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

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

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

D. Developing and implementing medical policy.

E. Resolving grievances related to medical quality of care.

F. Direct involvement in the implementation of Quality Improvement activities

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

7. Medical Director Changes

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

8. Administrative Duties/Responsibilities

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

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

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

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

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

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

9. Member Representation

Contractor shall ensure that Medi-Cal Members are represented and participate in establishing public policy within the plan's public policy advisory committee.

FINANCIAL INFORMATION

1. Financial Viability/Standards Compliance

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

A. Tangible Net Equity (TNE).

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

B. Administrative Costs.

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

C. Standards of Organization and Financial Soundness.

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

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

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

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

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

2. Financial Audit Reports

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

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

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

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

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

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

a) Jurat.

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

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

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

e) Report 4: Enrollment and Utilization Table.

f) Schedule F: Unpaid Claims Analysis.

g) Appropriate footnote disclosures in accordance with GAAP.

h) Schedule H: Aging Of All Claims.

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

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

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

3. Monthly Financial Statements

If Contractor and/or subcontractor is required to file monthly Financial Statements with the DMHC, Contractor and/or subcontractor shall file monthly Financial Statements with CDHS.

4. Compliance with Audit Requirements

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

5. Submittal of Financial Information

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

Contractor shall prepare and submit a stand-alone Medi-Cal line of business income statement for each financial reporting period required. This income statement shall be prepared in the DMHC required financial reporting format.

6. Fiscal Viability of Subcontracting Entities

Contractor shall maintain a system to evaluate and monitor the financial viability of all risk bearing sub-contracting provider groups including, but not limited to, HMOs, independent physician/provider associations (IPAs), medical groups, and Federally Qualified Health Centers.

MANAGEMENT INFORMATION SYSTEM

1. Management Information System Capability

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

1) All Medi-Cal eligibility data,

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

3) Provider claims status and payment data,

4) Health care services delivery encounter data,

5) Provider network information, and

6) Financial information as specified in Exhibit A, Attachment 1, provision 8. Administrative Duties/Responsibilities.

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

2. Encounter Data Submittal

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

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

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

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

3. MIS/Data Correspondence

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

4. Health Insurance Portability and Accountability Act (HIPAA)

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

QUALITY IMPROVEMENT SYSTEM

1. General Requirement

Contractor shall implement an effective Quality Improvement System (QIS) in accordance with the standards in Title 28, CCR, Section 1300.70. Contractor shall monitor, evaluate, and take effective action to address any needed improvements in the quality of care delivered by all providers rendering services on its behalf, in any setting. Contractor shall be accountable for the quality of all Covered Services regardless of the number of contracting and subcontracting layers between Contractor and the provider. This provision does not create a cause of action against the Contractor on behalf of a Medi-Cal beneficiary for malpractice committed by a subcontractor.

2. Accountability

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

3. Governing Body

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

A. Approves the overall QIS and the annual report of the QIS.

B. Appoints an accountable entity or entities within Contractor's organization to provide oversight of the QIS.

C. Routinely receives written progress reports from the quality improvement committee describing actions taken, progress in meeting QIS objectives, and improvements made.

D. Directs the operational QIS to be modified on an ongoing basis, and tracks all review findings for follow-up.

4. Quality Improvement Committee

Contractor shall implement and maintain a Quality Improvement Committee designated by, and accountable to the governing body and shall be facilitated by

the medical director or a physician designee. Contractor must ensure that subcontractors, who are representative of the composition of the contracted provider network, shall actively participate on the committee.

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

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

5. Provider Participation

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

6. Delegation of Quality Improvement Activities

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

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

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

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

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

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

1) Evaluates subcontractor’s ability to perform the delegated activities including an initial review to assure that the subcontractor has the administrative capacity, task experience, and budgetary resources to fulfill its responsibilities.

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

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

7. Written Description

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

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

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

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

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

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

F. The processes and procedures designed to ensure that all Medically Necessary Covered Services are available and accessible to all Members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender marital status, sexual orientation, health status, or disability, and that all Covered Services are provided in a culturally and linguistically appropriate manner.

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

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

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

8. Quality Improvement Annual Report

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

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

B. Copies of all final reports of non-governmental accrediting agencies (e.g. JCAHO, NCQA) relevant to the Contractor's Medi-Cal line of business, including accreditation status and any deficiencies noted. Include the corrective action plan developed to address noted deficiencies.

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

9. External Quality Review Requirements

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

A. External Accountability Set (EAS) Performance Measures

The External Accountability Set (EAS) consists of a set of Health Plan Employer Data and Information Set (HEDIS®) measures developed by the

National Committee for Quality Assurance (NCQA) and CDHS developed performance measures selected by CDHS for evaluation of health plan performance.

1) On an annual basis, Contractor shall submit to an on-site EAS Compliance Audit (also referred to as the Health Plan Employer Data and Information Set (HEDIS®) Compliance Audit™) to assess the Contractor's information and reporting systems, as well as the Contractor's methodologies for calculating performance measure rates. Contractor shall use the CDHS-selected contractor for performance of the EAS/HEDIS Compliance Audit and calculation of CDHS-developed performance measures that constitute the EAS. Compliance Audits will be performed by an EQRO as contracted and paid for by the State.

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

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

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

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

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

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

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

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

B. Under/Over-Utilization Monitoring

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

C. Quality Improvement Projects (QIPs)

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

1) Among the four QIPs:

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

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

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

Contractors may include only one county in a collaborative regardless of whether the health plan's contract covers multiple counties. However, if multiple counties are to be

included, Contractor shall demonstrate that the measurement strategies are adequate to assess the impact of the intervention within each county. CDHS must approve the Contractor's proposal before the Contractor proceeds with their intended approach for multiple county measurement.

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

2) Among the above listed four QIPs:

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

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

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

D. Consumer Satisfaction Survey

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

10. Site Review

A. General Requirement

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

B. Pre-Operational Site Reviews

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

C. Credentialing Site Review

A site review is required as part of the credentialing process when both the facility and the provider are added to the Contractor's provider network. If a provider is added to Contractor's provider network, and the provider site has a current passing site review survey score, a site survey need not be repeated for provider credentialing or recredentialing.

D. Corrective Actions

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

E. Data Submission

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

F. Continuing Oversight

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

11. Disease Surveillance

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

12. Credentialing and Recredentialing

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

A. Standards

All providers of Covered Services must be qualified in accordance with current applicable legal, professional, and technical standards and appropriately licensed, certified or registered. All providers must have good standing in the Medicare and Medicaid/Medi-Cal programs. Providers that have been terminated from either Medicare or Medicaid/Medi-Cal cannot participate in Contractor's provider network.

B. Delegated Credentialing

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

C. Credentialing Provider Organization Certification

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

D. Disciplinary Actions

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

E. Medi-Cal and Medicare Provider Status

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

F. Health Plan Accreditation

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

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

G. Credentialing of Other Non-Physician Medical Practitioners

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

13. Medical Records

A. General Requirement

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

B. Medical Records

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

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

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

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

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

C. On-Site Medical Records

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

D. Member Medical Record

Contractor shall ensure that a complete medical record is maintained for each Member in accordance with Title 22, CCR, Section 53861, that reflects all aspects of patient care, including ancillary services, and at a minimum includes:

1) Member identification on each page; personal/biographical data in the record.

2) Member's preferred language (if other than English) prominently noted in the record, as well as the request or refusal of language/interpretation services.

3) All entries dated and author identified; for member visits, the entries shall include at a minimum, the subjective complaints, the objective findings, and the plan for diagnosis and treatment.

4) The record shall contain a problem list, a complete record of immunizations and health maintenance or preventive services rendered.

5) Allergies and adverse reactions are prominently noted in the record.

6) All informed consent documentation, including the human sterilization consent procedures required by Title 22, CCR, Sections 51305.1 through 51305.6, if applicable.

7) Reports of emergency care provided (directly by the contracted provider or through an emergency room) and the hospital discharge summaries for all hospital admissions.

8) Consultations, referrals, specialists', pathology, and laboratory reports. Any abnormal results shall have an explicit notation in the record.

9) For medical records of adults, documentation of whether the individual has been informed and has executed an advanced directive such as a Durable Power of Attorney for Health Care.

10) Health education behavioral assessment and referrals to health education services.

UTILIZATION MANAGEMENT

1. Utilization Management Program

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

A. Qualified staff responsible for the UM program.

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

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

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

E. Contractor shall communicate to health care practitioners the procedures and services that require prior authorization and ensure that all contracting health care practitioners are aware of the procedures and timeframes necessary to obtain prior authorization for these services.

F. An established specialty referral system to track and monitor referrals requiring prior authorization through the Contractor. The system shall include authorized, denied, deferred, or modified referrals, and the timeliness of the referrals. This specialty referral system should include non-contracting providers.

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

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

These activities shall be done in accordance with Health and Safety Code Section 1363.5 and Title 28, CCR, Section 1300.70(b)(2)(H) & (c).

2. Pre-Authorizations and Review Procedures

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

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

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

C. Reasons for decisions are clearly documented.

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

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

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

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

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

3. Timeframes for Medical Authorization

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

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

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

D. Concurrent Review of authorization for treatment regimen already in place: Within five (5) working days or less, consistent with urgency of the Member's medical condition and in accordance with Health & Safety Code Section 1367.01, or any future amendments thereto.

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

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

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

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

I. Hospice inpatient care: 24-hour response.

4. Review of Utilization Data

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

5. Delegating UM Activities

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

PROVIDER NETWORK

1. Network Capacity

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

2. Network Composition

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

3. Provider to Member Ratios

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

1)	Primary Care Physicians	1:2,000
2)	Total Physicians	1:1,200

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

4. Physician Supervisor to Non-Physician Medical Practitioner Ratios

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

A.	Nurse Practitioners	1:4
B.	Physician Assistants	1:2

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

5. Emergency Services

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

6. Specialists

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

7. Federally Qualified Health Center (FQHC) Services

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

8. Time and Distance Standard

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

9. Plan Physician Availability

Contractor shall have a plan or contracting Physician available 24 hours per day, seven (7) days per week to coordinate the transfer of care of a Member whose emergency condition is stabilized, to authorize Medically Necessary post-stabilization services, and for general communication with emergency room personnel.

10. Provider Network Report

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

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

1) Geographic access for the Members;

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

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

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

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

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

B. Contractor shall submit the report 30 calendar days following the end of the reporting quarter.

11. Plan Subcontractors

Contractor shall submit to CDHS, a quarterly report containing the names of all direct subcontracting provider groups including health maintenance organizations, independent physician associations, medical groups, and FQHCs and their subcontracting health maintenance organizations, independent physician associations, medical groups, and FQHCs. The report must be sorted by subcontractor type, indicating the county or counties in which Members are served. In addition, the report should also indicate where relationships or affiliations exist between direct and indirect subcontractors. The report shall be submitted within 30 calendar days following the end of the reporting quarter.

12. Ethnic and Cultural Composition

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

13. Subcontracts

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

A. Laws and Regulations

All Subcontracts shall be in writing and in accordance with the requirements of the Knox-Keene Health Care Services Plan Act of 1975, Health and Safety Code Section 1340 et seq.; Title 28, CCR, Section 1300 et seq.; W&I Code Section 14200 et seq.; Title 22, CCR, Section 53800 et seq.; and applicable federal and State laws and regulations.

B. Subcontract Requirements

Each Subcontract as defined in Exhibit E, Attachment 1, item 100. A. shall contain:

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

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

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

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

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

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

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

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

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

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

d) For a term of at least five years from the close of the current fiscal year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

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

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

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

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

b) Retain such books and records for a term of at least five years from the close of the current fiscal year for the last year in which the sub-subcontract is in effect and in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created.

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

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

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

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

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

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

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

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

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

19) If Contractor delegates Quality Improvement activities, Subcontract shall include those provisions stipulated in Exhibit A, Attachment 4, provision 6. Delegation of Quality Improvement Activities.

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

C. Departmental Approval—Non-Federally Qualified HMOs

Except as provided in Exhibit A, Attachment 8, Provider Compensation Arrangements, provision 7 regarding Federally Qualified Health Centers and Rural Health Clinics, a provider or management Subcontract entered into by Contractor which is not a federally qualified HMO shall become

effective upon approval by CDHS in writing, or by operation of law where CDHS has acknowledged receipt of the proposed Subcontract, and has failed to approve or disapprove the proposed Subcontract within 60 calendar days of receipt. Within five (5) Working days of receipt, CDHS shall acknowledge in writing the receipt of any material sent to CDHS by Contractor for approval.

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

D. Departmental Approval—Federally Qualified HMOs

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

1) Exempt from prior approval by CDHS.

2) Submitted to CDHS upon request.

E. Public Records

Subcontracts entered into by the Contractor and all information received in accordance with this subsection will be public records on file with CDHS, except as specifically exempted in statute. CDHS shall ensure the confidentiality of information and contractual provisions filed with CDHS which are specifically exempted by statute from disclosure, in accordance with the statutes providing the exemption. The names of the officers and owners of the subcontractor, stockholders owning more than ten (10) percent of the stock issued by the subcontractor and major creditors holding more than five (5) percent of the debt of the subcontractor will be attached to the Subcontract at the time the Subcontract is presented to CDHS.

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

Subcontracts with FQHCs shall also meet Subcontract requirements of provision 13 above and reimbursement requirements in Exhibit A, Attachment 8, provision

7. In Subcontracts with FQHCs and RHCs where a negotiated reimbursement rate is agreed to as total payment, a provision that such rate constitutes total payment shall be included in the Subcontract.

15. Traditional and Safety-Net Providers Participation

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

16. Nondiscrimination In Provider Contracts

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

PROVIDER RELATIONS

1. Exclusivity

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

2. Provider Grievances

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

3. Non-Contracting, Non-Emergency Provider Communication

Contractor shall develop and maintain protocols for payment of claims, and communicating and interacting with non-contracting, non-emergency providers.

4. Provider Manual

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

5. Provider Training

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

6. Submittal of Inpatient Days Information

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

7. Emergency Department Protocols

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

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

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

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

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

8. Prohibited Punitive Action Against the Provider

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

PROVIDER COMPENSATION ARRANGEMENTS

1. Compensation

Contractor may compensate providers as Contractor and provider negotiate and agree. Compensation cannot be determined by a percentage of the Contractor's payment from CDHS. This provision will not be construed to prohibit Subcontracts in which compensation or other consideration is determined to be on a capitation basis.

2. Capitation Payments

Capitation payments by a Contractor to a Primary Care Provider or clinic contracting with the Contractor on a capitation basis shall be payable effective the date of the Member's enrollment where the Member's assignment to or selection of a Primary Care Provider or clinic has been confirmed by the Contractor. However, capitation payments by a Contractor to a Primary Care Provider or clinic for a Member whose assignment to or selection of a Primary Care Provider or clinic was not confirmed by the Contractor on the date of the beneficiary's enrollment, but is later confirmed by the Contractor, shall be payable no later than 30 calendar days after the Member's enrollment.

3. Physician Incentive Plan Requirements

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

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

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

4. Identification of Responsible Payor

Contractor shall provide the information that identifies the payor responsible for reimbursement of services provided to a Member enrolled in Contractor's Medi-Cal Managed Care health plan to CDHS' Fiscal Intermediary (FI) contractor. Contractor shall identify the subcontractor (if applicable) or Independent Physician Association (IPA) responsible for payment, and the Primary Care Provider name and telephone number responsible for providing care. Contractor shall provide this information in a manner prescribed by CDHS once CDHS and the FI contractor have implemented the enhancement to the California Automated Eligibility Verification and Claims Management System (CA-AEV/CMS).

5. Claims Processing

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

A. Contractor shall comply with Section 1932(f), Title XIX, Social Security Act (42 U.S.C. Section 1396u-2(f), and Health and Safety Code Sections 1371 through 1371.36. Contractor shall be subject to any remedies, including interest payments provided for in these sections, if it fails to meet the standards specified in these sections.

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

C. Contractor shall maintain sufficient claims processing/tracking/payment systems capability to: comply with applicable State and federal law, regulations and Contract requirements, determine the status of received claims, and calculate the estimate for incurred and unreported claims, as specified by Title 28, CCR, Sections 1300.77.1 and 1300.77.2.

D. Contractor shall submit claims payment summary reports to CDHS on a quarterly basis as specified in Exhibit A, Attachment 2, provision 2, paragraph B. subparagraph 2).

6. Prohibited Claims

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

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

A. FQHCs Availability and Reimbursement Requirement

If FQHC services are not available in the provider network of either the Local Initiative Health Plan in the county or Contractor, Contractor shall reimburse non-contracting FQHCs for services provided to Contractor’s

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

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

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

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

C. Indian Health Service Facilities

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

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

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

9. Non-Contracting Family Planning Providers' Reimbursement

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

10. Sexually Transmitted Disease (STD)

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

11. HIV Testing and Counseling

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

12. Immunizations

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

13. Non-Contracting Emergency Service Providers

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

A. Contractor shall pay for Emergency Services received by a Member from non-contracting providers. Payments to non-contracting providers shall be for the treatment of the Emergency Medical Condition including Medically Necessary services rendered to a Member until the Member's condition has stabilized sufficiently to permit discharge, or referral and transfer in accordance with instructions from Contractor. Emergency Services shall not be subject to Prior Authorization by Contractor.

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

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

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

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

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

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

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

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

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

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

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

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

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

ACCESS AND AVAILABILITY

1. General Requirement

Contractor shall ensure that each Member has a Primary Care Provider who is available and physically present at the service site for sufficient time to ensure access for the assigned Member when medically required. This requirement does not preclude an appropriately licensed professional from being a substitute for the Primary Care Provider in the event of vacation, illness, or other unforeseen circumstances.

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

2. Existing Patient-Physician Relationships

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

3. Access Requirements

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

A. Appointments

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

B. First Prenatal Visit

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

C. Waiting Times

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

D. Telephone Procedures

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

E. Urgent Care

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

F. After Hours Calls

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

G. Unusual Specialty Services

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

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

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

5. Standing Referrals

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

6. Emergency Care

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

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

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

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

7. Nurse Midwife and Nurse Practitioner Services

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

8. Access to Services with Special Arrangements

A. Family Planning

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

1) Informed Consent

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

2) Out-Of-Network Family Planning Services

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

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

b) Limited history and physical examination.

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

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

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

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

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

h) Tubal ligation.

i) Vasectomies.

j) Pregnancy testing and counseling.

B. Sexually Transmitted Diseases (STDs)

Contractor shall provide access to STD services without Prior Authorization to all Members both within and outside its provider network. Members may access out-of-plan STD services through local health

department (LHD) clinics, family planning clinics, or through other community STD service providers. Members may access LHD clinics and family planning clinics for diagnosis and treatment of a STD episode. For community providers other than LHD and family planning providers, out-of-plan services are limited to one office visit per disease episode for the purposes of: (1) diagnosis and treatment of vaginal discharge and urethral discharge, (2) those STDs that are amenable to immediate diagnosis and treatment, and this includes syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, Trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale and (3) evaluation and treatment of pelvic inflammatory disease. Contractor shall provide follow-up care.

C. HIV Testing and Counseling

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

D. Minor Consent Services

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

1) Sexual assault, including rape.

2) Drug or alcohol abuse for children 12 years of age or older.

3) Pregnancy.

4) Family planning.

5) Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

6) Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either 1) there is a danger of serious physical or mental harm to the minor or others, or 2) the children are the alleged victims of incest or child abuse.

E. Immunizations

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

9. Changes in Availability or Location of Covered Services

Contractor shall provide notification to CDHS 60 calendar days prior to making any substantial change in the availability or location of services to be provided under this Contract. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to CDHS as soon as possible.

10. Access for Disabled Members

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

11. Civil Rights Act of 1964

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

12. Cultural and Linguistic Program

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

A. Written Description

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

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

2) Goals and objectives.

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

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

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

B. Linguistic Capability of Employees

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

C. Group Needs Assessment

Contractor shall conduct a group needs assessments, as specified below, to identify the health education and cultural and linguistic needs of its' Members; and utilize the findings for continuous development and improvement of contractually required health education and cultural linguistic programs and services. Contractor must use multiple reliable data sources, methodologies, techniques, and tools to conduct the group needs assessment.

1) Contractor shall conduct an initial group needs assessment (GNA) within 12 months from the commencement of operations within a Service Area and at least every five (5) years from the commencement of operations thereafter. For Contracts existing at

the time this provision becomes effective, the next GNA will be required at a time within the five (5) year period from the effective date of this provision, to be determined by CDHS.

2) Contractor shall submit a GNA Summary Report to the CDHS within six (6) months of the completion of each GNA. The summary report must include:

   a) The objectives; methodology; data sources; survey instruments; findings and conclusions; program and policy implications; and, references contained in the GNA.

   b) The findings and conclusions must include the following information for Medi-Cal plan Members: 1) demographic profile; 2) related health risks, problems and conditions; 3) related knowledge, attitudes and practices including cultural beliefs and practices; 4) perceived health education needs including learning needs, preferred methods of learning and literacy level; 5) culturally competent community resources.

3) Contractor shall annually update the GNA summary report, including a current update on the information required in item 2) b) above. Contractor shall maintain, and have available for CDHS review, the GNA summary report updates.

4) Contractor shall demonstrate that GNA and summary report findings and conclusions in item 2) b) above are utilized for continuous development of its health education and cultural and linguistic services program. Contractor must maintain documentation of program priorities, target populations, and program goals/objectives as they are revised to meet the identified and changing needs of the Member population.

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

E. Cultural Competency Training

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

F. Program Implementation and Evaluation

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

13. Linguistic Services

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

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

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

2) Fully translated written informing materials, including but not limited to the Member Services Guide, enrollee information, welcome packets, marketing information, and form letters including notice of action letters and grievance acknowledgement and resolution letters. Contractor shall provide translated written informing materials to all monolingual or LEP Members that speak the identified threshold or concentration standard languages. The threshold or concentration languages are identified by CDHS within the Contractor's Service Area, and by the Contractor in its group needs assessment.

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

4) Telecommunications Device for the Deaf (TDD).

C. Contractor shall provide translated materials to the following population groups within its Service Area as determined by CDHS:

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

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

D. Key points of contact include:

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

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

14. Community Advisory Committee

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

SCOPE OF SERVICES

1. Covered Services

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

Except as set forth in Attachment 3.1.B.1 (effective 1/1/2006) of the California Medicaid State Plan or as otherwise authorized by Welfare & Institutions Code Section 14133.23, effective January 1, 2006, drug benefits for full-benefit dual eligible beneficiaries who are eligible for drug benefits under Part D of Title XVIII of the Social Security Act (42 USC Section 1395w-101 et seq) are not a Covered Service under this Contract. Consequently, effective January 1, 2006, the capitation rates shall not include reimbursement for such drug benefits and existing capitation rates shall be adjusted accordingly, even if the adjustment results in a change of less than one percent of cost to Contractor. Additionally, Contractor shall comply with all applicable provisions of the Medicare Prescription Drug Improvement and Modernization Act of 2003, 42 USC 1395(x) et seq.

2. Medically Necessary Services

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

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

3. Initial Health Assessment (IHA)

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

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

B. Contractor shall ensure that the IHA includes a health education behavioral assessment as described in Exhibit A, Attachment 10, provision 7, paragraph A, item 10) using an age appropriate CDHS approved assessment tool. Contractor is responsible for assuring that arrangements are made for follow-up services that reflect the findings or risk factors discovered during the IHA and health education behavioral assessment.

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

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

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

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

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

A. Provision of IHAs for Members under Age 21

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

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

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

B. Children's Preventive Services

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

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

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

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

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

C. Immunizations

Contractor shall ensure that all children receive necessary immunizations at the time of any health care visit. Contractor shall cover and ensure the timely provision of vaccines in accordance with the most recent childhood immunization schedule and recommendations published by the Advisory Committee on Immunization Practices (ACIP). Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the immunization shall be considered sufficient in meeting this requirement.

If immunizations cannot be given at the time of the visit, the Member must be instructed as to how to obtain necessary immunizations or a scheduled and documented appointment must be made.

Appropriate documentation shall be entered in the Member's Medical Record that, indicates all attempts to provide immunization(s); instructions as to how to obtain necessary immunizations; the receipt of vaccines or proof of prior immunizations; or proof of voluntary refusal of vaccines in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

Upon federal Food and Drug Administration (FDA) approval of any vaccine for childhood immunization purposes, Contractor shall develop policies and procedures for the provision and administration of the vaccine. Such policies and procedures shall be developed within thirty (30) calendar days of the vaccine's approval date. Contractor shall cover and ensure the provision of the vaccine from the date of its approval regardless of whether or not the vaccine has been incorporated into the Vaccines for Children (VFC) Program. Policies and procedures must be in accordance with any Medi-Cal Fee-For-Service guidelines issued prior to final ACIP recommendations.

Contractor shall provide information to all network providers regarding the VFC Program.

D. Blood Lead Screens

Contractor shall cover and ensure the provision of a blood lead screening test to Members at ages one (1) and two (2) in accordance with Title 17, Division 1, Chapter 9, Articles 1 and 2, commencing with Section 37000. Contractor shall document and appropriately follow up on blood lead screening test results.

Contractor shall make reasonable attempts to ensure the blood lead screen test is provided and shall document attempts to provide test. If the blood lead screen test is refused by the Member, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the blood lead screen test shall be considered evidence in meeting this requirement.

E. Screening for Chlamydia

Contractor shall screen all females less than 21 years of age, who have been determined to be sexually active, for chlamydia. Follow up of positive results must be documented in the medical record.

Contractor shall make reasonable attempts to contact the appropriately identified Members and provide screening for chlamydia. All attempts shall be documented. Documented attempts that demonstrate Contractor's unsuccessful efforts to contact a Member and screen for chlamydia shall be considered evidence in meeting this requirement.

If the Member refuses the screening, proof of voluntary refusal of the test in the form of a signed statement by the Member (if an emancipated minor) or the Parent(s) or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record.

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

For Members under the age of 21 years, Contractor shall provide or arrange and pay for EPSDT supplemental services, including case management and supplemental nursing services, as defined in Title 22, CCR, Section 51184, except when EPSDT supplemental services are

provide as CCS services pursuant to Exhibit A, Attachment 11, provision 8, regarding CCS Services, or as mental health services pursuant to provision 7 below, regarding Mental Health Services. Contractor shall determine the Medical Necessity of EPSDT supplemental services using the criteria established in Title 22, CCR, Sections 51340 and 51340.1.

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

5. Services for Adults

A. IHAs for Adults (Age 21 and older)

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

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

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

B. Adult Preventive Services

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

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

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

C. Immunizations

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

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

Contractor shall document attempts to provide immunizations. If the Member refuses the immunization, proof of voluntary refusal of the immunization in the form of a signed statement by the Member or guardian of the Member shall be documented in the Member's Medical Record. If the responsible party refuses to sign this statement, the refusal shall be noted in the Member's Medical Record. Documented attempts that demonstrate Contractor's unsuccessful efforts to provide the immunization shall be considered evidence in meeting this requirement.

6. Pregnant Women

A. Prenatal Care

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

B. Risk Assessment

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

C. Referral to Specialists

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

7. Services for All Members

A. Health Education

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

2) Contractor shall ensure administrative oversight of the health education system by a qualified full-time health educator. This individual shall possess a master’s degree in public or community health with specialization in health education.

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

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

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

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

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

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

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

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

8) Contractor shall maintain health education policies and procedures, and standards and guidelines; conduct appropriate levels of program evaluation; and, monitor performance of providers that are contracted to deliver health education services to ensure effectiveness.

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

10) Contractor shall ensure that all new Members complete the individual health education behavioral assessment within 120 calendar days of enrollment as part of the initial health assessment; and that all existing Members complete the individual health education behavioral assessment at their next non-acute care visit. Contractor shall ensure: 1) that primary care providers use the CDHS standardized "Staying Healthy" assessment tools, or alternative approved tools that comply with CDHS approval criteria for the individual health education behavioral assessment; and, 2) that the individual health education behavioral assessment tool is: a) administered and reviewed by the primary care provider during an office visit, b) reviewed at least annually by the primary care provider with Members who present for a scheduled visit; and, c) re-administered by the primary care provider at the appropriate age-intervals.

B. Hospice Care

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

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

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

C. Vision Care—Lenses

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

D. Mental Health Services

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

E. Tuberculosis (TB)

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

Contractor shall coordinate with Local Health Departments in the provision of direct observed therapy as required in Exhibit A, Attachment 11, provision 15. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB) and Attachment 12, Local Health Department Coordination.

F. Pharmaceutical Services and Provision of Prescribed Drugs

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

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

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

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

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

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

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

EXCLUDED PSYCHOTHERAPEUTIC DRUGS

Generic Name

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

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

Generic Name

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

CASE MANAGEMENT AND COORDINATION OF CARE

1. Comprehensive Case Management and Coordination of Care Services

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

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

2. Targeted Case Management Services

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

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

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

3. Disease Management Program

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

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

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

5. Specialty Mental Health

A. Specialty Mental Health Services

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

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

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

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

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

B. Local Mental Health Plan Coordination

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

6. Alcohol and Substance Abuse Treatment Services

Alcohol and substance abuse treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR, Section 51341.1, and outpatient heroin detoxification services defined in Title 22, CCR, Section 51328 are excluded from this Contract. These excluded services include the exclusion of all drugs used for the treatment of alcohol and substance abuse that are covered by the Drug Medi-Cal Program administered by the Department of Alcohol and Drug Programs (ADP) pursuant to Title 22, CCR, Section 51341.1(b)(2), and the drugs listed in Exhibit A, Attachment 11-A . The drugs listed in Exhibit A, Attachment 11-A are not covered by ADP but are covered by the Medi-Cal Fee-For-Service program.

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

7. Services for Children with Special Health Care Needs

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

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

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

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

C. Methods for ensuring that each CSHCN receives a comprehensive assessment of health and related needs, and that all medically necessary follow-up services are documented in the medical record, including needed referrals;

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

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

8. California Children Services (CCS)

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

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

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

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

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

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

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

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

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

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

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

9. Services for Persons with Developmental Disabilities

A. Contractor shall develop and implement procedures for the identification of Members with developmental disabilities.

B. Contractor shall refer Members with developmental disabilities to a Regional Center for the developmentally disabled for evaluation and for access to those non-medical services provided through the Regional Centers such as but not limited to, respite, out-of-home placement, and supportive living. Contractor shall participate with Regional Center staff in the development of the individual developmental services plan required for all persons with developmental disabilities, which includes identification of all appropriate services, including medical care services, which need to be provided to the Member.

C. Services provided under the Home and Community-Based Services (HCBS) waiver programs to persons with developmental disabilities are not covered under this Contract. Contractor shall implement and maintain systems to identify Members with developmental disabilities that may meet the requirements for participation in this waiver and refer these Members to the HCBS Waiver program administered by the State Department of Developmental Services (DDS).

If DDS concurs with the Contractor's assessment of the Member and there is available placement in the waiver program, the Member will receive waiver services while enrolled in the plan. Contractor shall continue to provide all Medically Necessary Covered Services.

D. Contractor shall execute a Memorandum of Understanding (MOU) with the local Regional Centers as stipulated in Exhibit A, Attachment 12, provision 2, for the coordination of services for Members with developmental disabilities.

10. Early Intervention Services

Contractor shall develop and implement systems to identify children who may be eligible to receive services from the Early Start program and refer them to the local Early Start program. These children would include those with a condition known to lead to developmental delay, those in whom a significant developmental delay is suspected, or whose early health history places them at risk for delay. Contractor shall collaborate with the local Regional Center or local Early Start program in determining the Medically Necessary diagnostic and preventive services and treatment plans for Members participating in the Early Start program. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the individual family service plan developed by the Early Start program, with Primary Care Provider participation.

11. Local Education Agency Services

Local Education Agency (LEA) assessment services are services specified in Title 22, CCR Section 51360(b) and provided to students who qualify based on Title 22, CCR, Section 51190.1. LEA services provided pursuant to an Individual Education Plan as set forth in Education Code, Section 56340 et seq. or Individual Family Service Plan as set forth in Government Code, Section 95020, are not covered under this Contract. However, the Contractor is responsible for providing a Primary Care Physician and all Medically Necessary Covered Services for the Member, and shall ensure that the Member's Primary Care

Physician cooperates and collaborates in the development of the Individual Education Plan or the Individual Family Service Plan. Contractor shall provide case management and care coordination to the Member to ensure the provision of all Medically Necessary covered diagnostic, preventive and treatment services identified in the Individual Education Plan developed by the LEA, with Primary Care Provider participation.

12. School Linked CHDP Services

A. Coordination of Care

Contractor shall maintain a “medical home” and ensure the overall coordination of care and case management of Members who obtain CHDP services through the local school districts or school sites.

B. Cooperative Arrangements

Contractor shall enter into one or a combination of the following arrangements with the local school district or school sites:

1) Cooperative arrangements (e.g. Subcontracts) with school districts or school sites to directly reimburse schools for the provision of some or all of the CHDP services, including guidelines for sharing of critical medical information. The arrangements shall also include guidelines specifying coordination of services, reporting requirements, quality standards, processes to ensure services are not duplicated, and processes for notification to Member/student/parent on where to receive initial and follow-up services.

2) Cooperative arrangements whereby the Contractor agrees to provide or contribute staff or resources to support the provision of school linked CHDP services.

3) Referral protocols/guidelines between the Contractor and the school sites, which merely screen, for the need of CHDP services receive those services from the Contractor within the required State and federal time frames. This shall include strategies for the Contractor to follow-up and document that services are provided to the Member.

4) Any innovative approach that the Contractor may develop to assure access to CHDP services and coordination with and support for school based health care services.

C. Subcontracts

Contractor shall ensure that the Subcontracts with the local school districts or school sites meet the requirements of Exhibit A, Attachment 6, provision 13, regarding Subcontracts, and address the following: the population covered, beginning and end dates of the agreement, services covered, practitioners covered, outreach, information dissemination, educational responsibilities, utilization review requirements, referral procedures, medical information flows, patient information confidentiality, quality assurance interface, data reporting requirements, and grievance/complaint procedures.

13. Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) Home and Community Based Services Waiver Program

Services provided under the HIV/AIDS Home and Community Based Services Waiver are not covered under this Contract. Contractor shall maintain procedures for identifying Members who may be eligible for the HIV/AIDS Home and Community Based Services Waiver Program and shall facilitate referrals of these Members to the HIV/AIDS Home and Community Based Services Waiver Program.

Medi-Cal beneficiaries enrolled in Medi-Cal managed care health plans who are subsequently diagnosed with HIV/AIDS, according to the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention, may participate in the HIV/AIDS Home and Community Based Services Waiver Program without having to disenroll from their Medi-Cal managed care plan. Members of Medi-Cal managed care plans must meet the eligibility requirements of the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program and enrollment is dependent on available space. Persons already enrolled in the HIV/AIDS Home and Community Based Services Medi-Cal Waiver Program may voluntarily enroll in a Medi-Cal managed care health plan.

14. Dental

Dental services are not covered under this Contract. Contractor shall cover and ensure that dental screenings for all Members are included as a part of the initial health assessment. For Members under 21 years of age, a dental screening/oral health assessment shall be performed as part of every periodic assessment, with annual dental referrals made commencing at age three (3) or earlier if conditions warrant. Contractor shall ensure that Members are referred to appropriate Medi-Cal dental providers.

Contractor shall cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists. Covered medical services include: contractually covered prescription drugs; laboratory services; and, pre-admission physical examinations required for admission to an out-patient surgical service center or an in-patient hospitalization required for a dental procedure (including facility fees and anesthesia services for both inpatient and outpatient services). Contractor may require Prior Authorization for medical services required in support of dental procedures.

If the Contractor requires pre-authorization for these services, Contractor shall develop and publish the procedures for obtaining pre-authorization to ensure that services for the Member are not unduly delayed. Contractor shall submit such procedures to CDHS for review and approval.

15. Direct Observed Therapy (DOT) for Treatment of Tuberculosis (TB)

A. DOT is offered by local health departments (LHDs) and is not covered under this Contract. Contractor shall assess the risk of noncompliance with drug therapy for each Member who requires placement on anti-tuberculosis drug therapy.

The following groups of individuals are at risk for non-compliance for the treatment of TB: Members with demonstrated multiple drug resistance (defined as resistance to Isoniazid and Rifampin); Members whose treatment has failed or who have relapsed after completing a prior regimen; children and adolescents; and, individuals who have demonstrated noncompliance (those who failed to keep office appointments). Contractor shall refer Members with active TB and who have any of these risks to the TB Control Officer of the LHD for DOT.

Contractor shall assess the following groups of Members for potential noncompliance and for consideration for DOT: substance abusers, persons with mental illness, the elderly, persons with unmet housing needs, and persons with language and/or cultural barriers. If, in the opinion of the Contractor’s providers, a Member with one or more of these risk factors is at risk for noncompliance, the Member shall be referred to the LHD for DOT.

Contractor shall provide all Medically Necessary Covered Services to the Member with TB on DOT and shall ensure joint case management and coordination of care with the LHD TB Control Officer.

B. Contractor shall execute a Memorandum of Understanding (MOU) with the LHD as stipulated in Exhibit A, Attachment 12, provision 2, for the provision of DOT.

16. Women, Infants, and Children (WIC) Supplemental Nutrition Program

A. WIC services are not covered under this Contract. However, Contractor shall have procedures to identify and refer eligible Members for WIC services. As part of the referral process, Contractor shall provide the WIC program with a current hemoglobin or hematocrit laboratory value. Contractor shall also document the laboratory values and the referral in the Member's medical record.

Contractor, as part of its initial health assessment of Members, or, as part of the initial evaluation of newly pregnant women, shall refer and document the referral of pregnant, breastfeeding, or postpartum women or a parent/guardian of a child under the age of five to the WIC program as mandated by Title 42, CFR 431.635(c).

B. Contractor shall execute a Memorandum of Understanding (MOU) with the WIC program as stipulated in Exhibit A, Attachment 12, provision 2, for services provided to Members through the WIC program.

17. Excluded Services Requiring Member Disenrollment

Contractor shall continue to cover and ensure that all Medically Necessary services are provided to Members who must disenroll and receive the following services through the Medi-Cal Fee-for-Service program until the date of disenrollment is effective.

A. Long Term Care (LTC)

Long-term care (LTC) is defined as care in a facility for longer than the month of admission plus one month. LTC services are not covered under this Contract. Contractor shall cover Medically Necessary nursing care provided from the time of admission and up to one month after the month of admission.

Contractor shall ensure that Members, other than Members requesting hospice services, in need of nursing Facility services are placed in a health care facility that provides the level of care most appropriate to the Member's medical needs. These health care facilities include Skilled Nursing Facilities, subacute facilities, pediatric subacute facilities, and Intermediate Care Facilities. Contractor shall base decisions on the appropriate level of care on the definitions set forth in Title 22, CCR, Sections 51118, 51120, 51120.5, 51121, 51124.5, and 51124.6 and the criteria for admission set forth in Title 22, CCR, Sections 51335, 51335.5, 51335.6, and 51334 and related sections of the Manual of Criteria for Medi-Cal Authorization referenced in Title 22, CCR, 51003(e).

Upon admission to an appropriate Facility, Contractor shall assess the Member's health care needs and estimate the potential length of stay of the Member. If the Member requires LTC, in the Facility for longer than the month of admission plus one month, Contractor shall submit a disenrollment request for the Member to CDHS for approval. Contractor shall provide all Medically Necessary Covered Services to the Member until the disenrollment is effective.

An approved disenrollment request will become effective the first day of the second month following the month of the Member's admission to the Facility, provided the Contractor submitted the disenrollment request at least 30 calendar days prior to that date. If the Contractor submitted the disenrollment request less than 30 calendar days prior to that date, disenrollment will be effective the first day of the month that begins at least 30 calendar days after submission of the disenrollment request. Upon the disenrollment effective date, Contractor shall ensure the Member's orderly transfer from the Contractor to the Medi-Cal Fee-For-Service program. This includes notifying the Member and his or her family or guardian of the disenrollment; assuring the appropriate transfer of medical records from the Contractor to the Medi-Cal fee-for-service provider; assuring that continuity of care is not interrupted; and, completion of all administrative work necessary to assure a smooth transfer of responsibility for the health care of the Medi-Cal beneficiary.

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

B. Major Organ Transplants

Except for kidney transplants, major organ transplant procedures that are Medi-Cal FFS benefits are not covered under the Contract. When a Member is identified as a potential major organ transplant candidate, Contractor shall refer the Member to a Medi-Cal approved transplant center. If the transplant center Physician considers the Member to be a suitable candidate, the Contractor shall submit a Prior Authorization Request to either the San Francisco Medi-Cal Field Office (for adults) or the California Children Services Program (for children) for approval. Contractor shall initiate disenrollment of the Member when all of the

following has occurred: referral of the Member to the organ transplant Facility; the Facility's evaluation has concurred that the Member is a candidate for major organ transplant; and, the major organ transplant is authorized by either CDHS' Medi-Cal Field Office (for adults) or the California Children Services Program (for children).

Contractor shall continue to provide all Medically Necessary Covered Services until the Member has been disenrolled from the plan.

Upon the disenrollment effective date, Contractor shall ensure continuity of care by transferring all of the Member's medical documentation to the transplant Physician. The effective date of the disenrollment will be retroactive to the beginning of the month in which the Member was approved as a major organ transplant candidate. The request for reimbursement for services in the month during which the transplant is approved are to be sent by the provider directly to the Medi-Cal FFS fiscal intermediary. The capitation payment for the Member will be recovered from the Contractor by CDHS.

If the Member is evaluated and determined not to be a candidate for a major organ transplant or CDHS denies authorization for a transplant, the Member will not be disenrolled. Contractor shall cover the cost of the evaluation performed by the Medi-Cal approved transplant center.

C. Waiver Programs

CDHS administers a number of Medi-Cal Home and Community Based Services (HCBS) Waiver Programs authorized under section 1915(c) of the Social Security Act. Contractor shall have procedures in place to identify Members who may benefit from the HCBS Waiver programs, and refer them to the Medical Care Coordination and Case Management Section of CDHS. These waiver programs include the In-Home Medical Care Waiver, the Nursing Facility Subacute Waiver, and the Nursing Facility A/B Waiver. If the agency administering the waiver program concurs with Contractor's assessment of the Member and there is available placement in the waiver program, Contractor shall initiate disenrollment for the Member. Contractor shall provide documentation to ensure the Member's orderly transfer to the Medi-Cal Fee-For-Service program. If the Member does not meet the criteria for the waiver program, or if placement is not available, Contractor shall continue comprehensive case management and shall continue to cover all Medically Necessary Covered Services to the Member.

18. Immunization Registry Reporting

Contractor shall ensure that member-specific immunization information is periodically reported to an immunization registry(ies) established in the Contractor's Service Area(s) as part of the Statewide Immunization Information System. Reports shall be made following the Member's initial health assessment and all other health care visits which result in an immunization being provided. Reporting shall be in accordance with all applicable State and federal laws.

19. Erectile Dysfunction (ED) Drugs and Other ED Therapies

Erectile dysfunction drugs and other ED therapies are excluded from this Contract. These excluded drugs include all drugs used for the treatment of ED that are listed in Exhibit A, Attachment 11-B. The drugs listed in Exhibit A, Attachment 11-B are covered by the Medi-Cal Fee-For-Service program.

Contractor shall identify individuals requiring ED drugs or ED therapies and arrange for their referral for appropriate services. Contractor shall assist Members in locating available treatment service sites. Contractor shall continue to cover and ensure the provision of primary care and other services unrelated to the ED drugs or ED therapies and coordinate services between the primary care providers and the treatment programs.

EXCLUDED DRUGS FOR ALCOHOL AND HEROIN (OPIOID) DEPENDENCE TREATMENT

Generic Name

Buprenorphine HCL
Buprenorphine HCL and Naloxone HCL dihydrate

EXCLUDED DRUGS FOR THE TREATMENT OF ERECTILE DYSFUNCTION (ED)

Generic Name
Alprostadil
Papaverine
Phentolamine Mesylate
Sildenafil Citrate
Tadalafil
Vardenafil HCL
Yohimbine HCL
Yohimbine HCL/Strychnine
Yohimbine HCL/Zinc Sulfate

LOCAL HEALTH DEPARTMENT COORDINATION

1. Subcontracts

Contractor shall negotiate in good faith and execute a Subcontract for public health services listed in A through D below with the Local Health Department (LHD) in each county that is covered by this Contract. The Subcontract shall specify: the scope and responsibilities of both parties in the provision of services to Members; billing and reimbursements; reporting responsibilities; and how services are to be coordinated between the LHD and the Contractor, including exchange of medical information as necessary. The Subcontract shall meet the requirements contained in Exhibit A, Attachment 6, provision 13, regarding Subcontracts.

A. Family Planning Services: as specified in Exhibit A, Attachment 8, provision 9.

B. STD services for the disease episode, as specified in Exhibit A, Attachment 8, provision 10, by CDHS, for each STD, including diagnosis and treatment of the following STDs: syphilis, gonorrhea, chlamydia, herpes simplex, chancroid, trichomoniasis, human papilloma virus, non-gonococcal urethritis, lymphogranuloma venereum and granuloma inguinale.

C. HIV Testing and Counseling as specified in Exhibit A, Attachment 8, provision 11.

D. Immunizations: as specified in Exhibit A, Attachment 8, provision 12.

To the extent that Contractor does not meet this requirement on or before four (4) months after the effective date of this Contract, Contractor shall submit documentation substantiating reasonable efforts to enter into Subcontracts.

2. Subcontracts or Memoranda of Understanding

If reimbursement is to be provided for services rendered by the following programs or agencies, Contractor shall execute a Subcontract with the LHD or agency as stipulated in provision 1 above. If no reimbursement is to be made, Contractor or agency shall negotiate in good faith and execute a Memorandum of Understanding (MOU) for services provided by these programs and agencies.

A. California Children Services (CCS)

B. Maternal and Child Health (MCH)

C. Child Health and Disability Prevention (CHDP) Program

D. Tuberculosis Direct Observed Therapy

E. Women, Infants, and Children (WIC) Supplemental Nutrition Program

F. Regional Centers for services for persons with developmental disabilities.

3. Local Mental Health Plan Coordination

A. Contractor shall negotiate in good faith and execute a MOU with the local mental health plan (MHP) in accordance with Welfare and Institutions Code, Section 5777.5. The MOU shall specify, consistent with this Contract, the respective responsibilities of Contractor and the MHP in delivering Medically Necessary Covered Services and Specialty Mental Health Services to Members. The MOU shall address:

1) Protocols and procedures for referrals between Contractor and the MHP;

2) Protocols for the delivery of Specialty Mental Health Services, including the MHP's provision of clinical consultation to Contractor for Members being treated by Contractor for mental illness;

3) Protocols for the delivery of mental health services within the Primary Care Physician's scope of practice;

4) Protocols and procedures for the exchange of Medical Records information, including procedures for maintaining the confidentiality of Medical Records;

5) Procedures for the delivery of Medically Necessary Covered Services to Members who require Specialty Mental Health Services, including:

a) Pharmaceutical services and prescription drugs;

b) Laboratory, radiological and radioisotope services;

c) Emergency room facility charges and professional services;

d) Emergency and non-emergency medical transportation;

e) Home health services;

f) Medically Necessary Covered Services to Members who are patients in psychiatric inpatient hospitals.

6) Procedures for transfers between inpatient psychiatric services and inpatient medical services to address changes in a Member's medical or mental health condition.

7) Procedures to resolve disputes between Contractor and the MHP.

4. MOU Monthly Reports

To the extent Contractor does not execute an MOU within four (4) months after the effective date of this Contract, Contractor shall submit documentation substantiating its good faith efforts to enter into an MOU. Until such time as an MOU is executed, Contractor shall submit monthly reports to CDHS documenting its continuing good faith efforts to execute an MOU and the justifications why such an MOU has not been executed.

MEMBER SERVICES

1. Members Rights And Responsibilities

A. Member Rights and Responsibilities

Contractor shall develop, implement and maintain written policies that address the Member's rights and responsibilities and shall communicate these to its Members, and providers.

1) Contractor's written policies regarding Member rights shall include the following:

a) to be treated with respect, giving due consideration to the Member's right to privacy and the need to maintain confidentiality of the Member's medical information.

b) to be provided with information about the organization and its services.

c) to be able to choose a Primary Care Provider within the Contractor's network.

d) to participate in decision making regarding their own health care, including the right to refuse treatment.

e) to voice grievances, either verbally or in writing, about the organization or the care received.

f) to receive oral interpretation services for their language.

g) to formulate advance directives.

h) to have access to family planning services, Federally Qualified Health Centers, Indian Health Service Facilities, sexually transmitted disease services and Emergency Services outside the Contractor's network pursuant to the federal law.

i) to request a State Medi-Cal fair hearing, including information on the circumstances under which an expedited fair hearing is possible.

j) to have access to, and where legally appropriate, receive copies of, amend or correct their Medical Record.

k) to disenroll upon request.

l) to access minor consent services.

m) to receive written Member informing materials in alternative formats, including Braille, large size print, and audio format upon request.

n) to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation.

o) to receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's condition and ability to understand.

p) freedom to exercise these rights without adversely affecting how they are treated by the Contractor, providers, or the State.

2) Contractor's written policy regarding Member responsibilities shall include providing accurate information to the professional staff, following instructions, and cooperating with the providers.

B. Members' Right to Confidentiality

Contractor shall implement and maintain policies and procedures to ensure the Members' right to confidentiality of medical information.

1) Contractor shall ensure that Facilities implement and maintain procedures that guard against disclosure of confidential information to unauthorized persons inside and outside the network.

2) Contractor shall counsel Members on their right to confidentiality and Contractor shall obtain Member's consent prior to release of confidential information, unless such consent is not required pursuant to Title 22, CCR, Section 51009.

C. Members' Rights to Advance Directives

Contractor shall implement and maintain written policies and procedures respecting advance directives in accordance with the requirements of 42 CFR 422.128 and 42 CFR 438.6(i).

2. Member Services Staff

A. Contractor shall maintain the capability to provide Member services to Medi-Cal Members through sufficient assigned and knowledgeable staff.

B. Contractor shall ensure Member services staff are trained on all contractually required Member service functions including, policies, procedures, and scope of benefits of this Contract.

3. Call Center Reports

Contractor shall report quarterly, in a format to be approved by CDHS, the number of calls received by call type (questions, grievances, access to services, request for health education, etc.); the average speed to answer Member services telephone calls with a live voice; and, the Member services telephone calls abandonment rate.

4. Written Member Information

A. Contractor shall provide all new Medi-Cal Members, and Potential Enrollees upon request only, with written Member information as specified in Title 22, CCR, Section 53895. Compliance with items required by Section 53895(b) may be met through distribution of the Member Services Guide.

The Member Services Guide shall meet the requirements of an Evidence of Coverage and Disclosure Form (EOC/DF) as stipulated by Title 28, CCR, Sections 1300.51(d), Exhibit T (EOC) or U (Combined EOC/DF) and Title 22, CCR, Section 53881. In addition, the Member Services Guide shall meet the requirements contained in Health and Safety Code, Section 1363, and Title 28, CCR, Section 1300.63(a), as to print size, readability, and understandability of text.

B. Contractor shall distribute the Member information no later than seven (7) calendar days after the effective date of the Member's Enrollment. Contractor shall revise this information, if necessary, and distribute it annually to each Member or family unit.

C. Contractor shall ensure that all written Member information is provided to Members at a sixth grade reading level or as determined appropriate through the Contractor's group needs assessment and approved by CDHS. The written Member information shall ensure Members' understanding of the health plan processes and ensure the Member's ability to make informed health decisions.

Written Member-informing materials shall be translated into the identified threshold and concentration languages discussed in Exhibit A, Attachment 9, provision 13. Linguistic Services.

Written Member informing materials shall be provided in alternative formats, including Braille, large size print, and audio format upon request.

D. Contractor shall develop and provide each Member, or family unit, a Member Services Guide that constitutes a fair disclosure of the provisions of the covered health care services. The Member Services Guide shall be submitted to CDHS for review prior to distribution to Members. The Member Services Guide shall include the following information:

1) The plan name, address, telephone number and service area covered by the health plan.

2) A description of the full scope of Medi-Cal Managed Care covered benefits and all available services including health education, interpretive services provided by plan personnel and at service sites, and "carve out" services and an explanation of any service limitations and exclusions from coverage or charges for services. Include information and identification of services to which the Contractor or subcontractor has a moral objection to perform or support.

3) Procedures for accessing Covered Services including that Covered Services shall be obtained through the plan's providers unless otherwise allowed under this Contract.

   A description of the Member identification card issued by the Contractor, if applicable, and an explanation as to its use in authorizing or assisting Members to obtain services.

4) Compliance with the following may be met through distribution of a provider directory:

   The address and telephone number of each Service Location (e.g., locations of hospitals, Primary Care Physicians (PCP), Specialists, optometrists, psychologists, pharmacies, Skilled Nursing Facilities, Urgent Care Facilities, FQHCs, Indian Health Centers). In the case of a medical group/foundation or independent practice association (IPA), the medical group/foundation or IPA name, address and telephone number shall appear for each Physician provider:

   The hours and days when each of these Facilities is open, the services and benefits available, the telephone number to call after normal business hours, and identification of providers that are not accepting new patients.

5) Procedures for selecting or requesting a change in PCP at any time; any requirements that a Member would have to change PCP; reasons for which a request for a specific PCP may be denied; and reasons why a provider may request a change.

6) The purpose and value of scheduling an initial health assessment appointment.

7) The appropriate use of health care services in a managed care system.

8) The availability and procedures for obtaining after hours services (24-hour basis) and care, including the appropriate provider locations and telephone numbers. This shall include an explanation of the Members' right to interpretive services, at no cost, to assist in receiving after hours services.

9) Procedures for obtaining emergency health care from specified plan providers or from non-plan providers, including outside Contractor's Service Area.

10) Process for referral to specialists in sufficient detail so Member can understand how the process works, including timeframes.

11) Procedures for obtaining any transportation services to Service Sites that are offered by Contractor or available through the Medi-Cal program, and how to obtain such services. Include a description of both medical and non-medical transportation services and the conditions under which non-medical transportation is available.

12) Procedures for filing a grievance with Contractor, either orally or in writing, including procedures for appealing decisions regarding Member's coverage, benefits, or relationship to the organization or other dissatisfaction with the Contractor and/or providers. Include the title, address, and telephone number of the person responsible for processing and resolving grievances and responsible for providing assistance completing the request. Information regarding the process shall include the requirements and the timelines for the Contractor to acknowledge receipt of grievances, to resolve grievances, and to notify the Member of the resolution of grievances or appeals. Information shall be provided informing the Member that services previously authorized by the Contractor will continue while the grievance is being resolved.

13) The causes for which a Member shall lose entitlement to receive services under this Contract as stipulated in Exhibit A, Attachment 16, provision 3. Disenrollment.

14) Procedures for Disenrollment, including an explanation of the Member's right to disenroll without cause at any time, subject to any restricted disenrollment period.

15) Information on the Member's right to the Medi-Cal fair hearing process and information on the circumstances under which an expedited fair hearing is possible and information regarding

assistance in completing the request, regardless of whether or not a grievance has been submitted or if the grievance has been resolved, pursuant to Title 22, CCR, Section 53452, when a health care service requested by the Member or provider has been denied, deferred or modified. Information on State Fair Hearing shall also include information on the timelines which govern a Member's right to a State Fair Hearing, pursuant to Welfare & Institutions Code §10951 and the State Department of Social Services' Public Inquiry and Response Unit toll-free telephone number (1-800-952-5253) to request a State hearing.

16) Information on the availability of, and procedures for obtaining, services at FQHCs and Indian Health Clinics.

17) Information on the Member's right to seek family planning services from any qualified provider of family planning services under the Medi-Cal program, including providers outside Contractor's provider network, how to access these services, and a description of the limitations on the services that Members may seek outside the plan. Contractor may use the following statement:

Family planning services are provided to Members of childbearing age to enable them to determine the number and spacing of children. These services include all methods of birth control approved by the Federal Food and Drug Administration. As a Member, you pick a doctor who is located near you and will give you the services you need. Our Primary Care Physicians and OB/GYN specialists are available for family planning services. For family planning services, you may also pick a doctor or clinic not connected with [Plan Name (Contractor)] without having to get permission from [Plan Name (Contractor)]. [Plan Name (Contractor)] shall pay that doctor or clinic for the family planning services you get.

18) Procedures for providing female Members with direct access to a women's health specialist within the network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the Member's designated source of primary care if that source is not a woman's health specialist.

19) CDHS' Office of Family Planning toll-free telephone number (1-800-942-1054) providing consultation and referral to family planning clinics.

20) Information on the availability of, and procedures for obtaining, Certified Nurse Midwife and Certified Nurse Practitioner services, pursuant to Exhibit A, Attachment 9, provision 7. Nurse Midwife and Nurse Practitioner Services.

21) Information on the availability of transitional Medi-Cal eligibility and how the Member may apply for this program. Contractor shall include this information with all Member Service Guides sent to Members after the date such information is furnished to Contractor by CDHS.

22) Information on how to access State resources for investigation and resolution of Member complaints, including a description of the CDHS Medi-Cal Managed Care Ombudsman Program and toll-free telephone number (1-888-452-8609), and the Department of Managed Health Care, Health Maintenance Organization (HMO) Consumer Service toll-free telephone number (1-800-400-0815).

23) Information concerning the provision and availability of services covered under the CCS program from providers outside Contractor's provider network and how to access these services.

24) An explanation of the expedited Disenrollment process for Members qualifying under conditions specified under Title 22, CCR, Section 53889(j) which includes children receiving services under the Foster Care or Adoption Assistance Programs; Members with special health care needs, including, but not limited to major organ transplants; and Members already enrolled in another Medi-Cal, Medicare or commercial managed care plan.

25) Information on how to obtain Minor Consent Services through Contractor's provider network, an explanation of those services, and information on how they can also be obtained out of the Contractor's provider network.

26) An explanation on how to use the Fee-For-Service system when Medi-Cal Covered Services are excluded or limited under this Contract and how to obtain additional information.

27) An explanation of an American Indian Member's right to not enroll in a Medi-Cal Managed Care plan, to be able to access Indian Health Service facilities, and to disenroll from Contractor's plan at any time, without cause.

28) A notice regarding the positive benefits of organ donations and how a Member can become an organ or tissue donor. Pursuant to California Health and Safety Code, Section 7158.2, this notice must be provided upon enrollment and annually thereafter in the evidence of coverage (Member Services Guide), health plan newsletter or any other direct communication with Members.

29) A statement as to whether the Contractor uses provider financial bonuses or other incentives with its contracting providers of health care services and that the Member may request additional information about these bonuses or incentives from the plan, the Member's provider or the provider's medical group or independent practice association, pursuant to California Health and Safety Code, Section 1367.10.

30) A notice as to whether the Contractor uses a drug formulary. Pursuant to California Health and Safety Code, Section 1363.01, the notice shall: (1) be in the language that is easily understood and in a format that is easy to understand; (2) include an explanation of what a formulary is, how the plan decides which prescription drugs are included in or excluded from the formulary, and how often the formulary is updated; (3) indicate that the Member can request information regarding whether a specific drug is on the formulary and the telephone number for requesting this information; and (4) indicate that the presence of a drug on the plan's formulary does not guarantee that a Member will be prescribed that drug by his or her prescribing provider for a particular medical condition.

31) Policies and procedures regarding a Members' right to formulate advance directives. This information shall include the Member's right to be informed by the Contractor of State law regarding advance directives, and to receive information from the Contractor regarding any changes to that law. The information shall reflect changes in State law regarding advance directives as soon as possible, but no later than 90 calendar days after the effective date of change.

32) Any other information determined by CDHS to be essential for the proper receipt of Covered Services.

E. Member Identification Card

Contractor shall provide an identification card to each Member, which identifies the Member and authorizes the provision of Covered Services to the Member. The card shall specify that Emergency Services rendered to the Member by non-Contracting providers are reimbursable by the Contractor without Prior Authorization.

5. Notification of Changes in Access to Covered Services

Contractor shall ensure Medi-Cal Members are notified in writing of any changes in the availability or location of Covered Services, or any other changes in information listed in 42 CFR 438.10(f)(4), at least 30 calendar days prior to the effective date of such changes. In the event of an emergency or other unforeseeable circumstances, Contractor shall provide notice of the emergency or other unforeseeable circumstance to CDHS as soon as possible. The notification must also be presented to and approved in writing by CDHS prior to its' release.

6. Primary Care Provider Selection

A. Contractor shall implement and maintain CDHS approved procedures to ensure that each new Member has an appropriate and available Primary Care Physician. Contractor shall provide each new Member an opportunity to select a Primary Care Physician within the first 30 calendar days of enrollment. Contractor may allow Members to select a clinic that provides Primary Care. If the Contractor's provider network includes nurse practitioners, certified nurse midwives, or physician assistants, the Member may select a nurse practitioner, certified nurse midwife, or physician assistant within 30 calendar days of enrollment to provide Primary Care services in accordance with Title 22, CCR, Section 53853(a)(4). Contractor shall ensure that Members are allowed to change a Primary Care Physician, nurse practitioner, certified nurse midwife or physician assistant, upon request, by selecting a different Primary Care Provider from Contractor's network of providers.

B. Contractor shall disclose to affected Members any reasons for which their selection or change in Primary Care Physician could not be made.

C. Contractor shall ensure that Members with an established relationship with a provider in Contractor's network, who have expressed a desire to continue their patient/provider relationship, are assigned to that provider without disruption in their care.

D. Contractor shall ensure that Members may choose traditional and safety net providers as their Primary Care Provider.

7. Primary Care Provider Assignment

A. If the Member does not select a Primary Care Provider within 30 calendar days of the effective date of enrollment, Contractor shall assign that Member to a Primary Care Provider and notify the Member and the assigned Primary Care Provider no later than 40 calendar days after the Member's Enrollment. Contractor shall ensure that adverse selection does not occur during the assignment process of Members to providers.

B. Contractor shall notify the Primary Care Provider that a Member has selected or been assigned to the provider within ten (10) calendar days from when selection or assignment is completed by the Member or the Contractor, respectively.

C. Contractor shall maintain procedures that proportionately include contracting Traditional and Safety-Net providers in the assignment process for Members who do not choose a Primary Care Provider.

8. Denial, Deferral, or Modification of Prior Authorization Requests

A. Contractor shall notify Members of a decision to deny, defer, or modify requests for Prior Authorization, in accordance with Title 22, CCR, Sections 51014.1 and 53894 by providing written notification to Members and/or their authorized representative, regarding any denial, deferral or modification of a request for approval to provide a health care service. This notification must be provided as specified in Title 22, CCR, Sections 51014.1, 51014.2, 53894, and Health and Safety Code Section 1367.01.

B. Contractor shall provide for a written notification to the Member and the Member's representative on a standardized form informing the Member of all the following:

1) The Member's right to, and method of obtaining, a fair hearing to contest the denial, deferral, or modification action and the decision the Contractor has made.

2) The Member's right to represent himself/herself at the fair hearing or to be represented by legal counsel, friend or other spokesperson.

3) The name and address of Contractor and the State toll-free telephone number for obtaining information on legal service organizations for representation.

C. Contractor shall provide required notification to beneficiaries and their authorized representatives in accordance with the time frames set forth in Title 22, CCR, Sections 51014.1 and 53894. Such notice shall be deposited with the United States Postal Service in time for pick-up no later than the third Working day after the decision is made, not to exceed 14 calendar days from receipt of the original request. If the decision is deferred because an extension is requested or justified as explained in Exhibit A, Attachment 5, provision 3, Contractor shall notify the Member in writing of the deferral of the decision no later than 14 calendar days from the receipt of the original request. If the final decision is to deny or modify the request, Contractor shall provide written notification of the decision to Members no later than 28 calendar days from the receipt of the original request.

If the decision regarding a prior authorization request is not made within the time frames indicated in Exhibit A, Attachment 5, provision 3, the decision is considered denied and notice of the denial must be sent to the Member on the date the time frame expires.

MEMBER GRIEVANCE SYSTEM

1. Member Grievance System

Contractor shall implement and maintain a Member Grievance system in accordance with Title 28, CCR, Section 1300.68 and 1300.68.01, Title 22, CCR, Section 53858, Exhibit A, Attachment 13, provision 4, paragraph D, item 12), and 42 CFR 438.420(a)-(c).

2. Grievance System Oversight

Contractor shall implement and maintain procedures as described below to monitor the Member's Grievance system and the expedited review of grievances required under Title 28, CCR, Sections 1300.68 and 1300.68.01 and Title 22, CCR, Section 53858.

A. Procedure to ensure timely resolution and feedback to complainant.
Provide oral notice of the resolution of an expedited review.

B. Procedure for systematic aggregation and analysis of the grievance data and use for Quality Improvement.

C. Procedure to ensure that the grievance submitted is reported to an appropriate level, i.e., medical issues versus health care delivery issues. To this end, Contractor shall ensure that any grievance involving the appeal of a denial based on lack of Medical Necessity, appeal of a denial of a request for expedited resolution of a grievance, or an appeal that involves clinical issues shall be resolved by a health care professional with appropriate clinical expertise in treating the Member's condition or disease.

D. Procedure to ensure the participation of individuals with authority to require corrective action. Grievances related to medical quality of care issues shall be referred to the Contractor's Medical Director.

E. Procedure to ensure that requirements of Title 22 CCR Section 51014.2 are met regarding services to Members during the grievance process.

F. Procedure to ensure that the person making the final decision for the proposed resolution of a grievance has not participated in any prior decisions related to the grievance.

G. Procedures to ensure that Members are given a reasonable opportunity to present, in writing or in person before the individual(s) resolving the grievance, evidence, facts and law in support of their grievance. In the

case of a grievance subject to expedited review, Contactor shall inform the Member of the limited time available to present evidence. Contractor shall also comply with 42 CFR 438.406(b)(3) concerning a Member's request to review records in connection with a grievance.

3. Grievance Log and Quarterly Grievance Report

A. Contractor shall maintain, and have available for CDHS review, grievance logs, including copies of grievance logs of any sub-contracting entity delegated the responsibility to maintain and resolve grievances. Grievance logs shall include all the required information set forth in Title 22, CCR, Section 53858(e).

B. Contractor shall submit the quarterly grievance report for Medi-Cal Members only in the form that is required by and submitted to the DMHC as set forth in Title 28, CCR, Section 1300.68(f).

1) In addition to the types or nature of grievances listed in Title 28, CCR, Section 1300.68(f)(2)((D), the report shall also include, but not be limited to, timely assignments to a provider, issues related to cultural and linguistic sensitivity, and difficulty with accessing specialists.

2) For the Medi-Cal category of the report, provide the following additional information on each grievance: timeliness of responding to the Member, geographic region, ethnicity, gender, primary language of the Member, and final outcome of the grievance.

C. Contractor shall submit the quarterly grievance report for Medi-Cal Members the following quarters: April – June, July – September, October – December, January – March. The report is due 30 calendar days from the date of the end of the reporting quarter.

4. Responsibilities in Expedited State Fair Hearings

Within two (2) working days of being notified by CDHS or the Department of Social Services (DSS) that a Member has filed a request for fair hearing which meets the criteria for expedited resolution, Contractor shall deliver directly to the designated/appropriate DSS administrative law judge all information and documents which either support, or which the Contractor considered in connection with, the action which is the subject of the expedited fair hearing. This includes, but is not necessarily limited to, copies of the relevant treatment authorization request and notice of action (NOA), plus any pertinent grievance resolution notice. If the NOA or grievance resolution notice are not in English, fully translated copies shall be transmitted to DSS along with copies of the

original NOA and grievance resolution notice. One or more plan representatives with knowledge of the Member's condition and the reason(s) for the action, which is the subject of the expedited fair hearing, shall be available by phone during the scheduled fair hearing.

MARKETING

1. Training and Certification of Marketing Representatives

If Contractor conducts Marketing, Contractor shall develop a training and certification program for Marketing Representatives and ensure that all staff performing Marketing activities or distributing Marketing material are appropriately certified.

A. Contractor is responsible for all Marketing activity conducted on behalf of the Contractor. Contractor will be held liable for any and all violations by any Marketing Representatives. Marketing staff may not provide Marketing services for more than one Contractor. Marketing Representatives shall not engage in Marketing practices that discriminate against an Eligible Beneficiary or Potential Enrollee because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability.

B. Training Program

Contractor shall develop a training program that will train staff and prepare Marketing Representatives for certification. Contractor shall develop a staff orientation and Marketing representative's training/certification manual. The manual shall, at a minimum, cover the following topics:

1) An explanation of the Medi-Cal Program, including both FFS and capitated contractors, and eligibility.

2) Scope of Services

3) An explanation of the Contractor's administrative operations and health delivery system program, including the Service Area covered, excluded services, additional services, conditions of enrollment and aid categories.

4) An explanation of Utilization Management (how the beneficiary is obligated to obtain all non-emergency medical care through the Contractor's provider network and describing all precedents to receipt of care like referrals, prior authorizations, etc.).

5) An explanation of the Contractor's grievance procedures.

6) An explanation of how a beneficiary disenrolls from the Contractor and conditions for both voluntary and mandatory disenrollment reasons.

7) An explanation of the requirements of confidentiality of any information obtained from Medi-Cal beneficiaries including information regarding eligibility under any public welfare or social services program.

8) An explanation of how Marketing Representatives will be supervised and monitored to assure compliance with regulations.

9) An explanation of acceptable communication and sales techniques. This shall include an explanation of prohibited Marketing Representative activities and conduct.

10) An explanation that discrimination in enrollment and failure to enroll a beneficiary due to a pre-existing medical condition (except for conditions requiring contract-excluded services) are illegal.

11) An explanation of the consequences of misrepresentation and Marketing abuses (i.e., discipline, suspension of Marketing, termination, civil and criminal prosecution, etc.). The Marketing Representative must understand that any abuse of Marketing requirements can also cause the termination of the Contractor's contract with the State.

2. CDHS Approval

A. Contractor shall not conduct Marketing activities presented in provision 3, paragraph A, subparagraph 2), item d) below, without written approval of its Marketing plan, or changes to its Marketing plan, from CDHS. In cases where the Contractor wishes to conduct an activity not included in provision 3, paragraph A, subparagraph 2), items c) and d) below, Contractor shall submit a request to include the activity and obtain written, prior approval from CDHS. Contractor must submit the written request within 30 calendar days prior to the Marketing event, unless CDHS agrees to a shorter period.

B. All Marketing materials, and changes in Marketing materials, including but not limited to, all printed materials, illustrated materials, videotaped and media scripts, shall be approved in writing by CDHS prior to distribution.

C. Contractor's training and certification program and changes in the training and certification program shall be approved in writing by CDHS prior to implementation.

3. Marketing Plan

If Contractor conducts Marketing, Contractor shall develop a Marketing plan as specified below. The Marketing plan shall be specific to the Medi-Cal program only. Contractor shall implement and maintain the Marketing plan only after approval from CDHS. Contractor shall ensure that the Marketing plan, all procedures and materials are accurate and do not mislead, confuse or defraud.

A. Contractor shall submit a Marketing plan to CDHS for review and approval on an annual basis. The Marketing plan, whether new, revised, or updated, shall describe the Contractor's current Marketing procedures, activities, and methods. No Marketing activity shall occur until the Marketing plan has been approved by CDHS.

1) The Marketing plan shall have a table of contents section that divides the Marketing plan into chapters and sections. Each page shall be dated and numbered so chapters, sections, or pages, when revised, can be easily identified and replaced with revised submissions.

2) Contractor's Marketing plan shall contain the following items and exhibits:

a) Mission Statement or Statement of Purpose for the Marketing plan.

b) Organizational Chart and Narrative Description

The organizational chart shall include the Marketing director's name, address, telephone and facsimile number and key staff positions.

The description shall explain how the Contractor's internal Marketing department operates, identifying key staff positions, roles and responsibilities, and, reporting relationships including, if applicable, how the Contractor's commercial Marketing staff and functions interface with its Medi-Cal Marketing staff and functions.

c) Marketing Locations

All sites for proposed Marketing activities such as annual health fairs, and community events, in which the Contractor proposes to participate, shall be listed.

d) Marketing Activities

All Marketing methods and Marketing activities Contractor expects to use, or participate in, shall be described. Contractor shall comply with the guidelines described in Title 22, CCR, Sections 53880 and 53881, Welfare and Institutions Code, Sections 10850(b), 14407.1, 14408, 14409, 14410, and 14411, and as follows:

i. Contractor shall not engage in door to door or cold call Marketing for the purpose of enrolling Members or Potential Enrollees, or for any other purpose.

ii. Contractor shall obtain CDHS approval to perform in-home Marketing presentations and shall provide strict accountability, including documentation of the prospective Member's request for an in-home Marketing presentation or a documented telephone log entry showing the request was made.

iii. Contractor shall not conduct Marketing presentations at primary care sites.

iv. Include a letter or other document that verifies cooperation or agreement between the Contractor and an organization to undertake a Marketing activity together and certify or otherwise demonstrate that permission for use of the Marketing activity/event site has been granted.

e) Marketing Materials

Copies of all Marketing materials the Contractor will use for both English and non-English speaking populations shall be included.

A sample copy of the Marketing identification badge and business card that will clearly identify Marketing Representatives as employees of the Contractor shall be included. Marketing identification badges and business cards shall not resemble those of a government agency.

f) Marketing Distribution Methods

A description of the methods the Contractor will use for distributing Marketing materials.

g) Monitoring and Reporting Activities

Written formal measures to monitor performance of Marketing Representatives to ensure Marketing integrity pursuant to Welfare and Institutions Code, Section 14408(c).

h) Miscellaneous

All other information requested by CDHS to assess the Contractor's Marketing program.

B. Contractor shall not seek to influence enrollment in conjunction with the sale or offering of any private insurance.

4. Marketing Event Notification

Contractor shall notify CDHS at least 30 calendar days in advance of Contractor's participation in all Marketing events. In cases where Contractor learns of an event less than 30 calendar days in advance, Contractor shall provide notification to CDHS immediately. In no instance shall notification be less than 48 hours prior to the event.

ENROLLMENTS AND DISENROLLMENTS

1. Enrollment Program

Contractor shall cooperate with the CDHS Enrollment program and shall provide to CDHS' enrollment contractor a list of network providers (provider directory), linguistic capabilities of the providers and other information deemed necessary by CDHS to assist Medi-Cal beneficiaries, and Potential Enrollees, in making an informed choice in health plans. The provider directory will be submitted every six (6) months and in accordance with MMCD Policy Letter 00-02.

2. Enrollment

Contractor shall accept as Members Medi-Cal beneficiaries in the mandatory and voluntary aid categories as defined in Exhibit E, Attachment 1, Definitions, provision 30. Eligible Beneficiaries, including Medi-Cal beneficiaries in Aid Codes who elect to enroll with the Contractor or are assigned to the Contractor.

A. Enrollment - General

Eligible Beneficiaries residing within the Service Area of Contractor may be enrolled at any time during the term of this Contract. Eligible Beneficiaries shall be accepted by Contractor in the order in which they apply without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability.

B. Coverage

Member coverage shall begin at 12:01 a.m. on the first day of the calendar month for which the Eligible Beneficiary's name is added to the approved list of Members furnished by CDHS to Contractor. The term of enrollment shall continue indefinitely unless this Contract expires, is terminated, or the Member is disenrolled under the conditions described in provision 3. Disenrollment.

Contractor shall provide Covered Services to a child born to a Member for the month of birth and the following month. For a child born in the month immediately preceding the mother's membership, Contractor shall provide Covered Services to the child during the mother's first month of Enrollment. No additional capitation payment will be made to the Contractor by CDHS.

C. Exception to Enrollment

A Member in a mandatory aid code category is not required to enroll when a request for an exemption under Title 22, CCR, Section 53887 has been approved.

D. Enrollment Restriction

Enrollment will proceed unless restricted by CDHS. Such restrictions will be defined in writing and the Contractor notified at least ten (10) calendar days prior to the start of the period of restriction. Release of restrictions will be in writing and transmitted to the Contractor at least ten (10) days calendar prior to the date of the release.

3. Disenrollment

The enrollment contractor shall process a Member Disenrollment under the following conditions, subject to approval by CDHS, in accordance with the provisions of Title 22, CCR, Section 53891:

A. Disenrollment of a Member is mandatory when:

1) The Member requests Disenrollment, subject to any lock-in restrictions on Disenrollment under the federal lock-in option, if applicable.

2) The Member's eligibility for Enrollment with Contractor is terminated or eligibility for Medi-Cal is ended, including the death of the Member.

3) Enrollment was in violation of Title 22, CCR, Sections 53891(a)(2), or requirements of this Contract regarding Marketing, and CDHS or Member requests Disenrollment.

4) Disenrollment is requested in accordance with Welfare and Institutions Code, Sections 14303.1 regarding merger with other organizations, or 14303.2 regarding reorganizations or mergers with a parent or subsidiary corporation.

5) There is a change of a Member's place of residence to outside Contractor's Service Area.

6) Disenrollment is based on the circumstances described in Exhibit A, Attachment 11, provision 17. Excluded Services Requiring Member Disenrollment.

Such Disenrollment shall become effective on the first day of the second month following receipt by CDHS of all documentation necessary, as determined by CDHS, to process the Disenrollment, provided Disenrollment was requested at least 30 calendar days prior to that date, except for Disenrollments pursuant to Exhibit A, Attachment 11, provision 17, regarding Major Organ Transplants, for which Disenrollment shall be effective the beginning of the month in which the transplant is approved.

B. Contractor may recommend to CDHS the Disenrollment of any Member in the event of a breakdown in the "Contractor/Member relationship" which makes it impossible for Contractor's providers to render services adequately to a Member. Except in cases described in subparagraph 2) below or fraud, Contractor shall make, and document, significant efforts to resolve the problem with the Member through avenues such as reassignment of Primary Care Physician, education, or referral to services (such as mental health or substance abuse programs), before requesting a Contractor-initiated Disenrollment. In cases of Contractor-initiated Disenrollment of a Member, Contractor must submit to CDHS a written request with supporting documentation for Disenrollment based on the breakdown of the "Contractor/Member relationship." Contractor-initiated Disenrollments must be prior approved by CDHS and shall be considered only under any of the following circumstances:

1) Member is repeatedly verbally abusive to contracting providers, ancillary or administrative staff, subcontractor staff or to other plan Members.

2) Member physically assaults a Contractor's staff person, contracting provider or staff person, or other Member, or threatens another individual with a weapon on Contractor's premises or subcontractor's premises. In this instance, Contractor or subcontractor shall file a police or security agency report and file charges against the Member.

3) Member is disruptive to Contractor operations, in general.

4) Member habitually uses providers not affiliated with Contractor for non-Emergency Services without required authorizations (causing Contractor to be subjected to repeated provider demands for payment for those services or other demonstrable degradation in Contractor's relations with community providers).

5) Member has allowed the fraudulent use of Medi-Cal coverage under the plan, which includes allowing others to use the Member's plan identification card to receive services from Contractor.

C. A Member's failure to follow prescribed treatment (including failure to keep established medical appointments) shall not, in and of itself, be good cause for the approval by CDHS of a Contractor-initiated Disenrollment request unless Contractor can demonstrate to CDHS that, as a result of the failure, Contractor is exposed to a substantially greater and unforeseeable risk than that otherwise contemplated under the Contract and rate-setting assumptions.

D. The problem resolution attempted prior to a Contractor-initiated Disenrollment described in paragraph B, must be documented by Contractor. A formal procedure for Contractor-initiated Disenrollments shall be established by Contractor and approved by CDHS. As part of the procedure, the Member shall be notified in writing by Contractor of the intent to disenroll the Member for cause and allowed a period of no less than 20 calendar days to respond to the proposed action.

1) Contractor must submit a written request for Disenrollment and the documentation supporting the request to CDHS for approval. The supporting documentation must establish the pattern of behavior and Contractor's efforts to resolve the problem. CDHS shall review the request and render a decision in writing within ten (10) Working days of receipt of a Contractor request and necessary documentation. If the Contractor-initiated request for Disenrollment is approved by CDHS, CDHS shall submit the Disenrollment request to the enrollment contractor for processing. Contractor shall be notified by CDHS of the decision, and if the request is granted, shall be notified by the enrollment contractor of the effective date of the Disenrollment. Contractor shall notify the Member of the Disenrollment for cause if CDHS grants the Contractor-initiated request for Disenrollment.

2) Contractor shall continue to provide Covered Services to the Member until the effective date of the Disenrollment.

E. Except as provided in paragraph A, subparagraph 6, enrollment shall cease no later than midnight on the last day of the first calendar month after the Member's Disenrollment request and all required supporting documentation are received by CDHS. On the first day after enrollment ceases, Contractor is relieved of all obligations to provide Covered Services to the Member under the terms of this Contract. Contractor agrees in turn to return to CDHS any capitation payment forwarded to Contractor for persons no longer enrolled under this Contract.

F. Contractor shall implement and maintain procedures to ensure that all Members requesting Disenrollment or information regarding the Disenrollment process are immediately referred to the enrollment contractor.

REPORTING REQUIREMENTS

Contract Section	Requirement	Frequency
Exhibit A - SCOPE OF WORK		
Attachment 1 ORGANIZATION AND ADMINISTRATION OF THE PLAN		
2. A. Key Personnel (Disclosure Form)	Key Personnel (Disclosure Form)	Annually
Attachment 2 FINANCIAL INFORMATION		
2. Financial Audit Reports B. 1) **or** B. 2)	Annual certified Financial Statements and DMHC required reporting forms **or** Financial Statement	Annually
2. Financial Audit Reports B. 2)	Quarterly Financial Reports	Quarterly
3. Monthly Financial Statements	Monthly Financial Statements (If applicable)	Monthly
Attachment 3 MANAGEMENT INFORMATION SYSTEM		
2. Encounter Data Submittal 3rd paragraph	Encounter Data Submittal	Monthly
Attachment 4 QUALITY IMPROVEMENT SYSTEM (QIS)		
4. Quality Improvement Committee 3rd paragraph	Quality Improvement Committee meeting minutes	Quarterly
8. Quality Improvement Annual Report	Quality Improvement Annual Report	Annually
9. External Quality Review Requirements A. External Accountability Set (EAS) Performance Measures 2) b)	EAS Performance Measurement Rates	Annually
10. Site Review E. Data Submission	Site Review Data	Semi-Annually
Attachment 6 PROVIDER NETWORK		
10. Provider Network Report	Provider Network Report	Quarterly
11. Plan Subcontractors	Plan Subcontractors Report	Quarterly
Attachment 9 ACCESS AND AVAILABILITY		
12. Cultural and Linguistic Program C. Group Needs Assessment 4)	Group Needs Assessment Summary Report	Every 5 years

Contract Section	Requirement	Frequency
Attachment 10 SCOPE OF SERVICES		
4. Services for Members under Twenty-One(21) Years of Age B. Children's Preventive Services 5)	Confidential Screening/Billing Report Form, PM 160-PHP	Monthly
7. Services for All Members F. Pharmaceutical Services and Provision of Prescribed Drugs 2)	Report of Changes to the Formulary	Annually
Attachment 12 LOCAL HEALTH DEPARTMENT COORDINATION		
4. MOU Monthly Report	Local Health Department - MOU's Local Mental Health - - MOU's (If deemed necessary)	Monthly
Attachment 13 MEMBER SERVICES		
3. Call Center Report	Call Center Report	Quarterly
4. Written Member Information B.	Member Services Guide	Annually
Attachment 14 MEMBER GRIEVANCE SYSTEM		
3. Grievance Log and Quarterly Grievance Report	Grievance Report	Quarterly
Attachment 15 MARKETING		
3. Marketing Plan A.	Marketing Plan	Annually
Attachment 16 ENROLLMENTS AND DISENROLLMENTS		
1. Enrollment Program (Policy Letter 00-02)	Provider Directory	Semi-Annually
Exhibit B - BUDGET DETAIL AND PAYMENT PROVISIONS		
12. Payment of Aids Beneficiary Rates A. Compensation at the AIDS Beneficiary Rate (ABR) 1) c)	AIDS Beneficiaries Rate (ABR) Invoice	Monthly

IMPLEMENTATION PLAN AND DELIVERABLES

The Implementation Plan and Deliverables section describes CDHS requirements for specific deliverables, activities, and timeframes that the Contractor must complete during the Implementation Period before beginning Operations.

Once the Contract is awarded, the Contractor has 15 calendar days after they sign the Contract to submit a Workplan for each county that describes in detail how and when the Contractor will submit and complete the deliverables to CDHS in accordance with the Implementation Plan and Deliverables section. The Contractor's Workplan(s) will include a timetable to accomplish the activities to assure timely start-up of operations and contingency plans in the event of implementation delays.

The Implementation Period begins with the effective date of the Contract and extends to the beginning of the Operations Period (approximately 6 months after the effective date of the Contract). The Operations Period is the period of time beginning with the effective date of the first month of operations and continues on through the last month of capitation and services to Members.

The Contractor's Workplan(s) will identify all of the deliverables, milestones, and timeframes to achieve an orderly sequence of events that will lead to compliance with all contract requirements. CDHS will review and approve each of the Workplan(s). However, Contractor shall not delay the submission of deliverables required in the Workplan(s) while waiting for CDHS approval of previously submitted deliverables required by the Workplan(s). Contractor will continue to submit deliverables based on the milestones and timeframes set forth in the approved CDHS Workplan(s). In the event the Contractor fails to submit all deliverables in accordance with the milestones and timeframes in the approved CDHS Workplan(s), CDHS may impose Liquidated Damages in accordance with Exhibit E, Attachment 2 – Program Terms and Conditions, provision 17, Liquidated Damages Provisions.

In the event that this section omits a deliverable required by the Contract, the Contractor will still be responsible to assure that all contract requirements are met. Upon successful completion of the Implementation Plan and Deliverables section requirements, CDHS will authorize, in writing, that the Contractor may begin the Operations Period.

Knox-Keene Licensure

If not currently licensed to operate in awarded service area, a complete material modification to operate in the service area must be submitted to the DMHC within 30 working days of award of contract. Submit proof of the material modification submission to CDHS concurrently. Operation shall not begin until the material modification is approved by DMHC. Contractor shall submit a copy of their Knox-Keene license.

1. Organization and Administration of Plan

A. Submit documentation of employees (current and former State employees) who may present a conflict of interest.

B. Submit a complete organizational chart.

C. If the Contractor is a subsidiary organization, submit an attestation by the parent organization that this Contract will be a high priority to the parent organization.

D. Submit an attestation that the medical decisions made by the medical director will not be unduly influenced by fiscal or administrative management.

E. Submit policies and procedures describing the representation and participation of Medi-Cal Members on Contractor's Public Policy Advisory Committee.

F. Submit the following Knox-Keene license exhibits and forms reflecting current operation status:

1) Type of Organization: Submit the following applicable exhibits and forms as appropriate for its type of organization and administration of the health plan.

i. Corporation: Exhibits F-1-a-i through F-1-a-iii and Corporation Information Form, Form HP 1300.51-A. (See Appendix 8 of the Central Valley Counties RFP)

ii. Partnership: Exhibits F-1-b-i and F-1-b-ii and Partnership Information Form, Form HP 1300.51-B. (See Appendix 9 of the Central Valley Counties RFP)

iii. Sole Proprietorship: Exhibit F-1-c and Sole Proprietorship Information Form, Form HP 1300.51-C. (See Appendix 10 of the Central Valley Counties RFP)

iv. Other Organization: Exhibits F-1-d and F-1-d-ii, and Information Form for other than Corporations, Partnerships, and Sole Proprietorships, Form HP 1300.51-D.

v. Public Agency: Exhibits F-1-e-I through F-1-e-iii.

Title 28, CCR, Section 1300.51(d)(F)(1)(a) through (e)

2) Exhibit F-1-f: Individual Information Sheet (Form HP 1300.51.1) for each person named in response to item 1) above. (See Appendix 11 of the Central Valley Counties RFP) Title 28, CCR, Section 1300.51(d)(F)(1)(f)

3) Exhibits F-2-a and F-2-b: contracts with Affiliated person, Principal Creditors and Providers of Administrative Services.

4) Exhibit F-3 Other Controlling Persons. Title 28, CCR, Section 1300.51(d)(F)

5) In addition to Exhibits F, Contractor shall demonstrate compliance with requirements of Title 22, CCR, Sections 53874 and 53600. Identify any individual named in this item b. that was an employee of the State of California in the past 12 months. Describe their job position and function while a State employee.

G. Submit Exhibit M-2: Statements as to each person identified in Section L. Technical Proposal Requirements, provision 1. Organization and Administration, a. 2) (Exhibit L) and 3). (Exhibit M-1)

Title 28, CCR, Section 1300.51(d)(M)(2)

H. Submit Exhibits N-1 and N-2: Contracts for Administrative Services.

Title 28, CCR, Section 1300.51(d)(N)(2)

I. If, within the last five (5) years, Contractor has had a contract terminated or not renewed for poor performance, nonperformance, or any other reason, Contractor shall submit a summary of the circumstances surrounding the termination or non-renewal. Describe the parties involved, including address(es) and telephone number(s). Describe the Contractor's corrective actions to prevent future occurrences of any problems identified.

J. Contractor shall describe provisions and arrangements, existing, and proposed, for including Medi-Cal Members in their Public Policy Advisory Committee development process. Identify the composition and meeting frequency of any committee participating in establishing the Contractor's public policy. Describe the frequency of the committee's report submission to the Contractor's Governing Body, and the Governing body, and the Governing Body's process for handling reports and recommendations after receipt.

2. Financial Information

All submitted financial information must adhere to Generally Accepted Accounting Principles (GAAP), unless otherwise noted.

Note: Where Knox-Keene license exhibits are requested, the descriptions of exhibit content may have been amended to address Medi-Cal program needs or industry terminology.

A. Submit most recent audited annual financial reports

B. Submit quarterly financial statements with the most recent quarter prior to execution of the Contract.

C. Submit the following Knox-Keene license exhibits reflecting projected financial viability:

1) Exhibit HH-1

2) Exhibit HH-2

(Title 28, CCR, Section 1300.76)

3) In addition to Exhibit HH-2, include projected Medi-Cal enrollment for each month and cumulative Member months for quarterly financial projections.

D. Submit Knox-Keene license Exhibit HH-6. Include the following:

1) Exhibit HH-6-a

2) Exhibit HH-6-b

3) Exhibit HH-6-c

4) Exhibit HH-6-d

5) Exhibit HH-6-e

Title 28, CCR, Section 1300.51(d)(HH)

E. Describe any risk sharing or incentive arrangements. Explain any intent to enter into a stop loss option with CDHS. Also describe any reinsurance and risk-sharing arrangements with any subcontractors shown in this Proposal. Submit copies of all policies and agreements. For regulations related to Assumption of Financial Risk and Reinsurance, see Title 22, CCR, Sections 53863 and 53868.

F. Fiscal Arrangements: Submit the following Knox-Keene license exhibits reflecting current operation status:

1) Exhibit II-1

2) Exhibit II-2

3) Exhibit II-3

Title 28, CCR, Section 1300.51(d)(II)

G. Describe systems for ensuring that subcontractors, who are at risk for providing services to Medi-Cal Members, as well as any obligations or requirements delegated pursuant to a Subcontract, have the administrative and financial capacity to meet its contractual obligations.
Title 28, CCR Section 1300.70(b)(2)(H)1. Title 22, CCR, Section 53250.

H. Submit financial policies that relate to Contractor's systems for budgeting and operations forecasting. The policies should include comparison of actual operations to budgeted operations, timelines used in the budgetary process, number of years prospective forecasting is performed, and variance analysis and follow-up procedures.

I. Describe process to ensure timely filing of required financial reports. The description should include mechanisms for systems oversight for generating financial and operational information, including a tracking system with lead times and due dates for quarterly and annual reports. Describe how this process coincides with the organization's management information system. Additionally, Contractor shall describe how it will comply with the Administrative cost requirements in Title 22, CCR, Section 53864(b).

J. Submit policies and procedures for a system to evaluate and monitor the financial viability of all subcontracting entities.

3. Management Information System

Note: Contractor's readiness for operation will be reviewed against the "Model MIS Guidelines" (Appendix 4 of the Central Valley Counties RFP). See Appendix 6 of the Central Valley Counties RFP for additional information.

A. Submit a completed MCO Baseline Assessment Form (see Appendix 5 of the Central Valley Counties RFP).

B. If procuring a new MIS or modifying a current system, Contractor shall provide a detailed implementation plan that includes:

1) Outline of the tasks required;

2) The major milestones;

3) The responsible party for all related tasks;

The implementation plan must also include:

1) A full description of the acquisition of software and hardware, including the schedule for implementation;

2) Full documentation of support for software and hardware by the manufacturer or other contracted party;

3) System test flows through a documented process that has specific control points where evaluation data can be utilized to correct any deviations from expected results;

4) Documentation of system changes related to Exhibit G, Health Insurance Portability and Accountability Act (HIPAA) requirements.

C. Submit a detailed description of how Proposer will monitor the flow of encounter data from provider level to the organization.

D. Submit Encounter data test tape produced from State supplied data.

E. Submit policies and procedures for the complete, accurate, and timely submission of Encounter-level data.

F. Submit a work plan for compliance with Exhibit G, Health Insurance Portability and Accountability Act (HIPAA).

G. Submit the data security, backup, or other data disaster processes used in the event of a MIS failure.

H. Submit a detailed description of the proposed and/or existing MIS as it relates to the following subsystems;

1) Financial

2) Member/Eligibility

3) Provider

4) Encounter/Claims

5) Quality Management/Utilization

I. Submit a sample and description of the following reports generated by the MIS;

1) Member roster

2) Provider Listing

3) Capitation payments

4) Cost and Utilization

5) System edits/audits

6) Claims payment status/processing

7) Quality Assurance

8) Utilization

9) Monitoring of Complaints

4. Quality Improvement System

A. Submit a flow chart and/or organization chart identifying all components of the QIS and who is involved and responsible for each activity.

B. Submit policies that specify the responsibility of the Governing Body in the QIS.

C. Submit policies for the QI Committee including membership, activities, roles and responsibilities.

D. Submit procedures outlining how providers will be kept informed of the written QIS, its activities and outcomes.

E. Submit policies and procedures related to the delegation of the QIS activities.

F. Submit boilerplate Subcontract language showing accountability of delegated QIS functions and responsibilities.

G. Submit a written description of the QIS.

H. Policies and procedures to address how the Contractor will meet the requirements of:

1) External Accountability Set (EAS) Performance Measures

2) Quality Improvement Projects

3) Consumer Satisfaction Survey

I. Submit policies and procedures for performance of Primary Care Provider site reviews.

J. Submit a list of sites to be reviewed prior to initiating plan operation

K. Submit the aggregate results of pre-operational site review to CDHS at least six (6) weeks prior to Plan operation. The aggregate results shall include all data elements defined by CDHS.

L. Submit policies and procedures for reporting any disease or condition to public health authorities.

M. Submit policies and procedures for credentialing and re-credentialing.

N. Submit policies and procedures for appropriate handling and maintenance of medical records regardless of form (electronic, paper, etc.).

5. Utilization Management

A. Submit written description of UM program that describes appropriate processes to be used to review and approve the provision of medical services.

B. Submit policies and procedures for pre-authorization, concurrent review, and retrospective review.

C. Submit a list of services requiring prior authorization and the utilization review criteria.

D. Submit policies and procedures for the utilization review appeals process for providers and members.

E. Submit policies and procedures that specify timeframes for medical authorization.

F. Submit policies and procedures to detect both under- and over-utilization of health care services.

G. Submit policies and procedures showing how delegated activities will be regularly evaluated for compliance with Contract requirements and, that any issues identified through the UM program are appropriately resolved, and that UM activities are properly documented and reported.

6. Provider Network

A. Submit complete provider network showing the ability to serve sixty percent (60%) of the Eligible Beneficiaries in the county pursuant to the Contract.

B. Submit policies and procedures describing how Contractor will monitor provider to patient ratios to ensure they are within specified standards.

C. Submit policies and procedures regarding physician supervision of non-physician medical practitioners.

D. Submit policies and procedures for providing emergency services.

E. Submit a complete list of specialists by type within the Contractor's network.

F. Submit policies and procedures for how Contractor will meet Federal requirements for access and reimbursement for in-Plan and/or out-of-Plan FQHC services.

G. Submit a GeoAccess report (or similar) showing that the proposed provider network meets the appropriate time and distance standards set forth in the Contract.

H. Submit a policy regarding the availability of a health plan physician 24-hours a day, 7-days a week, and procedures for communicating with emergency room personnel.

I. Submit a report containing the names of all subcontracting provider groups (see Exhibit A, Attachment 6, provision 11).

J. Submit an analysis demonstrating the ability of the Contractor's provider network to meet the ethnic, cultural, and linguistic needs of the Contractor's Members.

K. Submit all boilerplate Subcontracts.

L. Submit policies and procedures that establish Traditional and Safety-Net Provider participation standards.

M. Submit an attestation as to the percentage of Traditional and Safety-Net Providers in the Contractor's network and agreement to maintain that percentage.

7. Provider Relations

A. Submit policies and procedures for provider grievances.

B. Submit a written description of how Contractor will communicate the provider grievance process to subcontracting and non-contracting providers.

C. Submit protocols for payment and communication with non-contracting providers.

D. Submit copy of provider manual.

E. Submit a schedule of provider training to be conducted during year one of operation. Include date, time and location, and complete curriculum.

F. Submit protocols for communicating and interacting with all emergency departments in the Service Area.

8. Provider Compensation Arrangements

A. Submit policies and procedures regarding timing of capitation payments to primary care providers or clinics.

B. Submit description of any physician incentive plans.

C. Submit policies and procedures for processing and payment of claims.

D. Submit policies regarding the prohibition of a claim or demand for services provided under the Medi-Cal managed care contract, to any Medi-Cal member.

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

F. Submit policies and procedures for the reimbursement of Non-Contracting Certified Nurse Midwives (CNM) and Certified Nurse Practitioners (CNP).

G. Submit policies and procedures for the reimbursement to local health department and non-contracting family planning providers for the provision of family planning service, STD episode, and HIV testing and counseling.

H. Submit policies and procedures for the reimbursement of immunization services to local health department.

I. Submit policies and procedures regarding payment to non-contracting emergency services providers. Include schedule of per diem rates and/or Fee-for-service rates for each of the following provider types;

1) Primary Care Providers

2) Medical Groups and Independent Practice Associations

3) Specialists

4) Hospitals

5) Pharmacies

9. Access and Availability

A. Submit policies and procedures that include standards for:

1) Appointment scheduling

2) Routine specialty referral

3) First prenatal visit

4) Waiting times

5) Urgent care

6) After-hours calls

7) Unusual specialty services

B. Submit policies and procedures for the timely referral and coordination of Covered Service to which the Contractor or subcontractor has objections to perform or otherwise support.

C. Submit policies and procedures for standing referrals.

D. Submit policies and procedures regarding 24-hr./day access without prior authorization, follow-up and coordination of emergency care services.

E. Submit policies and procedures regarding access to Nurse Midwives and Nurse Practitioners.

F. Submit applicable section of Member Services Guide stating Member's right to access family planning services without prior authorization.

G. Submit policies and procedures for the provision of and access to:

1) Family planning services

2) Sexually transmitted disease treatment

3) HIV testing and counseling services

4) Pregnancy termination

5) Minor consent services

6) Immunizations

H. Submit policies and procedures regarding access for disabled members pursuant to the Americans with Disabilities Act of 1990.

I. Submit policies and procedures regarding Contractor and subcontractor compliance with the Civil Rights Act of 1964.

J. Submit a written description of the Cultural and Linguistic Services Program.

K. Submit a timeline and work plan for the development and performance of a Group Needs Assessment.

L. Submit policies and procedures for providing cultural competency, sensitivity or diversity training for staff, providers, and subcontractors.

M. Submit policies and procedures for monitoring and evaluation of the Cultural and Linguistic Services Program.

N. Submit policies and procedures for the provision of 24-hour interpreter services at all provider sites.

O. Submit policies and procedures describing the membership of the Community Advisory Committee (CAC) and how the Contractor will ensure the CAC will be involved in appropriate policy decisions.

10. Scope of Services

A. Submit policies and procedures for providing Initial Health Assessments (IHA) for adults and children. Include components (including Behavioral Health Assessment) of the IHA.

B. Submit policies and procedures, including standards, for the provision of the following services for Members under 21 years of age:

1) Children’s preventive services
2) Immunizations
3) Blood Lead screens
4) Screening for Chlamydia
5) EPSDT supplemental services

C. Submit policies and procedures for the provision of adult preventive services, including immunization.

D. Submit policies and procedures for the provision of services to pregnant women, including:

1) Prenatal care
2) Use of American College of Obstetricians and Gynecologists (ACOG) standards and guidelines
3) Comprehensive risk assessment tool for all pregnant women
4) Referral to specialists

E. Submit a list of appropriate hospitals available within the provider network that provide necessary high-risk pregnancy services.

F. Provide a detailed description of health education system including policies and procedures regarding delivery of services, administration and oversight.

G. Provide a list and schedule of all health education classes and/or programs.

H. Submit policies and procedures for the provision of:

1) Hospice care

2) Vision care – Lenses

3) Mental health services

4) Tuberculosis services

I. Submit standards and guidelines for the provision of Pharmaceutical services and prescribed Drugs.

J. Submit a complete drug formulary.

K. Submit a process for review of drug formulary.

L. Submit policies and procedures for conducting drug utilization reviews.

11. Case Management and Coordination of Care

A. Submit procedures for monitoring the coordination of care provided to Members.

B. Submit policies and procedures for coordinating care of Members who are receiving services from a targeted case management provider.

C. Submit policies and procedures for the referral of Members under the age of 21 years that require case management services.

D. Submit policies and procedures for a disease management program. Include policies and procedures for identification and referral of Members eligible to participate in the disease management program.

E. Submit policies and procedures for referral and coordination of care for Members in need of Specialty Mental Health Services from the local Medi-Cal mental health plan or other community resources.

F. Submit policies and procedures for resolving disputes between Contractor and the local mental health plan.

G. Submit policies and procedures for identification, referral and coordination of care for Members requiring alcohol or substance abuse treatment services from both within and, if necessary, outside the Contractor's Service Area.

H. Submit a detailed description of Contractor's program for Children with Special Health Care Needs (CSHCN).

I. Submit policies and procedures for identifying and referring children with CCS-eligible conditions to the local CCS program.

J. Submit policies and procedures for the identification, referral and coordination of care for Members with developmental disabilities in need of non-medical services from the local Regional Center and the DDS-administered Home and Community Based Waiver program.

K. Submit policies and procedures for the identification, referral and coordination of care for Members at risk of developmental delay and eligible to receive services from the local Early Start program.

L. Submit policies and procedures for case management coordination of care of LEA services, including primary care physician involvement in the development of the Member's Individual Education Plan or Individual Family Service Plan.

M. Submit policies and procedures for case management coordination of care of Members who receive services through local school districts or school sites.

N. Submit a description of the cooperative arrangement Contractor has with the local school districts, including the Subcontracts or written protocols/guidelines, if applicable.

O. Submit policies and procedures describing the cooperative arrangement that Contractor has regarding care for children in Foster Care.

P. Submit policies and procedures for identification and referral of Members eligible to participate in the HIV/AIDS Home and Community Based Waiver Program.

Q. Submit policies and procedures for the provision of dental screening and covered medical services related to dental services.

R. Submit policies and procedures for coordination of care and case management of Members with the LHD TB Control Officer.

S. Submit policies and procedures for the assessment and referral of Members with active TB and at risk of non-compliance with TB drug therapy to the LHD.

T. Procedures to identify and refer eligible Members for WIC services.

U. Submit policies and procedures for the assessment and subsequent disenrollment of Members eligible for the following services:

1) Long-term care
2) Major organ transplants
3) Waiver programs

12. Local Health Department Coordination

A. Submit executed Subcontracts or documentation substantiating Contractor's efforts to enter into Subcontracts with the LHD for the following public health services:

1) Family planning services
2) STD services
3) HIV testing and counseling
4) Immunizations

B. Submit executed Subcontracts, Memoranda of Understanding, or documentation substantiating Contractor's efforts to negotiate an agreement with the following programs or agencies:

1) California Children Services (CCS)
2) Maternal and Child Health
3) Child Health and Disability Prevention Program (CHDP)
4) Tuberculosis Direct Observed Therapy
5) Women, Infants, and Children Supplemental Nutrition Program (WIC)
6) Regional centers for services for persons with developmental disabilities.

C. Executed MOU or documentation substantiating Contractor's efforts to negotiate a MOU with the local mental health plan.

13. Member Services

A. Submit policies and procedures that address Member's rights and responsibilities. Include method for communicating them to both Members and providers.

B. Submit policies addressing Member's rights to confidentiality of medical information. Include procedures for release of medical information.

C. Submit policies and procedures for addressing advance directives.

D. Submit policies and procedures for the training of Member Services staff.

E. Submit policies and procedures regarding the development content and distribution of Member information. Address appropriate reading level and translation of materials.

F. Submit final draft of Member Identification Card and Member Services Guide.

G. Submit policies and procedures for notifying Members of changes in availability or location of Covered Services.

H. Submit policies and procedures for Member selection of a primary care physician or non-physician medical practitioner.

I. Submit policies and procedures for Member assignment to a primary care physician.

J. Submit policies and procedures for notifying primary care provider that a member has selected or been assigned to the provider within 7-days.

K. Submit policies and procedures demonstrating how, upon entry into the Contractor's network, the relationship between traditional and safety-net providers and their patients is not disrupted, to the maximum extent possible.

L. Submit policies and procedures for notifying Members for denial, deferral, or modification of requests for Prior Authorization.

14. Member Grievance System

A. Submit policies and procedures relating to Contractor's Member Grievance system.

B. Submit policies and procedures for Contractor's oversight of the Member Grievance system for the receipts, processing and distribution including the expedited review of grievances. Please include a flow chart to demonstrate the process.

C. Submit format for Quarterly Grievance Log and Report.

15. Marketing

A. Submit policies and procedures for training and certification of marketing representatives.

B. Submit a description of training program, including the marketing representative's training/certification manual.

C. Submit Contractor's marketing plan.

D. Submit copy of boilerplate request form used to obtain CDHS approval of participation in a marketing event.

16. Enrollments and Disenrollments

A. Submit policies and procedures for how Contractor will update and maintain accurate information on its contracting providers.

B. Submit policies and procedures for how Contractor will access and utilize enrollment data from CDHS.

C. Submit policies and procedures relating to Member disenrollment, including, Contractor-initiated disenrollment.

Exhibit B
Budget Detail and Payment Provisions

Table of Contents

Exhibit B
Budget Detail and Payment Provisions

1. Budget Contingency Clause

A. It is mutually agreed that if the Budget Act of the current year and/or any subsequent years covered under this Agreement does not appropriate sufficient funds for the program, this Agreement shall be of no further force and effect. In this event, the State shall have no liability to pay any funds whatsoever to Contractor or to furnish any other considerations under this Agreement and Contractor shall not be obligated to perform any provisions of this Agreement.

B. If funding for any fiscal year is reduced or deleted by the Budget Act for purposes of this program, the State shall have the option to either cancel this Agreement with no liability occurring to the State, or offer an agreement amendment to Contractor to reflect the reduced amount.

2. Amounts Payable

A. The amounts payable under this agreement shall not exceed:

1) [ILLEGIBLE] for the 2006/07 Fiscal Year ending June 30, 2007.

2) [ILLEGIBLE] for the 2007/08 Fiscal Year ending June 30, 2008.

3) [ILLEGIBLE] for the 2008/09 Fiscal Year ending June 30, 2009.

B. Reimbursement shall be made for allowable expenses up to the amount annually encumbered commensurate with the state fiscal year in which services are performed and/or goods are received.

3. Contractor Risk In Providing Services

Contractor will assume the total risk of providing the Covered Services on the basis of the periodic capitation payment for each Member, except as otherwise allowed in this Contract. Any monies not expended by the Contractor after having fulfilled obligations under this Contract will be retained by the Contractor.

4. Capitation Rates

A. CDHS shall remit to Contractor a capitation payment each month for each Medi-Cal Member that appears on the approved list of Members supplied to Contractor by CDHS. The capitation rate shall be the amount specified below. The payment period for health care services shall commence on the first day of operations, as determined by CDHS. Capitation payments shall be made in accordance with the following schedule of capitation payment rates at the end of the month:

Exhibit B
Budget Detail and Payment Provisions

MEDI-CAL ONLY

For the period effective 04/01/07		Riverside*
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 45, 47, 54, 59, 72, 82, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R	
Disabled	20, 24, 26, 36, 60, 64, 66, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6V, 2E	
Aged	10, 14, 16, 1E, 1H	
Adult	86	
Aids Beneficiary		
Breast and Cervical Cancer Treatment Program	0N, 0P	

MEDI-CAL ONLY

For the period effective 04/01/07		San Bernardino*
Groups	**Aid Codes**	**Rate**
Family	01, 0A, 02, 03, 04, 08, 30, 32, 33, 34, 35, 38, 39, 40, 42, 45, 47, 54, 59, 72, 82, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P, 3R, 3U, 3W, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 5X, 7A, 7J, 7X, 8P, 8R	
Disabled	20, 24, 26, 36, 60, 64, 66, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6V, 2E	
Aged	10, 14, 16, 1E, 1H	
Adult	86	
Aids Beneficiary		
Breast and Cervical Cancer Treatment Program	0N, 0P	

Exhibit B
Budget Detail and Payment Provisions

DUAL ELIGIBLES – MEDI-CAL AND MEDICARE (Part D)

For the period effective 04/01/07		Riverside*
Groups	**Aid Codes**	**Rate**
Disabled Duals	20, 24, 26, 36, 60, 64, 66, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6V, 2E	
Aged Duals	10, 14, 16, 1E, 1H	
Aids Beneficiary Duals		

DUAL ELIGIBLES – MEDI-CAL AND MEDICARE (Part D)

For the period effective 04/01/07		San Bernardino*
Groups	**Aid Codes**	**Rate**
Disabled Duals	20, 24, 26, 36, 60, 64, 66, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6V, 2E	
Aged Duals	10, 14, 16, 1E, 1H	
Aids Beneficiary Duals		

* The rates for the 2006/07 Rate Period have not been developed as of the effective date of this contract. Reimbursement for Riverside and San Bernardino counties which become operational April 1, 2007 will be reimbursed at the above 1/1/06 – 9/30/06 rates from the 2005/06 rate period until the 2006/07 Rate Period rates are implemented via a contract Change Order or Amendment.

B. If CDHS creates a new aid code that is split or derived from an existing aid code covered under this Contract, and the aid code has a neutral revenue effect for the Contractor, then the split aid code will automatically be included in the same aid code rate group as the original aid code covered under this Contract Contractor agrees to continue providing Covered Services to the Members at the monthly capitation rate specified for the original aid code CDHS shall confirm all aid code splits, and the rates of payment for such new aid codes, in writing to Contractor as soon as practicable after such aid code splits occur.

C. Pursuant to Title 42, Code of Federal Regulations, Section 438.6(c)(2)(ii), the actuarial basis for the computation of the capitation payment rates shall be set forth in CDHS' most recent version of the annually-published Rate Manual for the rate period that is identified in the Capitation Rate Sheets attached hereto in Exhibit B, Attachment 1. Said Rate Manual is incorporated by reference in Exhibit E, Provision 1.

5. Capitation Rates Constitute Payment In Full

Capitation rates for each rate period, as calculated by CDHS, are prospective rates and constitute payment in full, subject to any stop loss reinsurance provisions, on behalf of a Member for all Covered Services required by such Member and for all Administrative Costs incurred by the Contractor in providing or arranging for such services. CDHS is not responsible for making payments for recoupment of losses.

6. Determination Of Rates

A. CDHS shall determine the capitation rates for the initial period April 1, 2007 or the Contract effective date of operations, through September 30, 2007. Subsequent to September 30, 2007 and through the duration of the Contract, CDHS shall make an annual redetermination of rates in accordance with Title 22, CCR, Section 53869 for each rate year defined as the 12-month period from October 1, through September 30. CDHS reserves the right to establish rates on an actuarial basis for each rate year. All payments and rate adjustments are subject to appropriations of funds by the Legislature and the Department of Finance approval. Further, all payments are subject to the availability of Federal congressional appropriation of funds.

B. Once CDHS establishes rates on an actuarially sound basis, it shall determine whether the rates shall be increased, decreased, or remain the same. If it is determined by CDHS that Contractor's capitation rates shall be increased or decreased, the increase or decrease shall be effectuated through a change order to this Contract in accordance with the provisions of Exhibit E, Attachment 2, provision 4. Change Requirements, subject to the following provisions:

1) The change order shall be effective as of October 1 of each year covered by this Contract.

2) In the event there is any delay in a determination to increase or decrease capitation rates, so that a change order may not be processed in time to permit payment of new rates commencing

October 1, the payment to Contractor shall continue at the rates then in effect. Those continued payments shall constitute interim payment only. Upon final approval of the change order providing for the rate change, CDHS shall make retroactive adjustments for those months for which interim payment was made.

3) By accepting payment of new annual rates prior to full approval by all control agencies of the change order to this Contract implementing such new rates, Contractor stipulates to a confession of judgment for any amounts received in excess of the final approved rate. If the final approved rate differs from the rates established by CDHS or agreed upon by Contractor and CDHS:

   a) Any underpayment by the State shall be paid to Contractor within 30 calendar days after final approval of the new rates.

   b) Any overpayment to Contractor shall be recaptured by the State's withholding the amount due from Contractor's next capitation check. If the amount to be withheld from that capitation check exceeds 25 percent of the capitation payment for that month, amounts up to 25 percent shall be withheld from successive capitation payments until the overpayment is fully recovered by the State.

4) If mutual agreement between CDHS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 2007 resulting from a rate change pursuant to this provision 6 or provision 7 below, Contractor shall retain the right to terminate the Contract, but no earlier than September 30, 2008. Notification of intent to terminate a Contract shall be in writing and provided to CDHS at least nine months prior to the effective date of termination, subject to any earlier termination date negotiated in accordance with Exhibit E, Attachment 2, provision 14, regarding Termination – Contractor. CDHS shall pay the capitation rates last offered for that rate period until the Contract is terminated.

5) CDHS shall make every effort to notify and consult with Contractor regarding proposed redetermination of rates pursuant to this section or provision 7, below at the earliest possible time prior to implementation of the new rate.

7. Redetermination Of Rates - Obligation Changes

The capitation rates may be adjusted during the rate year to provide for a change in obligations that results in an increase or decrease of more than one percent of

cost (as defined in Title 22, CCR, Section 53869) to the Contractor. Any adjustments shall be effectuated through a change order to the Contract subject to the following provisions:

A. The change order shall be effective as of the first day of the month in which the change in obligations is effective, as determined by CDHS.

B. In the event CDHS is unable to process the change order in time to permit payment of the adjusted rates as of the month in which the change in obligations is effective, payment to Contractor shall continue at the rates then in effect. Continued payment shall constitute interim payment only. Upon final approval of the change order providing for the change in obligations, CDHS shall make adjustments for those months for which interim payment was made.

C. CDHS and Contractor may negotiate an earlier termination date, pursuant to Exhibit E, Attachment 2, provision 14, regarding Termination – Contractor, if a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which Contractor entered into this Contract, such that Contractor can demonstrate to the satisfaction of CDHS that it cannot remain financially solvent until the termination date that would otherwise be established under this provision.

8. Reinsurance

A. Contractor may obtain reinsurance (stop loss coverage) through CDHS or other insurers to ensure maintenance of adequate capital by Contractor for the cost of providing Covered Services under this Contract. Reinsurance will not limit the Contractor's liability below $5,000 per Member for any 12-month period as specified by CDHS. The Contractor may obtain reinsurance for both of the factors described in Title 22, CCR, Section 53252 (a)(2)(A) & (B).

B. If Contractor selects State reinsurance, Contractor will submit a reinsurance claim form along with copies of the actual claims upon exceeding the reinsurance threshold. As part of the processing, actual claims are priced to appropriate Medi-Cal rates and the appropriate amount in excess of the reinsurance threshold is remitted to the Contractor by CDHS.

1) Claims submitted will not be paid by CDHS unless received by CDHS not later than the last day of the sixth month following the end of the 12-month contract period in which they were incurred.

2) The time specified for submission of claims may be extended for a period not to exceed one year upon a finding of "good cause" by the Director in the following circumstances:

   a) Where the claim involves health coverage, other than Medi-Cal, and the delay is necessary to permit the Contractor to obtain payment, partial payment, or proof of non-liability of that other health coverage.

   b) Where the claim submission was delayed due to eligibility certification or determination by the State or county.

   c) Where there was substantial interference with claim submission due to damage to, or destruction of, the Contractor's (or subcontractor's) business office or records by a natural disaster, including fire, flood or earthquake, or other similar circumstances.

   d) Where delay in claims submission was due to other circumstances that are clearly beyond the control of the Contractor. Circumstances that will not be considered beyond the control of the Contractor include, but are not limited to:

      i. Negligence or delay of the Contractor or Contractor's employees, agents, and subcontractors.

      ii. Misunderstanding of or unfamiliarity with Medi-Cal regulations, or the terms of this Contract.

      iii. Illness, absence or other incapacity of a Contractor's employee, agent, or subcontractor responsible for preparation and submission of claims.

      iv. Delays caused by the United States Postal Service or any private delivery service.

9. Catastrophic Coverage Limitation

CDHS may limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to Members, which results from or is greatly aggravated by, a catastrophic occurrence or disaster. Contractor will return a prorated amount of the capitation payment following the CDHS Director's invocation of the catastrophic coverage limitation. The amount returned will be determined by dividing the total capitation payment by the number of days in the month. The amount will be returned to CDHS for each day in the month after the Director has invoked the catastrophic coverage limitation clause.

Exhibit B
Budget Detail and Payment Provisions

10. Financial Performance Guarantee

Contractor shall provide satisfactory evidence of, and maintain Financial Performance Guarantee in, an amount equal to at least one month's capitation payment, in a manner specified by CDHS. At the Contractor's request, and with CDHS approval, Contractor may establish a phase-in schedule to accumulate the required Financial Performance Guarantee. Contractor may elect to satisfy the Financial Performance Guarantee requirement by receiving payment on a post payment basis. The Financial Performance Guarantee shall remain in effect for a period not exceeding 90 calendar days following termination or expiration of this Contract unless CDHS has a financial claim against Contractor. Further rights and obligations of the Contractor and the Department, in regards to the Financial Performance Guarantee, shall be as specified in Title 22, CCR, Section 53865.

11. Recovery Of Capitation Payments

CDHS shall have the right to recover from Contractor amounts paid to Contractor in the following circumstances as specified:

A. If CDHS determines that a Member has either been improperly enrolled due to ineligibility of the Member to enroll in Contractor's plan, residence outside of Contractor's Service Area, or pursuant to Title 22, Section 53891(a)(2), or should have been disenrolled with an effective date in a prior month, CDHS may recover or, upon request by Contractor, CDHS shall recover the capitation payments made to Contractor for the Member and absolve Contractor from all financial and other risk for the provision of services to the Member under the terms of the Contract for the month(s) in question. In such event, Contractor may seek to recover any payments made to providers for Covered Services rendered for the month(s) in question. Contractor shall inform providers that claims for services provided to Members during the month(s) in question shall be paid by CDHS' fiscal intermediary, if the Member is determined eligible for the Medi-Cal program.

Upon request by Contractor, CDHS may allow Contractor to retain the capitation payments made for Members that are eligible to enroll in Contractor's plan, but should have been retroactively disenrolled pursuant to Exhibit A, Attachment 11, provision 17. Excluded Services Requiring Member Disenrollment, or under other circumstances as approved by CDHS. If Contractor retains the capitation payments, Contractor shall provide or arrange and pay for all Medically Necessary Covered Services for the Member, until the Member is disenrolled on a nonretroactive basis pursuant to Exhibit A, Attachment 16, provision 3. Disenrollment.

B. As a result of Contractor's failure to perform contractual responsibilities to comply with mandatory federal Medicaid requirements, the Federal Department of Health and Human Services (DHHS) may disallow Federal Financial Participation (FFP) for payments made by CDHS to Contractor. CDHS may recover the amounts disallowed by DHHS by an offset to the capitation payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, CDHS at its discretion may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months.

C. If CDHS determines that any other erroneous or improper payment not mentioned above has been made to Contractor, CDHS may recover the amounts determined by an offset to the capitation payments made to Contractor. If recovery of the full amount at one time imposes a financial hardship on Contractor, CDHS, at its discretion, may grant a Contractor's request to repay the recoverable amounts in monthly installments over a period of consecutive months not to exceed six (6) months. At least 30 calendar days prior to seeking any such recovery, CDHS shall notify Contractor to explain the improper or erroneous nature of the payment and to describe the recovery process.

12. Payment Of AIDS Beneficiary Rate

A. Compensation at the AIDS Beneficiary Rate (ABR)

Subject to Contractor's compliance with the requirements contained in subparagraph 1. below, Contractor shall be eligible to receive compensation at the ABR for AIDS Beneficiaries. Compensation to Contractor at the ABR for each AIDS Beneficiary shall consist of payment at the ABR less the capitation rate initially paid for the AIDS beneficiary.

1) Compensation at the ABR shall be subject to the conditions listed below. Contractor's failure to comply with any of the conditions listed below for any request for compensation at the ABR on behalf of an individual AIDS Beneficiary for a specific month of Enrollment shall result in CDHS' denial of Contractor's claim for compensation at the ABR for that individual AIDS Beneficiary for that specific month of Enrollment. Contractor may submit a corrected claim, within the timeframes specified in paragraph d below, that complies with all the conditions listed below and CDHS shall reimburse Contractor at the ABR.

Exhibit B
Budget Detail and Payment Provisions

a) The ABR shall be in lieu of any other compensation for an AIDS Beneficiary in any month.

b) For AIDS Beneficiaries, Contractor shall be eligible to receive compensation at the ABR commencing in the month in which a Diagnosis of AIDS is made and recorded, dated and signed by the treating physician in the AIDS Beneficiary's Medical Record.

c) Contractor shall submit an invoice to CDHS by the 25th day of each month for claims for compensation at the ABR for AIDS Beneficiaries. The invoice shall include the following:

   i. A list of all AIDS Beneficiaries identified by Medi-Cal numbers only for whom the Contractor is claiming compensation at the ABR. Member names shall not be used.

   ii. The month(s) and year(s) for which compensation at the ABR is being claimed for each AIDS Beneficiary listed, sorted by month and year of service.

   iii. The capitation rate initially paid for the AIDS Beneficiary for each month being claimed by the Contractor, the ABR being claimed, and the difference between the ABR and the capitation rate initially paid for the AIDS Beneficiary.

   iv. The total amount being claimed on the invoice.

d) Invoices, containing originally submitted claims or corrected claims, for compensation at the ABR for any month of eligibility during the rate year beginning October 1, 2006, and ending September 30, 2007, or any rate year thereafter beginning October 1 and ending September 30, must be submitted by Contractor to CDHS no later than six months following the end of the subject rate year.

Exhibit B
Budget Detail and Payment Provisions

e) Invoices shall include the Agreement Number and shall be submitted to:

California Department of Health Services
Medi-Cal Managed Care Division
Attn: Fiscal Analysis Unit
Mailing Address: See Exhibit A, Scope of Work, provision 4

In addition, invoices shall:

i. Be prepared on company letterhead.

ii. Bear the Contractor's name as shown on the agreement.

iii. Be signed by an authorized official, employee or agent.

2) Contractor shall confirm Medi-Cal eligibility of AIDS Beneficiaries prior to submission of the monthly invoice to CDHS. CDHS may verify the Medi-Cal eligibility of each Member for whom the ABR is claimed and adjust the invoiced amounts to reflect any capitation payments that have been previously made to Contractor for each Member prior to submission of the invoice required under paragraph 1.c above.

3) If CDHS determines that a Member for whom compensation has been paid at the ABR did not meet the definition of an AIDS Beneficiary, in a month for which the ABR was paid, CDHS shall recover any amount improperly paid, by an offset to Contractor's capitation payment, in accordance with provision 11. Recovery of Capitation Payments, paragraph C. CDHS shall give Contractor 30 calendar days prior written notice of any such offset.

B. Prompt Payment Clause

Payment will be made in accordance with, and within the time specified in, Chapter 4.5 (commencing with Section 927), Part 3, Division 3.6, of Title 2 of the Government Code.

Exhibit B
Budget Detail and Payment Provisions

C. Timely Submission of Final Invoice

1) A final undisputed ABR invoice shall be submitted for payment no more than 90 calendar days following the expiration or termination date of this agreement, unless a later or alternate deadline is agreed to in writing by the program contract manager. Said ABR invoice should be clearly marked "Final Invoice - ABR", thus indicating that all payment obligations of the State under this agreement have ceased and that no further payments are due or outstanding.

2) The State may, at its discretion, choose not to honor any delinquent final ABR invoice if the Contractor fails to obtain prior written State approval of an alternate final ABR invoice submission deadline. Written State approval shall be sought from the program contract manager prior to the expiration or termination date of this agreement.

3) The Contractor is hereby advised of its obligation to submit, with the final ABR invoice, a "Contractor's Release (Exhibit F)" acknowledging submission of the final ABR invoice to the State and certifying the approximate percentage amount, if any, of recycled products used in performance of this agreement.

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Exhibit E
Additional Provisions

Table of Contents

Exhibit E
Additional Provisions

1. Additional Incorporated Provisions

A. The following documents and any subsequent updates are not attached, but are incorporated herein and made a part hereof by this reference. These documents may be updated periodically by CDHS, as required by program directives. CDHS shall provide the Contractor with copies of said documents and any periodic updates thereto, under separate cover. CDHS will maintain on file, all documents referenced herein and in any subsequent updates.

1) Managed Care Data Element Dictionary

2) Rate Manual

B. The following documents are not attached, but are incorporated herein and made a part hereof by this reference. Contractor agrees to provide the additional performance requirements that exceed the minimum requirements set forth in the Contract as described in the following documents:

1) Section 4.f. Innovative Quality Improvement Activities

2) Section 5.d. Innovative Utilization Management Activities

3) Section 9.e. Innovative Ideas/Practices

4) Section 13.d. Innovative Member Services Activities

5) Section 14.c. Innovative Activities

2. Priority of Provisions

In the even of a conflict between the provisions of Exhibit E and any other exhibit of this contract, excluding Exhibit C, the provisions of Exhibit E shall prevail.

DEFINITIONS

As used in this Contract, unless otherwise expressly provided or the context otherwise requires, the following definitions of terms will govern the construction of this Contract:

1. **Administrative Costs** means only those costs that arise out of the operation of the plan excluding direct and overhead costs incurred in the furnishing of health care services, which would ordinarily be incurred in the provision of these services whether or not through a plan.
2. **Affiliate** means an organization or person that directly or indirectly through one or more intermediaries' controls, or is controlled by, or is under control with the Contractor and that provides services to, or receives services from, the Contractor.
3. **AIDS Beneficiary** means a Member for whom a Diagnosis of Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome (HIV/AIDS) has been made by a treating Physician based on the definition most recently published in the Mortality and Morbidity Report from the Centers for Disease Control and Prevention.
4. **Allied Health Personnel** means specially trained, licensed, or credentialed health workers other than Physicians, podiatrists and Nurses.
5. **Ambulatory Care** means the type of health services that are provided on an outpatient basis.
6. **Beneficiary Assignment** means the act of the California Department of Health Services (CDHS) or CDHS' enrollment contractor of notifying a beneficiary in writing of the health plan in which the beneficiary shall be enrolled if the beneficiary fails to timely choose a health plan. If, at any time, the beneficiary notifies CDHS or CDHS' enrollment contractor of the beneficiary's health plan choice, such choice shall override the beneficiary assignment and be effective as provided in Exhibit A, Attachment 16, provision 2.
7. **Beneficiary Identification Card (BIC)** means a permanent plastic card issued by the State to Medi-Cal recipients which is used by Contractors and providers to verify Medi-Cal eligibility and health plan enrollment.
8. **California Children Services (CCS)** means those services authorized by the CCS program for the diagnosis and treatment of the CCS eligible conditions of a specific Member.
9. **California Children Services (CCS) Eligible Conditions** means a physically handicapping condition defined in Title 22, California Code of Regulations (CCR), Section 41800.

10. **California Children Services (CCS) Program** means the public health program which assures the delivery of specialized diagnostic, treatment, and therapy services to financially and medically eligible children under the age of 21 years who have CCS eligible conditions.
11. **Catastrophic Coverage Limitation** means the date beyond which Contractor is not at risk, as determined by the Director, to provide or make reimbursement for illness of or injury to beneficiaries which results from or is greatly aggravated by a catastrophic occurrence or disaster, including, but not limited to, an act of war, declared or undeclared, and which occurs subsequent to enrollment.
12. **Claims and Eligibility Real-Time System (CERTS)** means the mechanism for verifying a recipient's Medi-Cal or County Medical Services Program (CMSP) eligibility by computer.
13. **Comprehensive Medical Case Management Services** means services provided by a Primary Care Provider to ensure the coordination of Medically Necessary health care services, the provision of preventive services in accordance with established standards and periodicity schedules and the continuity of care for Medi-Cal enrollees. It includes health risk assessment, treatment planning, coordination, referral, follow-up, and monitoring of appropriate services and resources required to meet an individual's health care needs.
14. **Confidential Information** means specific facts or documents identified as "confidential" by any law, regulations or contractual language.
15. **Contract** means this written agreement between CDHS and the Contractor.
16. **Contracting Providers** means a Physician, Nurse, technician, teacher, researcher, hospital, home health agency, nursing home, or any other individual or institution that contracts with Contractor to provide medical services to Members.
17. **Corrective Actions** means specific identifiable activities or undertakings of the Contractor which address program deficiencies or problems.
18. **Cost Avoid** means Contractor requires a provider to bill all liable third parties and receive payment or proof of denial of coverage from such third parties prior to Contractor paying the provider for the services rendered.
19. **County Department** means the County Department of Social Services (DSS), or other county agency responsible for determining the initial and continued eligibility for the Medi-Cal program.

20. **Covered Services** means Medical Case Management and those services set forth in Title 22, CCR, Division 3, Subdivision 1, Chapter 3, beginning with Section 51301, and Title 17, CCR, Chapter 4, Subchapter 13, Article 4, beginning with Section 6840. Covered Services do not include:

A. Services for major organ transplants as specified in Exhibit A, Attachment 11, provision 17.

B. Long-term care services as specified in Exhibit A, Attachment 11, provision 17.

C. Home and Community Based Services (HCBS) as specified in Exhibit A, Attachment 11, provision 17 regarding Waiver Programs, and Department of Developmental Services (DDS) Administered Medicaid Home and Community Based Services Waiver. *HCBS do not include any service that is available as an EPSDT service, including EPSDT supplemental services, as described in Title 22, CCR, Sections 51184, 51340 and 51340.1. EPSDT supplemental services are covered under this Contract, as specified in Exhibit A, Attachment 10 regarding Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Supplemental Services.*

D. California Children Services (CCS) as specified in Exhibit A, Attachment 11, provision 8.

E. Specialty Mental health services as specified in Exhibit A, Attachment 11, provision 5.

F. Services provided by psychiatrists; psychologists; licensed clinical social workers; marriage, family, and child counselors; or other specialty mental health provider.

G. Alcohol and substance abuse treatment services and outpatient heroin detoxification as specified in Exhibit A, Attachment 11, provision 6.

H. Fabrication of optical lenses as specified in Exhibit A, Attachment 10, provision 7.

I. Directly observed therapy for treatment of tuberculosis as specified in Exhibit A, Attachment 11, provision 15.

J. Dental services as specified in Title 22, CCR, Section 51307 and EPSDT supplemental dental services as described in Title 22, CCR, Section 51340.1(a). *However, Contractor is responsible for all Covered Services as specified in Exhibit A, Attachment 11, provision 14 regarding dental services.*

K. Acupuncture services as specified in Title 22, CCR, Section 51308.5. L. Chiropractic services as specified in Title 22, CCR, Section 51308. M. Prayer or spiritual healing as specified in Title 22, CCR, Section 51312.

N. Local Education Agency (LEA) assessment services as specified in Title 22, CCR, Section 51360(b) provided to a Member who qualifies for LEA services based on Title 22, CCR, Section 51190.1.

O. Any LEA services as specified in Title 22, CCR, Section 51360 provided pursuant to an Individualized Education Plan (IEP) as set forth in Education Code, Section 56340 et seq. or an Individualized Family Service Plan (IFSP) as set forth in Government Code Section 95020, or LEA services provided under an Individualized Health and Support Plan (IHSP), as described in Title 22, CCR, Section 51360.

P. Laboratory services provided under the State serum alphafetoprotein-testing program administered by the Genetic Disease Branch of CDHS.

Q. Adult Day Health Care. R. Pediatric Day Health Care. S. Personal Care Services. T. State Supported Services.

U. Targeted case management services as specified in Title 22, CCR, Sections 51185 and 51351, and as described in Exhibit A, Attachment 11, provision 2.

V. Childhood lead poisoning case management provided by County health departments.

W. Psychotherapeutic drugs listed in Exhibit A, Attachment 10-A, and psychotherapeutic drugs classified as Anti-Psychotics and approved by the FDA after July 1, 1997.

X. Human Immunodeficiency Virus (HIV) and AIDS drugs listed in Exhibit A, Attachment 10-B, and HIV/AIDS drugs classified as Nucleoside Analogs, Protease Inhibitors, Fusion Inhibitors and Non-Nucleoside Reverse Transcriptase Inhibitors approved by the federal Food and Drug Administration (FDA) after March 1, 2003.

21. **Credentialing** means the recognition of professional or technical competence. The process involved may include registration, certification, licensure and professional association membership.
22. **Department of Health and Human Services (DHHS)** means the federal agency responsible for management of the Medicaid program.
23. **California Department of Health Services (CDHS)** means the single State Department responsible for administration of the federal Medicaid (referred to as Medi-Cal in California) Program, California Children Services (CCS), Genetically Handicapped Persons Program (GHPP), Child Health and Disabilities Prevention (CHDP), and other health related programs.
24. **Department of Managed Health Care (DMHC)** means the State agency responsible for administering the Knox-Keene Health Care Service Plan Act of 1975.
25. **Department of Mental Health (DMH)** means the State agency, in consultation with the California Mental Health Directors Association (CMHDA) and California Mental Health Planning Council, which sets policy and administers for the delivery of community based public mental health services statewide.
26. **Diagnosis of AIDS** means a clinical diagnosis of AIDS that meets the most recent communicable disease surveillance case definition of AIDS established by the federal Centers for Disease Control and Prevention (CDC), United States Department of Health and Human Services, and published in the Morbidity and Mortality Weekly Report (MMWR) or its supplements, in effect for the month in which the clinical diagnosis is made.
27. **Dietitian/Nutritionist** means a person who is registered or eligible for registration as a Registered Dietitian by the Commission on Dietetic Registration (Business and Professions Code, Chapter 5.65, Sections 2585 and 2586).
28. **Director** means the Director of the California Department of Health Services.
29. **Disproportionate Share Hospital (DSH)** means a health Facility licensed pursuant to Chapter 2, Division 2, Health and Safety Code, to provide acute inpatient hospital services, which is eligible to receive payment adjustments from the State pursuant to W&I Code, Section 14105.98.

30. **Eligible Beneficiary** means any Medi-Cal beneficiary who is residing in the Contractor's Service Area with one of the following aid codes:

Mandatory Aid Codes:

Group 1 – Family:
01, 02, 08, 0A, 30, 32, 33, 34, 35, 38, 39, 3A, 3C, 3E, 3G, 3H, 3L, 3M, 3N, 3P,
3R, 3U, 3W, 47, 54, 59, 5X, 72, 7A, 7X, 82, 8P, 8R

Non-Mandatory Aid Codes:

Group 1 – Family:
03, 04, 40, 42, 45, 4A, 4C, 4F, 4G, 4K, 4M, 5K, 7J

Group 2 – Disabled:
20, 24, 26, 2E, 36, 60, 64, 66, 6A, 6C, 6E, 6H, 6J, 6N, 6P, 6V

Group 3 – Aged:
10, 14, 16, 1E, 1H

Group 4 – Adult:
86

Group 5 – Breast & Cervical Cancer Treatment Program (BCCTP):
0N, 0P

An Eligible Beneficiary may continue to be a Member following any redetermination of Medi-Cal eligibility that determines that the individual is eligible for, and the individual thereafter enrolls in, the BCCTP.

The following exclusions apply to all the above:

A. Individuals who have been approved by the Medi-Cal Field Office or the California Children Services Program for any major organ transplant that is a Medi-Cal FFS benefit except kidney transplants.

B. Individuals who elect and are accepted to participate in the following Medi-Cal waiver programs: In-Home Medical Care Waiver, the Nursing Facility Subacute Waiver, and the Nursing Facility A/B Waiver.

C. Individual determined by the Medi-Cal Field Office to be in need of long term care and residing in a Skilled Nursing Facility for 30 calendar days past the month of admission.

D. Individuals who have commercial or Medicare HMO coverage, unless the Medicare HMO is a provider under this Contract and CDHS has agreed, as a term of the HMO's contract, that these individuals may be enrolled. Individuals with Medicare fee-for-service coverage are not excluded from enrolling under this Contract.

31. **Emergency Medical Condition** means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

A. Placing the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

B. Serious impairment to bodily function.

C. Serious dysfunction of any bodily organ or part.

32. **Emergency Services** means those health services needed to evaluate or stabilize an Emergency Medical Condition.

33. **Encounter** means any single medically related service rendered by (a) medical provider(s) to a Member enrolled in the health plan during the date of service. It includes, but is not limited to, all services for which the Contractor incurred any financial liability.

34. **Enrollment** means the process by which an Eligible Beneficiary becomes a Member of the Contractor's plan.

35. **External Accountability Set (EAS)** means a set of HEDIS® and CDHS-developed performance measures selected by CDHS for evaluation of health plan performance.

36. **External Quality Review Organization (EQRO)** means a Peer Review Organization (PRO), PRO-like entity, or accrediting body that is an expert in the scientific review of the quality of health care provided to Medicaid beneficiaries in a State's Medicaid managed care plans.

37. **Facility** means any premise that is:

A. Owned, leased, used or operated directly or indirectly by or for the Contractor or its Affiliates for purposes related to this Contract, or

B. Maintained by a provider to provide services on behalf of the Contractor.

38. **Federal Financial Participation** means federal expenditures provided to match proper State expenditures made under approved State Medicaid plans.
39. **Federally Qualified Health Center (FQHC)** means an entity defined in Section 1905 of the Social Security Act (42 United States Code Section 1396d(l)(2)(B)).
40. **Federally Qualified Health Maintenance Organization (FQHMO)** means a prepaid health delivery plan that has fulfilled the requirements of the HMO Act, along with its amendments and regulations, and has obtained the Federal Government's qualification status under Section 1310(d) of the Public Health Service Act (42 USC §300e).
41. **Fee-For-Service (FFS)** means a method of payment based upon per unit or per procedure billing for services rendered to an Eligible Beneficiary.
42. **Fee-For-Service Medi-Cal** means the component of the Medi-Cal Program which Medi-Cal providers are paid directly by the State for services not covered under this Contract.
43. **Fee-For-Service Medi-Cal Mental Health Services (FFS/MC)** means the services covered through Fee-For-Service Medi-Cal which includes mental health outpatient services and acute care inpatient services.
44. **Financial Performance Guarantee** means cash or cash equivalents which are immediately redeemable upon demand by CDHS, in an amount determined by CDHS, which shall not be less than one full month's capitation.
45. **Financial Statements** means the Financial Statements which include a Balance Sheet, Income Statement, Statement of Cash Flows, Statement of Equity and accompanying footnotes prepared in accordance with Generally Accepted Accounting Principles.
46. **Fiscal Year (FY)** means any 12-month period for which annual accounts are kept. The State Fiscal Year is July 1 through June 30, the federal Fiscal Year is October 1 through September 30.
47. **Health Maintenance Organization (HMO)** means an organization that is not a federally qualified HMO, but meets the State Plan's definition of an HMO including the requirements under Section 1903(m)(2)(A)(i-vii) of the Social Security Act. An Organization that, through a coordinated system of health care, provides or assures the delivery of an agreed upon set of comprehensive health maintenance and treatment services for an enrolled group of persons through a predetermined periodic fixed prepayment.

48. **Health Plan Employer Data and Information Set (HEDIS®)** means the set of standardized performance measures sponsored and maintained by the National Committee for Quality Assurance.

49. **HEDIS® Compliance Audit** means an audit process that uses specific standards and guidelines for assessing the collection, storage, analysis, and reporting of HEDIS® measures. This audit process is designed to ensure accurate HEDIS® reporting.

50. **Indian Health Service (IHS) Facilities** means Facilities operated with funds from the IHS under the Indian Self-Determination Act and the Indian Health Care Improvement Act, through which services are provided, directly or by contract, to the eligible Indian population within a defined geographic area. (See Title 22, Section 55000.)

51. **Intermediate Care Facility (ICF)** means a Facility which is licensed as an ICF by CDHS or a hospital or Skilled Nursing Facility which meets the standards specified in Title 22, CCR, Section 51212 and has been certified by CDHS for participation in the Medi-Cal program.

52. **Joint Commission on the Accreditation of Health Care Organizations (JCAHO)** means the organization composed of representatives of the American Hospital Association, the American Medical Association, the American College of Physicians, the American College of Surgeons, and the American Dental Association. JCAHO provides health care accreditation and related services that support performance improvement in health care organizations.

53. **Knox-Keene Health Care Service Plan Act of 1975** means the law that regulates HMOs and is administrated by the DMHC, commencing with Section 1340, Health & Safety Code.

54. **Marketing** means any activity conducted on behalf of the Contractor where information regarding the services offered by the Contractor is disseminated in order to persuade Eligible Beneficiaries to enroll. Marketing also includes any similar activity to secure the endorsement of any individual or organization on behalf of the Contractor.

55. **Marketing Representative** means a person who is engaged in marketing activities on behalf of the Contractor.

56. **Medi-Cal Eligibility Data System (MEDS)** means the automated eligibility information processing system operated by the State which provides on-line access for recipient information, update of recipient eligibility data and on-line printing of immediate need beneficiary identification cards.

57. **Medical Records** means written documentary evidence of treatments rendered to plan Members.

58. **Medically Necessary** or **Medical Necessity** means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.

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

59. **Member** means any Eligible Beneficiary who has enrolled in the Contractor's plan. For the purposes of this Contract, "Enrollee" shall have the same meaning as "Member".

60. **Member Grievance** means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Member. CDHS considers complaints and appeals the same as a grievance.

61. **Minimum Performance Level** refers to a minimum requirement of performance of Contractor on each of the External Accountability Set measures.

62. **Minor Consent Services** means those Covered Services of a sensitive nature which minors do not need parental consent to access, related to:

A. Sexual assault, including rape.

B. Drug or alcohol abuse for children 12 years of age or older.

C. Pregnancy.

D. Family planning.

E. Sexually transmitted diseases (STDs), designated by the Director, in children 12 years of age or older.

F. Outpatient mental health care for children 12 years of age or older who are mature enough to participate intelligently and where either (1) there is a danger of serious physical or mental harm to the minor or others or (2) the children are the alleged victims of incest or child abuse.

63. **National Committee for Quality Assurance (NCQA)** is a non-profit organization committed to evaluating and publicly reporting on the quality of managed care plans.

64. **NCQA Licensed Audit Organization** is an entity licensed to provide auditors certified to conduct HEDIS Compliance Audits.

65. **Newborn Child** means a child born to a Member during her membership or the month prior to her membership.

66. **Non-Emergency Medical Transportation** means inclusion of services outlined in Title 22, CCR, Sections 51231.1 and 51231.2 rendered by licensed providers.

67. **Non-Medical Transportation** means transportation of Members to medical services by passenger car, taxicabs, or other forms of public or private conveyances provided by persons **not** registered as Medi-Cal providers. Does not include the transportation of sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members by ambulances, litter vans, or wheelchair vans licensed, operated and equipped in accordance with State and local statutes, ordinances or regulations.

68. **Non-Physician Medical Practitioners (Mid-Level Practitioner)** means a nurse practitioner, certified nurse midwife, or physician assistant authorized to provide Primary Care under Physician supervision.

69. **Not Reported** means: 1) Contractor calculated the measure but the result was materially biased; 2) Contractor did not calculate the measure even though a population existed for which the measure could have been calculated; and/or, 3) Contractor calculated the measure but chose not to report the rate.

70. **Nurse** means a person licensed by the California Board of Nursing as, at least, a Registered Nurse (RN).

71. **Other Healthcare Coverage Sources** (OHCS) means the responsibility of an individual or entity, other than Contractor or the Member, for the payment of the reasonable value of all or part of the healthcare benefits provided to a Member. Such OHCS may originate under any other State, federal or local medical care program or under other contractual or legal entitlement, including, but not limited to, a private group or indemnification program. This responsibility may result from a health insurance policy or other contractual agreement or legal obligation, excluding tort liability.

72. **Outpatient Care** means treatment provided to a Member who is not confined in a health care Facility.

73. **Pediatric Subacute Care** means health care services needed by a person under 21 years of age who uses a medical technology that compensates for the loss of vital bodily function. Medical Necessity criteria are described in the Physician’s Manual of Criteria for Medi-Cal Authorization.

74. **Physician** means a person duly licensed as a Physician by the Medical Board of California.

75. **Physician Incentive Plan** means any compensation arrangement between Contractor and a Physician or a Physician group that may not directly or indirectly have the effect of reducing or limiting services provided to Members under this Contract.

76. **Policy Letter** means a document that has been dated, numbered, and issued by the Medi-Cal Managed Care Division, provides clarification of Contractor's obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

77. **Post-Payment Recovery** means Contractor pays the provider for the services rendered and then uses all reasonable efforts to recover the cost of the services from all liable third parties.

78. **Potential Enrollee** means a Medi-Cal recipient who is subject to mandatory enrollment or may voluntarily elect to enroll in a given managed care program, but is not yet an enrollee of a specific plan."

79. **Preventive Care** means health care designed to prevent disease and /or its consequences.

80. **Primary Care** means a basic level of health care usually rendered in ambulatory settings by general practitioners, family practitioners, internists, obstetricians, pediatricians, and mid-level practitioners. This type of care emphasizes caring for the Member's general health needs as opposed to specialists focusing on specific needs.

81. **Primary Care Physician (PCP)** means a Physician responsible for supervising, coordinating, and providing initial and Primary Care to patients and serves as the medical home for Members. The medical home is where care is accessible, continuous, comprehensive, and culturally competent. The PCP is a general practitioner, internist, pediatrician, family practitioner, or obstetrician/gynecologist (OB/GYN).

82. **Primary Care Provider** means a person responsible for supervising, coordinating, and providing initial and Primary Care to patients; for initiating referrals; and, for maintaining the continuity of patient care. A Primary Care Provider may be a Primary Care Physician or Non-Physician Medical Practitioner.

83. **Prior Authorization** means a formal process requiring a health care provider to obtain advance approval to provide specific services or procedures.

84. **Provider Grievance** means an oral or written expression of dissatisfaction, including any complaint, dispute, request for reconsideration or appeal made by a Provider. CDHS considers complaints and appeals the same as a grievance.

85. **Quality Improvement (QI)** means the result of an effective Quality Improvement System.

86. **Quality Improvement Projects (QIPs**) means studies selected by Medi-Cal Managed Care Plans, either independently or in collaboration with CDHS and other participating health plans, to be used for quality improvement purposes. The studies include four phases and may occur within a 24 month time frame.

87. **Quality Improvement System (QIS)** means the systematic activities to monitor and evaluate the medical care delivered to Members according to the standards set forth in regulations and Contract language. Contractor must have processes in place, which measure the effectiveness of care, identify problems, and implement improvement on a continuing basis.

88. **Quality of Care** means the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

89. **Quality Indicators** means measurable variables relating to a specific clinic or health services delivery area which are reviewed over a period of time to screen delivered health care and to monitor the process or outcome of care delivered in that clinical area.

90. **Rural Health Clinic (RHC)** means an entity defined in Title 22, CCR, Section 51115.5.

91. **Safety-Net Provider** means any provider of comprehensive primary care or acute hospital inpatient services that provides these services to a significant total number of Medi-Cal and charity and/or medically indigent patients in relation to the total number of patients served by the provider. Examples of safety net providers include Federally Qualified Health Centers; governmentally operated health systems; community health centers; rural and Indian Health Service Facilities; disproportionate share hospitals; and, public, university, rural, and children’s hospitals.

92. **Service Area** means the county or counties that the Contractor is approved to operate in under the terms of this Contract. A Service Area may have designated ZIP Codes (under the U.S. Postal Service) within a county that are approved by CDHS to operate under the terms of this Contract.

93. **Service Location** means any location at which a Member obtains any health care service provided by the Contractor under the terms of this Contract.

94. **Skilled Nursing Facility (SNF)** means, as defined in Title 22, CCR, Section 51121(a), any institution, place, building, or agency which is licensed as a SNF by CDHS or is a distinct part or unit of a hospital, meets the standard specified in Section 51215 of these regulations (except that the distinct part of a hospital does not need to be licensed as a SNF) and has been certified by CDHS for participation as a SNF in the Medi-Cal program. Section 51121(b) further defines the term "Skilled Nursing Facility" as including terms "skilled nursing home", "convalescent hospital", "nursing home", or "nursing Facility".

95. **Specialty Mental Health Provider** means a person or entity who is licensed, certified or otherwise recognized or authorized under State law governing the healing arts to provide Specialty Mental Health Services and who meets the standards for participation in the Medi-Cal program.

96. **Specialty Mental Health Service** means:

A. Rehabilitative services, which includes mental health services, medication support services, day treatment intensive, day rehabilitation, crisis intervention, crisis stabilization, adult residential treatment services, crisis residential services, and psychiatric health facility services;

B. Psychiatric inpatient hospital services;

C. Targeted Case Management;

D. Psychiatrist services;

E. Psychologist services; and,

F. EPSDT supplemental specialty mental health services.

97. **State** means the State of California.

98. **State Supported Services** means those services that are provided under a different contract between the Contractor and the Department.

99. **Subacute Care** means, as defined in Title 22, CCR, Section 51124.5, a level of care needed by a patient who does not require hospital acute care but who requires more intensive licensed skilled nursing care than is provided to the majority of patients in a SNF.

100. **Subcontract** means a written agreement entered into by the Contractor with any of the following:

A. A provider of health care services who agrees to furnish Covered Services to Members.

B. Any other organization or person(s) who agree(s) to perform any administrative function or service for the Contractor specifically related to fulfilling the Contractor's obligations to CDHS under the terms of this Contract.

101. **Sub-Subcontractor** means any party to an agreement with a subcontractor descending from and subordinate to a Subcontract, which is entered into for the purpose of providing any goods or services connected with the obligations under this Contract.

102. **Supplemental Security Income (SSI)** means the program authorized by Title XVI of the Social Security Act for aged, blind, and disabled persons.

103. **Targeted Case Management (TCM)** means services which assist Medi-Cal Members within specified target groups to gain access to needed medical, social, educational and other services. In prescribed circumstances, TCM is available as a Medi-Cal benefit as a discrete service, as well as through State or local government entities and their contractors.

104. **Third Party Tort Liability (TPTL)** means the responsibility of an individual or entity other than Contractor or the Member for the payment of claims for injuries or trauma sustained by a Member. This responsibility may be contractual, a legal obligation, or as a result of, or the fault or negligence of, third parties (e.g., auto accidents or other personal injury casualty claims or Workers' Compensation appeals).

105. **Traditional Provider** means any physician who has delivered services to Medi-Cal beneficiaries within the last six months either through FFS Medi-Cal or a Medi-Cal Managed Care plan. The term includes physician and hospital providers only, either profit or non-profit entities, publicly or non-publicly owned and operated.

106. **Urgent Care** means services required to prevent serious deterioration of health following the onset of an unforeseen condition or injury (i.e., sore throats, fever, minor lacerations, and some broken bones).

107. **Utilization Review** means the process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and Facilities.

108. **Vaccines for Children (VFC) Program** means the federally funded program that provides free vaccines for eligible children (including all Medi-Cal eligible children age 18 or younger) and distributes immunization updates and related information to participating providers. Providers contracting with the Contractor are eligible to participate in this program.

109. Working day(s) mean State calendar (State Appointment Calendar, Standard 101) working day(s).

PROGRAM TERMS AND CONDITIONS

1. Governing Law

In addition to Exhibit C, provision 14. Governing Law, Contractor also agrees to the following:

A. If it is necessary to interpret this Contract, all applicable laws may be used as aids in interpreting the Contract. However, the parties agree that any such applicable laws shall not be interpreted to create contractual obligations upon CDHS or Contractor, unless such applicable laws are expressly incorporated into this Contract in some section other than this provision, Governing Law. Except for provision 16. Sanctions, and provision 17. Liquidated Damages Provision, the parties agree that any remedies for CDHS' or Contractor's non-compliance with laws not expressly incorporated into this Contract, or any covenants implied to be part of this Contract, shall not include money damages, but may include equitable remedies such as injunctive relief or specific performance. This Contract is the product of mutual negotiation, and if any ambiguities should arise in the interpretation of this Contract, both parties shall be deemed authors of this Contract.

B. Any provision of this Contract which is in conflict with current or future applicable Federal or State laws or regulations is hereby amended to conform to the provisions of those laws and regulations. Such amendment of the Contract shall be effective on the effective date of the statutes or regulations necessitating it, and shall be binding on the parties even though such amendment may not have been reduced to writing and formally agreed upon and executed by the parties.

Such amendment shall constitute grounds for termination of this Contract in accordance with the procedures and provisions of provision 14, paragraph C. Termination - Contractor. The parties shall be bound by the terms of the amendment until the effective date of the termination.

C. The final Balanced Budget Act of 1997 regulations are published in the Federal Register/ Volume 67, Number 115/ June 14, 2002, at 42 Code of Federal Regulations, Parts 400, 430, 431, 434, 435, 438, 440 and 447. Contractor shall be in compliance with the final Balance Budget Act of 1997 regulations by August 13, 2003.

D. All existing final Policy Letters issued by MMCD can be viewed at www.dhs.ca.gov/mcs/mcmcd and shall be complied with by Contractor. All Policy Letters issued by MMCD subsequent to the effective date of this Contract shall provide clarification of Contractors obligations pursuant to this Contract, and may include instructions to the Contractor regarding implementation of mandated obligations pursuant to changes in State or federal statutes or regulations, or pursuant to judicial interpretation.

In the event CDHS determines that there is an inconsistency between this Contract and a Policy Letter, the Contract shall prevail.

2. Entire Agreement

This written Contract and any amendments shall constitute the entire agreement between the parties. No oral representations shall be binding on either party unless such representations are reduced to writing and made an amendment to the Contract.

3. Amendment Process

In addition to Exhibit C, provision 2. Amendment, Contractor also agrees to the following:

Should either party, during the life of this Contract, desire a change in this Contract, that change shall be proposed in writing to the other party. The other party shall acknowledge receipt of the proposal within ten (10) calendar days of receipt of the proposal. The party proposing any such change shall have the right to withdraw the proposal any time prior to acceptance or rejection by the other party. Any proposal shall set forth an explanation of the reason and basis for the proposed change and the text of the desired amendment to this Contract which would provide for the change. If the proposal is accepted, this Contract shall be amended to provide for the change mutually agreed to by the parties on the condition that the amendment is approved by DHHS, and the State Department of Finance, if necessary.

4. Change Requirements

A. General Provisions

The parties recognize that during the life of this Contract, the Medi-Cal Managed Care program will be a dynamic program requiring numerous changes to its operations and that the scope and complexity of changes will vary widely over the life of the Contract. The parties agree that the development of a system which has the capability to implement such changes in an orderly and timely manner is of considerable importance.

B. Contractor's Obligation to Implement

The Contractor will make changes mandated by CDHS. In the case of mandated changes in regulations, statutes, federal guidelines, or judicial interpretation, CDHS may direct the Contractor to immediately begin

implementation of any change by issuing a change order. If CDHS issues a change order, the Contractor will be obligated to implement the required changes while discussions relevant to any capitation rate adjustment, if applicable, are taking place.

CDHS may, at any time, within the general scope of the Contract, by written notice, issue change orders to the Contract.

C. Moral or Religious Objections to Providing a Service

If the Contractor has a moral or religious objection to providing a service or referral for a service for which the Contractor is not responsible, during the term of this agreement, the Contractor shall notify the CDHS in writing providing sufficient detail to establish the moral or religious grounds for the objection.

5. Delegation Of Authority

CDHS intends to implement this Contract through a single administrator, called the "Contracting Officer". The Director of CDHS will appoint the Contracting Officer. The Contracting Officer, on behalf of CDHS, will make all determinations and take all actions as are appropriate under this Contract, subject to the limitations of applicable Federal and State laws and regulations. The Contracting Officer may delegate his/her authority to act to an authorized representative through written notice to the Contractor.

Contractor will designate a single administrator; hereafter called the "Contractor's Representative". The Contractor's Representative, on behalf of the Contractor, will make all determinations and take all actions as are appropriate to implement this Contract, subject to the limitations of the Contract, Federal and State laws and regulations. The Contractor's Representative may delegate his/her authority to act to an authorized representative through written notice to the Contracting Officer. The Contractor's Representative will be empowered to legally bind the Contractor to all agreements reached with CDHS.

Contractor shall designate Contractor's Representative in writing and shall notify the Contracting Officer in accordance with Exhibit E, Attachment 2, provision 10. Notices.

6. Authority of the State

Sole authority to establish, define, or determine the reasonableness, the necessity and level and scope of covered benefits under the Medi-Cal Managed Care program administered in this Contract or coverage for such benefits, or the eligibility of the beneficiaries or providers to participate in the Medi-Cal Managed Care Program reside with CDHS.

Sole authority to establish or interpret policy and its application related to the above areas will reside with CDHS.

The Contractor may not make any limitations, exclusions, or changes in benefits or benefit coverage; any changes in definition or interpretation of benefits; or any changes in the administration of the Contract related to the scope of benefits, allowable coverage for those benefits, or eligibility of beneficiaries or providers to participate in the program, without the express, written direction or approval of the Contracting Officer.

7. Fulfillment of Obligations

No covenant, condition, duty, obligation, or undertaking continued or made a part of this Contract will be waived except by written agreement of the parties hereto, and forbearance or indulgence in any other form or manner by either party in any regard whatsoever will not constitute a waiver of the covenant, condition, duty, obligation, or undertaking to be kept, performed or discharged by the party to which the same may apply; and, until performance or satisfaction of all covenants, conditions, duties, obligations, and undertakings is complete, the other party will have the right to invoke any remedy available under this Contract, or under law, notwithstanding such forbearance or indulgence.

8. Obtaining CDHS Approval

Contractor shall obtain written approval from CDHS, as provided in Exhibit E, Attachment 3, provision 5. CDHS Approval Process, prior to commencement of operation under this Contract.

CDHS reserves the right to review and approve any changes to Contractor’s protocols, policies, and procedures as specified in this Contract.

9. Certifications

Contractor shall comply with certification requirements set forth in 42 CFR 438.604 and 42 CFR 438.606.

In addition to Exhibit C, provision 11. Certification Clauses, Contractor also agrees to the following:

With respect to any report, invoice, record, papers, documents, books of account, or other Contract required data submitted, pursuant to the requirements of this Contract, the Contractor's Representative or his/her designee will certify, under penalty of perjury, that the report, invoice, record, papers, documents, books of account or other Contract required data is current, accurate, complete and in full compliance with legal and contractual requirements to the best of that individual's knowledge and belief, unless the requirement for such certification is expressly waived by CDHS in writing.

10. Notices

All notices to be given under this Contract will be in writing and will be deemed to have been given when mailed to CDHS or the Contractor:

California Department of
Health Services
Medi-Cal Managed Care Division
MS 4407, P.O. Box 997413
Sacramento, CA 95899-7413
Attn: Contracting Officer

Molina Healthcare of California
Partner Plan, Inc.
Attn: Joann Zarza-Garrido, CEO
One Golden Shore
Long Beach, CA 90802

11. Term

The Contract will become effective August 1, 2006, and will continue in full force and effect through March 31, 2009 at the latest, subject to the provisions of Exhibit B, provision 1. Budget Contingency Clause and Exhibit D(F), provision 9. Federal Contract Funds because the State has currently appropriated and available for encumbrance only funds to cover costs through June 30, 2007.

The term of the Contract consists of the following three periods: 1) The Implementation Period shall extend from August 1, 2006 to March 31, 2007; 2) The Operations Period shall extend from April 1, 2007 to March 31, 2009, at the latest, subject to the termination provisions of provision 14. Termination for Cause and Other Terminations, and provision 16. Sanctions, and subject to the limitation provisions of Exhibit B, provision 1. Budget Contingency Clause; and 3) The Phaseout Period shall extend for six (6) months from the end of the Operations Period, subject to provision 13. Contract Extension, in which case the Phaseout Period shall apply to the six (6) month period beginning the first day after the end of the Operations Period, as extended. The Operations Period will commence subject to CDHS acceptance of the Contractor's readiness to begin the Operations period.

12. Service Area

The Service Area covered under this Contract includes:

Riverside and San Bernardino Counties

All Contract provisions apply separately to each Service Area. This Contract may expire for some Service Areas and still remain in effect for others with each Service Area having its own Operations and Phaseout periods.

13. Contract Extension

CDHS will have the exclusive option to extend the term of the Contract for any Service Area during the last twelve (12) months of the Contract, as determined by the original expiration date or by a new expiration date if an extension option has been exercised. CDHS may invoke up to three (3) separate extensions of up to twenty-four months each. The Contractor will be given at least nine (9) months prior written notice of CDHS' decision on whether or not it will exercise this option to extend the Contract for each Service Area.

Contractor will provide written notification to CDHS of its intent to accept or reject the extension within five (5) working days of the receipt of the notice from CDHS.

14. Termination for Cause and Other Terminations

In addition to Exhibit C, provision 7. Termination for Cause, Contractor also agrees to the following:

A. Termination - State or Director

CDHS may terminate performance of work under this Contract in whole, or in part, whenever for any reason CDHS determines that the termination is in the best interest of the State.

1) Notification shall be given at least six (6) months prior to the effective date of termination, except in cases described below in paragraph B. Termination for Cause.

2) If CDHS awards a new contract for one or more of the Service Areas to another Contractor during one of the amendment periods as described above in provision 13. Contract Extension, CDHS shall provide the Contractor written notification at least six (6) months prior to termination to allow for all Phaseout Requirements to be completed.

B. Termination for Cause

1) CDHS shall terminate this Contract pursuant to the provisions of Welfare and Institutions Code, Section 14304(a) and Title 22, CCR, Section 53873.

2) CDHS shall terminate this Contract in the event that: (1) the Secretary, DHHS, determines that the Contractor does not meet the requirements for participation in the Medicaid program, Title XIX of the Social Security Act (42 U.S. Code § 1396), or (2) the Department of Managed Health Care finds that the Contractor no longer qualifies for licensure under the Knox-Keene Health Care Service Plan Act (Health and Safety Code § 1340 et seq.) by giving written notice to the Contractor. The termination will be effectuated consistent with the provisions of Title 22, CCR, Section 53873. Notification will be given by CDHS at least 60 calendar days prior to the effective date of termination.

3) In cases where the Director determines the health and welfare of Members is jeopardized by continuation of the Contract, the Contract will be immediately terminated. Notification will state the effective date of, and the reason for, the termination.

Except for termination pursuant to paragraph B, item 3) above, termination of the Contract shall be effective on the last day of the month in which the Secretary, DHHS, or the DMHC makes such determination, provided that CDHS provides Contractor with at least 60 calendar days notice of termination. The termination of this Contract shall be effective on the last day of the second full month from the date of the notice of termination. Contractor agrees that 60 calendar days notice is reasonable. Termination under this section does not relieve Contractor of its obligations under provision 15. Phaseout Requirements below. Phaseout Requirements shall be performed after Contract termination.

C. Termination - Contractor

If mutual agreement between CDHS and Contractor cannot be attained on capitation rates for rate years subsequent to September 30, 2007, Contractor shall retain the right to terminate the Contract, no earlier than September 30, 2008, by giving at least nine (9) months written notice to CDHS to that effect. The effective date of any termination under this section shall be September 30.

Grounds under which Contractor may terminate this Contract are limited to: (1) Unwillingness to accept the capitation rates determined by CDHS, or if CDHS decides to negotiate rates, failure to reach mutual agreement

on rates; or (2) When a change in contractual obligations is created by a State or Federal change in the Medi-Cal program, or a lawsuit, that substantially alters the financial assumptions and conditions under which the Contractor entered into this Contract, such that the

Contractor can demonstrate to the satisfaction of CDHS that it cannot remain financially solvent through the term of the Contract.

If Contractor invokes ground number 2, Contractor shall submit a detailed written financial analysis to CDHS supporting its conclusions that it cannot remain financially solvent. At the request of CDHS, Contractor shall submit or otherwise make conveniently available to CDHS, all of Contractor's financial work papers, financial reports, financial books and other records, bank statements, computer records, and any other information required by CDHS to evaluate Contractor's financial analysis.

CDHS and Contractor may negotiate an earlier termination date if Contractor can demonstrate to the satisfaction of CDHS that it cannot remain financially solvent until the termination date that would otherwise be established under this section. Termination under these circumstances shall not relieve Contractor from performing the Phaseout Requirements described in provision 15. below.

D. Termination of Obligations

All obligations to provide Covered Services under this Contract or Contract extension will automatically terminate on the date the Operations Period ends.

E. Notice to Members of Transfer of Care

At least 60 calendar days prior to the termination of the Contract, CDHS will notify Members about their medical benefits and available options.

15. Phaseout Requirements

A. CDHS shall retain the lesser of an amount equal to 10% of the last month's Service Area capitation payment or one million dollars ($1,000,000) for each Service Area unless provided otherwise by the Financial Performance Guarantee, from the capitation payment of the last month of the Operations Period for each Service Area until all activities required during the Phaseout Period for each Service Area are fully completed to the satisfaction of CDHS, in its sole discretion.

If all Phaseout activities for each Service Area are completed by the end of the Phaseout Period, the withhold will be paid to the Contractor. If the Contractor fails to meet any requirement(s) by the end of the Phaseout

Period for each Service Area, CDHS will deduct the costs of the remaining activities from the withhold amount and continue to withhold payment until all activities are completed.

B. The objective of the Phaseout Period is to ensure that, at the termination of this Contract, the orderly transfer of necessary data and history records is made from the Contractor to CDHS or to a successor Contractor. The Contractor shall not provide services to Members during the Phaseout Period.

Ninety (90) calendar days prior to termination or expiration of this Contract and through the Phaseout Period for each Service Area, the Contractor shall assist CDHS in the transition of Members, and in ensuring, to the extent possible, continuity of Member-Provider relationships. In doing this, the Contractor will make available to CDHS copies of Medical Records, patient files, and any other pertinent information, including information maintained by any subcontractor, necessary for efficient case management of Members, as determined by the Director. In no circumstances will a Medi-Cal Member be billed for this activity.

C. Phaseout for this Contract will consist of the processing, payment and monetary reconciliation(s) necessary regarding claims for payment for Covered Services.

Phaseout for the Contract will consist of the completion of all financial and reporting obligations of the Contractor. The Contractor will remain liable for the processing and payment of invoices and other claims for payment for Covered Services and other services provided to Members pursuant to this Contract prior to the expiration or termination. The Contractor will submit to CDHS all reports required in Exhibit A, Attachment 17, Reporting Requirements, for the period from the last submitted report through the expiration or termination date.

All data and information provided by the Contractor will be accompanied by letter, signed by the responsible authority, certifying, under penalty of perjury, to the accuracy and completeness of the materials supplied.

D. Phaseout Period will commence on the date the Operations Period of the Contract or Contract extension ends. Phaseout related activities are non-payable items.

16. Sanctions

Contractor is subject to sanctions and civil penalties taken pursuant to Welfare and Institutions Code Section 14304 and Title 22 of the California Code of Regulations, Section 53872, however, such sanctions and civil penalties may not

exceed the amounts allowable pursuant to 42 CFR, 438.704. If required by CDHS, Contractor shall ensure subcontractors cease specified activities which may include, but are not limited to, referrals, assignment of beneficiaries, and reporting, until CDHS determines that Contractor is again in compliance.

A. In the event CDHS finds Contractor non-compliant with any provisions of this Contract, applicable statutes or regulations, CDHS may impose sanctions provided in Welfare and Institutions Code, Section 14304 and Title 22, CCR, Section 53872 as modified for purposes of this Contract. Title 22, CCR, Section 53872 is so modified as follows:

1) Subsection (b)(1) is modified by replacing “Article 2” with “Article 6”

2) Subsection (b)(2) is modified by replacing “Article 3” with “Article 7”

B. The requirements of Exhibit A, Attachment 4, regarding QIS are all Contract provisions which are not specifically governed by Chapter 4.1 (commencing with Section 53800) of Division 3 of Title 22, CCR. Therefore, sanctions for violations of the requirements of Exhibit A, Attachment 4, regarding QIS shall be governed by Subsection 53872 (b)(4).

C. For purposes of Sanctions, good cause includes, but is not limited to, the following:

1) Three repeated and uncorrected findings of serious deficiencies that have the potential to endanger patient care identified in the medical audits conducted by CDHS.

2) In the case of Exhibit A, Attachment 4, the Contractor consistently fails to achieve the minimum performance levels, or receives a “Not Reported” designation on an External Accountability Set measure, after implementation of Corrective Actions.

D. Sanctions in the form of denial of payments provided for under the contract for new enrollees shall be taken, when and for as long as, payment for those enrollees is denied by Centers for Medicare and Medicaid Services (CMS) under 42 CFR § 438.730.

17. Liquidated Damages Provisions

A. General

It is agreed by the State and Contractor that:

1) If Contractor does not provide or perform the requirements of this Contract or applicable laws and regulations, damage to the State shall result;

a) Proving such damages shall be costly, difficult, and time-consuming;

b) Should the State choose to impose liquidated damages, Contractor shall pay the State those damages for not providing or performing the specified requirements;

c) Additional damages may occur in specified areas by prolonged periods in which Contractor does not provide or perform requirements;

d) The damage figures listed below represent a good faith effort to quantify the range of harm that could reasonably be anticipated at the time of the making of the Contract;

e) CDHS may, at its discretion, offset liquidated damages from capitation payments owed to Contractor;

2) Imposition of liquidated damages as specified in paragraphs B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period, and C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period, shall follow the administrative processes described below;

3) CDHS shall provide Contractor with written notice specifying the Contractor requirement(s), contained in the Contract or as required by federal and State law or regulation, not provided or performed;

4) During the Implementation Period, Contractor shall submit or complete the outstanding requirement(s) specified in the written notice within five (5) working days from the date of the notice, unless, subject to the Contracting Officer’s written approval, Contractor submits a written request for an extension. The request must include the following: the requirement(s) requiring an extension; the reason for the delay; and the proposed date of the submission of the requirement.

5) During the Implementation Period, if Contractor has not performed or completed an Implementation Period requirement or secured an extension for the submission of the outstanding requirement, CDHS may impose liquidated damages for the amount specified in paragraph B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period.

6) During the Operations Period, Contractor shall demonstrate the provision or performance of Contractor's requirement(s) specified in the written notice within a 30 calendar day Corrective Action period from the date of the notice, unless a request for an extension is submitted to the Contracting Officer, subject to CDHS' approval, within five (5) calendar days from the end of the Corrective Action period. If Contractor has not demonstrated the provision or performance of Contractor's requirement(s) specified in the written notice during the Corrective Action period, CDHS may impose liquidated damages for each day the specified Contractor's requirement is not performed or provided for the amount specified in paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

7) During the Operations Period, if Contractor has not performed or provided Contractor's requirement(s) specified in the written notice or secured the written approval for an extension, after 30 calendar days from the first day of the imposition of liquidated damages, CDHS shall notify Contractor in writing of the increase of the liquidated damages to the amount specified in paragraph C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period.

Nothing in this provision shall be construed as relieving Contractor from performing any other Contract duty not listed herein, nor is the State's right to enforce or to seek other remedies for failure to perform any other Contract duty hereby diminished.

B. Liquidated Damages for Violation of Contract Terms Regarding the Implementation Period CDHS may impose liquidated damages of $25,000 per requirement specified in the written notice for each day of the delay in completion or submission of Implementation Period requirements beyond the Implementation Period as specified in provision 11. Term above.

If CDHS determines that a delay or other non-performance was caused in part by the State, CDHS will reduce the liquidated damages proportionately.

C. Liquidated Damages for Violation of Contract Terms or Regulations Regarding the Operations Period

1) Site Reviews

CDHS may impose liquidated damages of $2,500 per day for each violation of contract requirement not performed in accordance with Exhibit A, Attachment 4 – Quality Improvement System, provision 10. Site Review, paragraph D. Corrective Actions, until Contract requirement is performed or provided.

2) Third-Party Tort Liability

CDHS may impose liquidated damages of $3,500 per instance or case, per Medi-Cal Member if a Contractor fails to deliver the requested information in accordance with Exhibit E, Attachment 2, provision 24 Third-Party Tort Liability.

3) Plan Physician Availability

CDHS may impose liquidated damages of $3,500 per violation of Contract requirement not performed in accordance with Exhibit A, Attachment 6, Provider Network, provision 9. Plan Physician Availability.

D. Conditions for Termination of Liquidated Damages

Except as waived by the Contracting Officer, no liquidated damages imposed on the Contractor will be terminated or suspended until the Contractor issues a written notice of correction to the Contracting Officer certifying, under penalty of perjury, the correction of condition(s) for which liquidated damages were imposed. Liquidated damages will cease on the day of the Contractor's certification only if subsequent verification of the correction by CDHS establishes that the correction has been made in the manner and at the time certified to by the Contractor.

The Contracting Officer will determine whether the necessary level of documentation has been submitted to verify corrections. The Contracting Officer will be the sole judge of the sufficiency and accuracy of any documentation. Corrections must be sustained for a reasonable period of at least 90 calendar days from CDHS acceptance; otherwise, liquidated damages may be reimposed without a succeeding grace period within which to correct. The Contractor's use of resources to correct deficiencies will not be allowed to cause other contract compliance problems.

E. Severability of Individual Liquidated Damages Clauses

If any portion of these liquidated damages provisions is determined to be unenforceable, the other portions will remain in full force and effect.

18. Disputes

In addition to Exhibit C, provision 6. Disputes, Contractor also agrees to the following:

This Disputes section will be used by the Contractor as the means of seeking resolution of disputes on contractual issues.

Filing a dispute will not preclude CDHS from recouping the value of the amount in dispute from the Contractor or from offsetting this amount from subsequent capitation payment(s). If the amount to be recouped exceeds 25 percent of the capitation payment, amounts of up to 25 percent will be withheld from successive capitation payments until the amount in dispute is fully recouped.

A. Disputes Resolution by Negotiation

CDHS and Contractor agree to try to resolve all contractual issues by negotiation and mutual agreement at the Contracting Officer level without litigation. The parties recognize that the implementation of this policy depends on open-mindedness, and the need for both sides to present adequate supporting information on matters in question.

B. Notification of Dispute

Within 15 calendar days of the date the dispute concerning performance of this Contract arises or otherwise becomes known to the Contractor, the Contractor will notify the Contracting Officer in writing of the dispute, describing the conduct (including actions, inactions, and written or oral communications) which it is disputing.

The Contractor’s notification will state, on the basis of the most accurate information then available to the Contractor, the following:

1) That it is a dispute pursuant to this section.

2) The date, nature, and circumstances of the conduct which is subject of the dispute.

3) The names, phone numbers, function, and activity of each Contractor, subcontractor, CDHS/State official or employee involved in or knowledgeable about the conduct.

4) The identification of any documents and the substances of any oral communications involved in the conduct. Copies of all identified documents will be attached.

5) The reason the Contractor is disputing the conduct.

6) The cost impact to the Contractor directly attributable to the alleged conduct, if any.

7) The Contractor's desired remedy.

The required documentation, including cost impact data, will be carefully prepared and submitted with substantiating documentation by the Contractor. This documentation will serve as the basis for any subsequent appeal.

Following submission of the required notification, with supporting documentation, the Contractor will comply with the requirements of Title 22, CCR, Section 53851(d) and diligently continue performance of this Contract, including matters identified in the Notification of Dispute, to the maximum extent possible.

C. Contracting Officer's or Alternate Dispute Officer's Decision

Pursuant to a request by Contractor, the Contracting Officer may provide for a dispute to be decided by an alternate dispute officer designated by CDHS, who is not the Contracting Officer and is not directly involved in the Medi-Cal Managed Care Program. Any disputes concerning performance of this Contract shall be decided by the Contracting Officer or the alternate dispute officer in a written decision stating the factual basis for the decision. Within 30 calendar days of receipt of a Notification of Dispute, the Contracting Officer or the alternate dispute officer, shall either:

1) Find in favor of Contractor, in which case the Contracting Officer or alternate dispute officer may:

   a) Countermand the earlier conduct which caused Contractor to file a dispute; or

   b) Reaffirm the conduct and, if there is a cost impact sufficient to constitute a change in obligations pursuant to the payment provisions contained in Exhibit B, direct CDHS to comply with that Exhibit.

Or,

2) Deny Contractor's dispute and, where necessary, direct the manner of future performance; or

3) Request additional substantiating documentation in the event the information in Contractor's notification is inadequate to permit a decision to be made under 1) or 2) above, and shall advise Contractor as to what additional information is required, and establish how that information shall be furnished. Contractor shall have 30 calendar days to respond to the Contracting Officer's or alternate dispute officer's request for further information. Upon receipt of this additional requested information, the Contracting Officer or alternate dispute officer shall have 30 calendar days to respond with a decision. Failure to supply additional information required by the Contracting Officer or alternate dispute officer within the time period specified above shall constitute waiver by Contractor of all claims in accordance with paragraph F. Waiver of Claims below.

A copy of the decision shall be served on Contractor.

D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision

Contractor shall have 30 calendar days following the receipt of the decision to file an appeal of the decision to the Director. All appeals shall be governed by Health and Safety Code Section 100171, except for those provisions of Section 100171(d)(1) relating to accusations, statements of issues, statement to respondent, and notice of defense. All appeals shall be in writing and shall be filed with CDHS' Office of Administrative Hearings and Appeals. An appeal shall be deemed filed on the date it is received by the Office of Administrative Hearings and Appeals. An appeal shall specifically set forth each issue in dispute, and include Contractor's contentions as to those issues. However, Contractor's appeal shall be limited to those issues raised in its Notification of Dispute filed pursuant to paragraph B. Notification of Dispute above. Failure to timely appeal the decision shall constitute a waiver by Contractor of all claims arising out of that conduct, in accordance with paragraph F. Waiver of Claims. Contractor shall exhaust all procedures provided for in this provision 18. Disputes, prior to initiating any other action to enforce this Contract.

E. Contractor Duty to Perform

Pending final determination of any dispute hereunder, Contractor shall comply with the requirements of Title 22, CCR, Section 53851 (d) and proceed diligently with the performance of this Contract and in accordance with the Contracting Officer's or alternate dispute officer's decision.

If pursuant to an appeal under paragraph D. Appeal of Contracting Officer's or Alternate Dispute Officer's Decision above, the Contracting Officer's or alternate dispute officer's decision is reversed, the effect of the decision pursuant to paragraph D. shall be retroactive to the date of the Contracting Officer's or alternate dispute officer's decision, and Contractor shall promptly receive any benefits of such decision. CDHS shall not pay interest on any amounts paid pursuant to a Contracting Officer's or alternate dispute officer's decision or any appeal of such decision.

F. Waiver of Claims

If Contractor fails to submit a Notification of Dispute, supporting and substantiating documentation, any additionally required information, or an appeal of the Contracting Officer's or alternate dispute officer's decision, in the manner and within the time specified in this provision 18. Disputes, that failure shall constitute a waiver by Contractor of all claims arising out of that conduct, whether direct or consequential in nature.

19. Audit

In addition to Exhibit C, provision 4. Audit, Contractor also agrees to the following:

The Contractor will maintain such books and records necessary to disclose how the Contractor discharged its obligations under this Contract. These books and records will disclose the quantity of Covered Services provided under this Contract, the quality of those services, the manner and amount of payment made for those services, the persons eligible to receive Covered Services, the manner in which the Contractor administered its daily business, and the cost thereof.

A. Books and Records

These books and records will include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract including working papers; reports submitted to CDHS; financial records; all Medical Records, medical charts and prescription files; and other documentation pertaining to medical and non-medical services rendered to Members.

B. Records Retention

Notwithstanding any other records retention time period set forth in this Contract, these books and records will be maintained for a minimum of five years from the end of the current Fiscal Year in which the date of service occurred; in which the record or data was created or applied; and for which the financial record was created or the Contract is terminated,

or, in the event the Contractor has been duly notified that CDHS, DHHS, DOJ, or the Comptroller General of the United States, or their duly authorized representatives, have commenced an audit or investigation of the Contract, until such time as the matter under audit or investigation has been resolved, whichever is later.

20. Inspection Rights

In addition to Exhibit D(F), provision 8. Site Inspection, Contractor also agrees to the following:

Through the end of the records retention period specified in provision 19. Audit, paragraph B. Records Retention, Contractor shall allow the CDHS, Department of Health and Human Services, the Comptroller General of the United States, Department of Justice (DOJ) Bureau of Medi-Cal Fraud, DMHC, and other authorized State agencies, or their duly authorized representatives, including CDHS' external quality review organization contractor, to inspect, monitor or otherwise evaluate the quality, appropriateness, and timeliness of services performed under this Contract, and to inspect, evaluate, and audit any and all books, records, and Facilities maintained by Contractor and subcontractors pertaining to these services at any time during normal business hours.

Books and records include, but are not limited to, all physical records originated or prepared pursuant to the performance under this Contract, including working papers, reports, financial records, and books of account, Medical Records, prescription files, laboratory results, Subcontracts, information systems and procedures, and any other documentation pertaining to medical and non-medical services rendered to Members. Upon request, through the end of the records retention period specified in provision 19. Audit, paragraph B. Records Retention, Contractor shall furnish any record, or copy of it, to CDHS or any other entity listed in this section, at Contractor's sole expense.

A. Facility Inspections

CDHS shall conduct unannounced validation reviews on a number of the Contractor's Primary Care sites, selected at CDHS' discretion, to verify compliance of these sites with CDHS requirements.

B. Access Requirements and State's Right To Monitor

Authorized State and Federal agencies will have the right to monitor all aspects of the Contractor's operation for compliance with the provisions of this Contract and applicable federal and State laws and regulations. Such monitoring activities will include, but are not limited to, inspection and auditing of Contractor, subcontractor, and provider facilities, management systems and procedures, and books and records as the Director deems

appropriate, at any time during the Contractor's or other facility's normal business hours. The monitoring activities will be either announced or unannounced.

To assure compliance with the Contract and for any other reasonable purpose, the State and its authorized representatives and designees will have the right to premises access, with or without notice to the Contractor. This will include the MIS operations site or such other place where duties under the Contract are being performed.

Staff designated by authorized State agencies will have access to all security areas and the Contractor will provide, and will require any and all of its subcontractors to provide, reasonable facilities, cooperation and assistance to State representative(s) in the performance of their duties. Access will be undertaken in such a manner as to not unduly delay the work of the Contractor and/or the subcontractor(s).

21. Confidentiality of Information

In addition to Exhibit D(F), provision 13. Confidentiality of Information, Contractor also agrees to the following duties and responsibilities with respect to confidentiality of information and data:

A. Notwithstanding any other provision of this Contract, names of persons receiving public social services are confidential and are to be protected from unauthorized disclosure in accordance with Title 42, CFR, Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder. For the purpose of this Contract, all information, records, data, and data elements collected and maintained for the operation of the Contract and pertaining to Members shall be protected by the Contractor from unauthorized disclosure.

Contractor may release Medical Records in accordance with applicable law pertaining to the release of this type of information. Contractor is not required to report requests for Medical Records made in accordance with applicable law.

B. With respect to any identifiable information concerning a Member under this Contract that is obtained by the Contractor or its subcontractors, the Contractor: (1) will not use any such information for any purpose other than carrying out the express terms of this Contract, (2) will promptly transmit to CDHS all requests for disclosure of such information, except requests for Medical Records in accordance with applicable law, (3) will not disclose except as otherwise specifically permitted by this Contract, any such information to any party other than CDHS without CDHS' prior written authorization specifying that the information is releasable under

Title 42, CFR, Section 431.300 et seq., Section 14100.2, W&I Code, and regulations adopted thereunder, and (4) will, at the termination of this Contract, return all such information to CDHS or maintain such information according to written procedures sent to the Contractor by CDHS for this purpose.

22. Pilot Projects

CDHS may establish pilot projects to test alternative managed care models tailored to suit the needs of populations with special health care needs. The operation of these pilot projects may result in the disenrollment of Members that participate. Implementation of a pilot project may affect the Contractor's obligations under this Contract. Any changes in the obligations of the Contractor that are necessary for the operation of a pilot project in the Contractor's Service Area will be implemented through a Contract amendment.

23. Cost Avoidance and Post-Payment Recovery of Other Health Coverage Sources (OHCS)

A. Contractor shall Cost Avoid or make a Post-Payment Recovery for the reasonable value of services paid for by Contractor and rendered to a Member whenever a Member's OHCS covers the same services, either fully or partially. However, in no event shall Contractor Cost Avoid or seek Post-Payment Recovery for the reasonable value of services from a Third-Party Tort Liability (TPTL) action or make a claim against the estates of deceased Members.

B. Contractor retains all monies recovered by Contractor.

C. Contractor shall coordinate benefits with other coverage programs or entitlements, recognizing the OHCS as primary and the Medi-Cal program as the payor of last resort.

D. Cost Avoidance

1) If Contractor reimburses the provider on a fee-for-service basis, Contractor shall not pay claims for services provided to a Member whose Medi-Cal eligibility record indicates third party coverage, designated by a Other Health Coverage (OHC) code or Medicare coverage, without proof that the provider has first exhausted all sources of other payments. Contractor shall have written procedures implementing this requirement.

2) Proof of third party billing is not required prior to payment for services provided to Members with OHC codes A, M, X, Y, or Z.

E. Post-Payment Recovery

1) If Contractor reimburses the provider on a fee-for-service basis, Contractor shall pay the provider's claim and then seek to recover the cost of the claim by billing the liable third parties:

a) For services provided to Members with OHC codes A, M, X, Y, or Z;

b) For services defined by CDHS as prenatal or preventive pediatric services; or

c) In child-support enforcement cases, identifiable by Contractor. If Contractor does not have access to sufficient information to determine whether or not the OHC coverage is the result of a child enforcement case, Contractor shall follow the procedures for Cost Avoidance.

2) In instances where Contractor does not reimburse the provider on a fee-for-service basis, Contractor shall pay for services provided to a Member whose eligibility record indicates third party coverage, designated by a OHC code or Medicare coverage, and then shall bill the liable third parties for the cost of actual services rendered.

3) Contractor shall also bill the liable third parties for the cost of services provided to Members who are retroactively identified by Contractor or CDHS as having OHC.

4) Contractor shall have written procedures implementing the above requirements.

F. Reporting Requirements

1) Contractor shall maintain reports that display claims counts and dollar amounts of costs avoided and the amount of Post-Payment Recoveries, by aid category, as well as the amount of outstanding recovery claims (accounts receivable) by age of account. The report shall display separate claim counts and dollar amounts for Medicare Part A, Part B, and Part D. Reports shall be made available upon CDHS request.

2) When Contractor identifies OHC unknown to CDHS, Contractor shall report this information to CDHS within ten (10) calendar days of discovery in automated format as prescribed by CDHS. This information shall be sent to the California Department of Health Services, Third Party Liability Branch, Other Coverage Unit, P.O. Box 997422, Sacramento, CA 95899-7422.

3) Contractor shall demonstrate to CDHS that where Contractor does not Cost Avoid or perform Post-Payment Recovery that the aggregate cost of this activity exceeds the total revenues Contractor projects it would receive from such activity.

24. Third-Party Tort Liability

Contractor shall identify and notify CDHS' Third Party Liability Branch of all instances or cases in which Contractor believes an action by the Medi-Cal Member involving casualty insurance or tort or Workers' Compensation liability of a third party could result in recovery by the Member of funds to which CDHS has lien rights under Article 3.5 (commencing with Section 14124.70), Part 3, Division 9, Welfare and Institutions Code. Contractor shall make no claim for recovery of the value of Covered Services rendered to a Member in such cases or instances and such case or instance shall be referred to CDHS' Third Party Liability Branch within ten (10) calendar days of discovery. To assist CDHS in exercising its responsibility for such recoveries, Contractor shall meet the following requirements:

A. If CDHS requests service information and/or copies of paid invoices/claims for Covered Services to an individual Member, Contractor shall deliver the requested information within 30 calendar days of the request. Service information includes subcontractor and out-of-plan provider data. The value of the Covered Services shall be calculated as the usual, customary and reasonable charge made to the general public for similar services or the amount paid to subcontracted providers or out-of-plan providers for similar services.

B. Information to be delivered shall contain the following data items:

1) Member name.

2) Full 14 digit Medi-Cal number.

3) Social Security Number.

4) Date of birth.

5) Contractor name.

6) Provider name (if different from Contractor).

7) Dates of service.

8) Diagnosis code and description of illness/injury.

9) Procedure code and/or description of services rendered.

10) Amount billed by a subcontractor or out-of-plan provider to Contractor (if applicable).

11) Amount paid by other health insurance to Contractor or subcontractor (if applicable).

12) Amounts and dates of claims paid by Contractor to subcontractor or out-of-plan provider (if applicable).

13) Date of denial and reasons for denial of claims (if applicable).

14) Date of death (if applicable).

C. Contractor shall identify to CDHS' Third Party Liability Branch the name, address and telephone number of the person responsible for receiving and complying with requests for mandatory and/or optional at-risk service information.

D. If Contractor receives any requests from attorneys, insurers, or beneficiaries for copies of bills, Contractor shall refer the request to Third Party Liability Branch with the information contained in paragraph B above, and shall provide the name, address and telephone number of the requesting party.

E. Information submitted to CDHS under this section shall be sent to the California Department of Health Services, Third Party Liability Branch, Recovery Section, MS 4720, P.O. Box 997425, Sacramento, CA 95899-7425.

25. Records Related To Recovery For Litigation

A. Records

Upon request by CDHS, Contractor shall timely gather, preserve and provide to CDHS, in the form and manner specified by CDHS, any information specified by CDHS, subject to any lawful privileges, in Contractor's or its subcontractors' possession, relating to threatened or pending litigation by or against CDHS. (If Contractor asserts that any requested documents are covered by a privilege, Contractor shall: 1) identify such privileged documents with sufficient particularity to reasonably identify the document while retaining the privilege; and 2) state

the privilege being claimed that supports withholding production of the document.) Such request shall include, but is not limited to, a response to a request for documents submitted by any party in any litigation by or against CDHS. Contractor acknowledges that time may be of the essence in responding to such request. Contractor shall use all reasonable efforts to immediately notify CDHS of any subpoenas, document production requests, or requests for records, received by Contractor or its subcontractors related to this Contract or subcontracts entered into under this Contract.

B. Payment for Records

In addition to the payments provided for in Exhibit B, Budget Detail and Payment Provisions, CDHS agrees to pay Contractor for complying with paragraph A, Records, above, as follows:

1) CDHS shall reimburse Contractor amounts paid by Contractor to third parties for services necessary to comply with paragraph A. Any third party assisting Contractor with compliance with paragraph A above, shall comply with all applicable confidentiality requirements. Amounts paid by Contractor to any third party for assisting Contractor in complying with paragraph A, shall not exceed normal and customary charges for similar services and such charges and supporting documentation shall be subject to review by CDHS.

2) If Contractor uses existing personnel and resources to comply with paragraph A, CDHS shall reimburse Contractor as specified below. Contractor shall maintain and provide to CDHS time reports supporting the time spent by each employee as a condition of reimbursement. Reimbursement claims and supporting documentation shall be subject to review by CDHS.

   a) Compensation and payroll taxes and benefits, on a prorated basis, for the employees' time devoted directly to compiling information pursuant to paragraph A.

   b) Costs for copies of all documentation submitted to CDHS pursuant to paragraph A, subject to a maximum reimbursement of ten (10) cents per copied page.

3) Contractor shall submit to CDHS all information needed by CDHS to determine reimbursement to Contractor under this provision, including, but not limited to, copies of invoices from third parties and payroll records.

26. Fraud and Abuse Reporting

Contractor shall meet requirements set forth in 42 CFR 438.608. Contractor shall report to the Contracting Officer all cases of suspected fraud and/or abuse, as defined in 42 Code of Federal Regulations, Section 455.2, where there is reason to believe that an incident of fraud and/or abuse has occurred, by subcontractors, Members, providers, or employees within ten (10) working days of the date when Contractor first becomes aware of or is on notice of such activity. Contractor shall establish policies and procedures for identifying, investigating and taking appropriate corrective action against fraud and/or abuse in the provision of health care services under the Medi-Cal program. Contractor shall notify CDHS prior to conducting any investigations, based upon Contractor's finding that there is reason to believe that an incident of fraud and/or abuse has occurred, and, upon the request of CDHS, consult with CDHS prior to conducting such investigations. Without waiving any privileges of Contractor, Contractor shall report investigation results within ten (10) working days of conclusion of any fraud and/or abuse investigation.

27. Equal Opportunity Employer

Contractor will, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, state that it is an equal opportunity employer, and will send to each labor union or representative of workers with which it has a collective bargaining agreement or other contract or understanding, a notice to be provided by CDHS, advising the labor union or workers' representative of the Contractor's commitment as an equal opportunity employer and will post copies of the notice in conspicuous places available to employees and applicants for employment.

28. Discrimination Prohibitions

A. Member Discrimination Prohibition

Contractor shall not discriminate against Members or Eligible Beneficiaries because of race, color, creed, religion, ancestry, marital status, sexual orientation, national origin, age, sex, or physical or mental handicap in accordance with Title VI of the Civil Rights Act of 1964, 42 USC Section 2000d, rules and regulations promulgated pursuant thereto, or as otherwise provided by law or regulations. For the purpose of this Contract, discriminations on the grounds of race, color, creed, religion, ancestry, age, sex, national origin, marital status, sexual orientation, or physical or mental handicap include, but are not limited to, the following:

1) Denying any Member any Covered Services or availability of a Facility;

2) Providing to a Member any Covered Service which is different, or is provided in a different manner or at a different time from that provided to other Members under this Contract except where medically indicated;

3) Subjecting a Member to segregation or separate treatment in any manner related to the receipt of any Covered Service;

4) Restricting a Member in anyway in the enjoyment of any advantage or privilege enjoyed by others receiving any Covered Service, treating a Member or Eligible Beneficiary differently from others in determining whether he or she satisfies any admission, Enrollment, quota, eligibility, membership, or other requirement or condition which individuals must meet in order to be provided any Covered Service;

5) The assignment of times or places for the provision of services on the basis of the race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability of the participants to be served.

Contractor shall take affirmative action to ensure that Members are provided Covered Services without regard to race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, except where medically indicated.

For the purposes of this section, physical handicap includes the carrying of a gene which may, under some circumstances, be associated with disability in that person's offspring, but which causes no adverse effects on the carrier. Such genes will include, but are not limited to, Tay-Sachs trait, sickle cell trait, thalassemia trait, and X-linked hemophilia.

B. Discrimination Related To Health Status

Contractor shall not discriminate among eligible individuals on the basis of their health status requirements or requirements for health care services during enrollment, re-enrollment or disenrollment. Contractor will not terminate the enrollment of an eligible individual based on an adverse change in the Member's health.

C. Discrimination Complaints

Contractor agrees that copies of all grievances alleging discrimination against Members or Eligible Beneficiaries because of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status, or disability, will be forwarded to CDHS for review and appropriate action.

29. Americans With Disabilities Act Of 1990 Requirements

Contractor shall comply with all applicable federal requirements in Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990 (42 USC, Section 12101 et seq.), Title 45, Code of Federal Regulations (CFR), Part 84 and Title 28, CFR, Part 36. Title IX of the Education Amendments of 1972 (regarding education programs and activities), and the Age Discrimination Act of 1975.

30. Disabled Veteran Business Enterprises (DVBE)

Contractor shall comply with applicable requirements of California law relating to Disabled Veteran Business Enterprises (DVBE) commencing at Section 10115 of the Public Contract Code.

31. Word Usage

Unless the context of this Contract clearly requires otherwise, (a) the plural and singular numbers shall each be deemed to include the other; (b) the masculine, feminine, and neuter genders shall each be deemed to include the others; (c) “shall,” “will,” “must,” or “agrees” are mandatory, and “may” is permissive; (d) “or” is not exclusive; and (e) “includes” and “including” are not limiting.

32. Parties to State Fair Hearing

The parties to the State fair hearing include the Contractor as well as the Member and his or her representative or the representative of a deceased enrollee’s estate.

DUTIES OF THE STATE

1. Payment For Services

CDHS shall pay the appropriate capitation payments set forth in Exhibit B. Budget Detail and Payment Provisions, provision 4. Capitation Rates to the Contractor for each eligible Member under this Contract, and ensure that such payments are based on actuarially sound capitation rates as defined in 42 CFR, Section 438.6(c). Payments will be made monthly for the duration of this Contract. Any adjustments for Federally Qualified Health Centers will be made in accordance with Section 14087.325 of the Welfare and Institutions Code.

2. Medical Reviews

CDHS shall conduct medical reviews in accordance with the provisions of Section 14456, Welfare and Institutions Code. CDHS shall have the discretion to accept plan performance reports, audits or reviews conducted by other agencies or accrediting bodies that use standards comparable to those of CDHS. These plan performance reports, audits and reviews may be in lieu of an audit or review conducted by CDHS in order to eliminate duplication of auditing efforts.

3. Enrollment Processing by CDHS

A. General

The parties to this Contract agree that the primary purpose of CDHS' Medi-Cal managed care system is to improve quality and access to care for Medi-Cal beneficiaries. The parties acknowledge that the Medi-Cal eligibility process and the managed care enrollment system are dynamic and complex programs. The parties also acknowledge that it is impractical to ensure that every beneficiary eligible for enrollment in the Contractor's plan will be enrolled in a timely manner. Furthermore, the parties recognize that for a variety of reasons some Eligible Beneficiaries will not be enrolled in Contractor's plan and will receive Covered Services in the Medi-Cal fee-for-service system. These reasons include, but are not limited to, the exclusion of some beneficiaries from participating in Medi-Cal managed care, the time it takes to enroll beneficiaries, and the lack of a current valid address for some beneficiaries. The parties desire to work together in a cooperative manner so that Eligible Beneficiaries who choose to or should be assigned to Contractor's plan are enrolled in Contractor's plan pursuant to the requirements of this entire provision 3. The parties agree that to accomplish this goal it is necessary to be reasonably flexible with regard to the enrollment process.

B. Enrollment Processing Definitions

For purposes of this entire provision 3. Enrollment Processing by CDHS, the following definitions shall apply:

1) Fully Converted County means a county in which the following circumstances exist, except for those Medi-Cal beneficiaries covered by Title 22, CCR, Section 53887:

   a) Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) may no longer choose to receive Covered Services on a Fee-for-Service basis; and

   b) All new Eligible Beneficiaries who meet the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) must now choose a managed care plan or they will be assigned to a managed care plan; and

   c) All Eligible Beneficiaries listed in the Medi-Cal Eligibility Data System (MEDS) as meeting the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a) on the last date that both a. and b. above occur:

      i. Have been notified of the requirement to choose a managed care plan and informed that if they fail to choose a plan they will be assigned to a managed care plan; and

      ii. Those beneficiaries still eligible for Medi-Cal and enrollment into a managed care plan at the time their plan enrollment is processed in MEDS have been enrolled into a managed care plan.

2) Mandatory Plan Beneficiary means:

   a) A new Eligible Beneficiary who meets the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a), both at the time her/his plan enrollment is processed by the CDHS Enrollment Contractor and by MEDS; or

   b) An Eligible Beneficiary previously receiving Covered Services in a county without mandatory managed care enrollment who now resides in a county where mandatory enrollment is in effect and who meets the mandatory enrollment criteria contained in Title 22, CCR, Section 53845(a); or

c) An Eligible Beneficiary meeting the criteria of Title 22, CCR, Section 53845(b), and who subsequently meets the criteria of Title 22, CCR, Section 53845(a).

3) Mandatory Plan Beneficiary shall not include any Eligible Beneficiary who:

a) is eligible to receive Covered Services on a Fee-for-Service basis because her/his MEDS eligibility for managed care plan enrollment is interrupted due to aid code, ZIP code or county code changes; or

b) becomes eligible for enrollment in a managed care plan on a retroactive basis.

C. CDHS Enrollment Obligations

1) CDHS shall receive applications for enrollment from its enrollment contractor and shall verify the current eligibility of applicants for enrollment in Contractor's plan under this Contract. If the Contractor has the capacity to accept new Members, CDHS or its enrollment contractor shall enroll or assign Eligible Beneficiaries in Contractor's plan when selected by the Eligible Beneficiary or when the Eligible Beneficiary fails to timely select a plan. Of those to be enrolled or assigned in Contractor's plan, CDHS will ensure that in a Fully Converted County a Mandatory Plan Beneficiary will receive an effective date of plan enrollment that is no later than 90 calendar days from the date that MEDS lists such an individual as meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a), if all changes to MEDS have been made to allow for the enrollment of the individual and all changes necessary to this Contract to accommodate such enrollment, including, but not limited to rate changes and aid code changes, have been executed. CDHS will use due diligence in making any changes to MEDS and to this Contract. CDHS will provide Contractor a list of Members on a monthly basis.

2) CDHS or its enrollment contractor shall assign Eligible Beneficiaries meeting the enrollment criteria contained in Title 22, CCR, Section 53845(a) to plans in accordance with Title 22, CCR, Section 53884.

3) Notwithstanding any other provision in this Contract, subparagraphs 1) and 2) above shall not apply to:

a) Eligible Beneficiaries previously eligible to receive Medi-Cal services from a Prepaid Health Plan or Primary Care Case Management plan and such plan's contract with CDHS expires, terminates, or is assigned or transferred to Contractor;

b) Members who are enrolled into another managed care plan on account of assignment, assumption, termination, or expiration of this Contract;

c) Eligible Beneficiaries covered by a new mandatory aid code, added to this Contract;

d) Eligible Beneficiaries meeting the criteria of Title 22, CCR, Section 53845(b), who subsequently meet the criteria of Title 22, CCR, Section 53845(a) due solely to CDHS designating a prior voluntary aid code as a new mandatory aid code;

e) Eligible Beneficiaries residing in an excluded zip code area within a County that is not a fully Converted County; or

f) Eligible Beneficiaries without a current valid deliverable address or with an address designated as a County post office box for homeless beneficiaries.

D. Disputes Concerning CDHS Enrollment Obligations

1) Contractor shall notify CDHS of CDHS' noncompliance with this provision 3. Enrollment Processing pursuant to the requirements and procedures contained in Exhibit E, Attachment 2, provision 18. Disputes.

2) CDHS shall have 120 calendar days from the date of CDHS' receipt of Contractor's notice (the "cure period") to cure any noncompliance with this provision 3. Enrollment Processing, identified in Contractor's notice, without incurring any financial liability to the Contractor. For purposes of this section, CDHS shall be deemed to have cured any noncompliance with this provision 3. Enrollment Processing, identified in Contractor's notice if within the cure period any of the following occurs:

a) Mandatory Plan Beneficiaries receive an effective date of plan enrollment that is within the cure period, or

b) CDHS corrects enrollment that failed to comply with this provision 3. Enrollment Processing, by redirecting enrollment from one Contractor to another within the cure period in order to comply with this provision 3. Enrollment Processing, or

c) Within the cure period, CDHS changes the distribution of beneficiary Assignment (subject to the requirements of Title 22, CCR, Section 53845), to the maximum extent new beneficiaries are available to be assigned, to make up the number of incorrectly assigned beneficiaries as soon as possible.

3) If it is necessary to redirect enrollment or change the distribution of beneficiary Assignment due to noncompliance with this provision 3. Enrollment Processing, and such change varies from the requirements of Title 22, CCR, Section 53884(b)(5) or (b)(6), Contractor agrees it will neither seek legal nor equitable relief for such variance or the results of such variance if CDHS resumes assignment consistent with Sections 53884(b)(5) or (b)(6) after correcting a noncompliance with this provision 3. Enrollment Processing.

4) Notwithstanding Exhibit E, Attachment 2, provision 1. Governing Law or any other provision of this Contract, if CDHS fails to cure a noncompliance with this provision 3. Enrollment Processing, within the cure period, CDHS will be financially liable for such noncompliance as follows:

CDHS will be financially liable for Contractor's demonstrated actual reasonable losses as a result of the noncompliance, beginning with CDHS' first failure to comply with its enrollment obligation set forth herein. CDHS' financial liability shall not exceed 15 percent of Contractor's monthly capitation payment calculated as if noncompliance with this provision 3. Enrollment Processing did not occur, for each month in which CDHS has not cured noncompliance pursuant to paragraph D. subparagraph 2) above, beginning with CDHS' first failure to comply with its enrollment obligation set forth herein.

5) Notwithstanding paragraph D. subparagraph 4) above, CDHS shall not be financially liable to Contractor for any noncompliance with provision 3. Enrollment Processing, in an affected county (on a county-by-county basis) if Contractor's loss of Mandatory Plan Beneficiaries, in a month in which any noncompliance occurs, is less than five percent of Contractor's total Members in that affected

county in the month in which the noncompliance occurs. The parties acknowledge that the above-referenced five-percent threshold shall apply on a county-by-county basis, not in the aggregate.

4. Disenrollment Processing

CDHS shall review and process requests for Disenrollment and notify the Contractor and the Member of its decision.

5. CDHS Approval Process

A. Within five (5) working days of receipt, CDHS shall acknowledge in writing the receipt of any material sent to CDHS by Contractor pursuant to Exhibit E, Attachment 2, provision 8. Obtaining CDHS Approval.

B. Within 60 calendar days of receipt, CDHS shall make all reasonable efforts to approve in writing the use of such material provided to CDHS pursuant to Exhibit E, Attachment 2, provision 8. Obtaining CDHS Approval, provide Contractor with a written explanation why its use is not approved, or provide a written estimated date of completion of CDHS' review process. If CDHS does not complete its review of submitted material within 60 calendar days of receipt, or within the estimated date of completion of CDHS review, Contractor may elect to implement or use the material at Contractor's sole risk and subject to possible subsequent disapproval by CDHS. This paragraph shall not be construed to imply CDHS approval of any material that has not received written CDHS approval. This paragraph shall not apply to Subcontracts or sub-subcontracts subject to CDHS approval in accordance with Exhibit A, Attachment 6, provision 13. Subcontracts, paragraph C. regarding Departmental Approval – Non-Federally Qualified HMOs, and paragraph D. regarding Departmental Approval – Federally Qualified HMOs.

6. Program Information

CDHS shall provide Contractor with complete and current information with respect to pertinent policies, procedures, and guidelines affecting the operation of this Contract, within 30 calendar days of receipt of Contractor's written request for information, to the extent that the information is readily available. If the requested information is not available, CDHS shall notify Contractor within 30 calendar days, in writing, of the reason for the delay and when Contractor may expect the information.

7. Catastrophic Coverage Limitation

CDHS shall limit the Contractor's liability to provide or arrange and pay for care for illness of, or injury to, Members which results from or is greatly aggravated by, a catastrophic occurrence or disaster.

8. Risk Limitation

CDHS shall agree that there will be no risk limitation and that Contractor will have full financial liability to provide Medically Necessary Covered Services to Members.

9. Notice Of Termination Of Contract

CDHS shall notify Members of their health care benefits and options available upon termination or expiration of this Contract.

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DO NOT DELETE THIS PAGE ELECTRONICALLY – It is coded to be “hidden” and the

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
4f Innovative Quality Improvement Activities				
NCQA Accreditation	X			The plan has received NCQA accreditation through January 2008.
Appointment Acces Survey	X			
Nurse Advice line 24/7 Service	X			
Transportation Summit		X		This was a one-time summit coordinated by the plan that has been completed.
ER Management		X		The ER management study was conducted by the plan over a 24 month period. It was completed at the time of RFP.
Provider Profiling Collaborative		X		The Asthma Partnership with IEHP concluded in 2005. The plan continues participation with IEHP through the Plan Practice Improvement Project.
Asthma Disease Management Program “Breathe with Ease”	X			
Asthma Management (inhaled steroid/high beta-agonist use study)		X		The plan completed the Use of High Amounts of Short Acting Beta Agonist Medications by Members Receiving inhaled Steroids (ages 3-50) study in 2004. The plan has an on-going asthma medication studies and continues with both quarterly and semi annual initiatives.
Diabetes Management (Hgb A1C screening, control and LDL-C screening study)		X		The Plan completed the LDL-C Screening/Lipids in Good Control study in 2004. The plan conducts on-going diabetes management studies.
Diabetes Disease Management Program Living Well Diabetes Program	X			
Pregnancy Program Motherhood matters Program	X			
Continuity/Coordination of care studies	X			The plan participates in on-going quality improvement studies including semi-annual reporting
Disease Registries	X			
Cervical cancer Improving the rate of Cervical Cancer Screening.	X			The plan is continuing this preventive care and HEDIS initiative, which includes HEDIS data collection and enhanced member education efforts.

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
Chlamydia Screening, treatment & re-screening		X		The Chlamydia Screening, Treatment and Re-screening study was complete in 2005. The plan continues with preventive care and HEDIS initiatives, including HEDIS data collection and enhanced member education.
Breast Cancer Improving the Rate of Breast Cancer Screening	X			The plan continues with preventive care and HEDIS initiatives, including HEDIS data collection and enhanced breast cancer member education.
HEDIS incentives	X			The plan is currently enhancing a provider incentive program to increase encounter data submission rates and improve overall HEDIS performance.
Immunization Registries	X			
Cultural and linguistic Advisory Committee	X			
Ask the Anthropologist (web based)	X			The plan is revising this program to better serve members. A new initiative is being developed to allow members to contact the plan's cultural & linguistics staff to received answers about cultural and linguistic questions/issues.
Interpreter wallet card	X			
Interpretation Services	X			
Welcome Call/New Member Outreach program	X			
After delivery home visit	X			The plan has modified this program, called the Motherhood Matters Program. The plan sends trimester specific information including postpartum materials to members. The plan continues telephonic outreach to encourage members to complete their postpartum check up. Also, the plan coordinates home visits to members based upon medical need.
Ask the Registered Dietician (web based)	X			
Member Services telephone Responsiveness	X			
Pharmacy Services-Language Matching	X			
Pharmacy: Timeless of Eligibility Release	X			
Medical Nutrition Therapy	X			
Population-Based Member Surveys			X	DHS approves plan's request to remove this activity. The plan has discontinued this initiative. In its place, the plan participates in CAHPS surveys.
Provider Satisfaction Surveys	X			

Activity Name	Current Acitivity	Completed Activity	Discontinued Activity	Comments
SMO Community Outreach Activities	X			In the RFP, the plan listed a number of achievements that have been completed. The plan continues to participate in a variety of outreach events in communities surrounding the plan's staff model offices. ("SMOs").
Hablamos Juntos		X		The plan has completed this activity. The Report Wood Johnson Foundation awarded a two (2) year grant to the plan to perform this activity. The grant funding was from December 2004 through April 2006.
TeleSalud	X			The plan's TeleSalud bilingual 24/7 Nurse Advice Line is available to members. Interpreter services are provided telephonically by the plan's language services vendor.
Moreno Valley School District Immunization Program		X		In the RFP, the plan listed this initiative that is now completed. The plan continues to participate in a variety of community outreach activates, including working with community based organizations ("CBOs") to facilitates outreach and coordination efforts.
School Nebulizer Project		X		The plan has completed this limited-time activity, in which the plan donated nebulizers to 35 local schools.
THRIVE Project		X		The plan has completed this limited-time activity, in which the plan supported the development of a community center.
Book Buddies Program	X			
Payment Mechanism for Interpreter Service	X			
Cultural Competency Training	X			The plan provides cultural competency training in various settings to members, providers and community groups.
RSV Quality Improvement Project		X		The RSV Quality Improvement study was completed in 2004. In 2006, under the joint leadership of the plan's Medical Director, Dr. Kenneth Smith, the RSV Taskforce reconvened to review and reconfirm recommendations for Synagis usage utilizing AAP guidelines.
NCQA National Medicaid Work Group		X		The NCQA Medicaid workgroup concluded in 2003. The plan's Medical Director, Kenneth Smith, MD, continues to be actively involved with NCQA and serves as an expert in national NCQA Medicaid issues.

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
HEDIS Incentive Program Enhancements	X			The plan is currently enhancing a provider incentive program to increase encounter data submission rates and Improve overall HEDIS performance.
Dental Health Education	X			The plan continues to perform this activity. This activity will conclude in 2007.
Healthy Kids Coalition	X			Molina Healthcare participates in the Teachers for Healthy Kids Initiative, as well as other outreach and enrollment programs targeting uninsured children and families.
5.d. Innovative Utilization Management Activities				
Ask the Pharmacist (Web-based Interactive Program)	X			
Asthma DHS/CHCS Collaborative		X		The Asthma DHS/CHCS collaborative concluded in 2004. The new collaborative Plan Practice Improvement Project runs from 2005-2006. The plan continues to participate in various ongoing quality improvement studies, projects and collaboratives, such as the Asthma study Improvement Project.
Asthma Partnership with IEHP		X		
Clinical Practice Guideline (Asthma, Diabetes, hypertension, Gestational Diabetes, and Pregnancy)	X			
Diabetes DHS Collaborative		X		The Diabetes DHS Collaborative concluded in 2005. The plan continues to participate in various ongoing collaboratives, such as the Adolescent Well Care collaborative.
Disease Registries	X			
ER Use and Abuse Program	X			
Hospital On-Site Review	X			
Language Matching for Pharmacy Services	X			
Maternal Home Health	X			
Medical Director Ambassador Program	X			

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
Medical Nutrition Therapy (Registered Dietician Services)	X			
Nurse Advice Line	X			
PharmaCheck Program	X			
Population-based Member Surveys			X	DHS approves plan's request to remove this activity. The plan has discontinued this initiative. In its place, the plan participates in CAHPS surveys.
Respiratory Syncytial Virus (RSV Care Management)	X			
Riverside/San Bernardino County Asthma Coalition	X			
School Nebulizer Project		X		The plan has completed this limited-time activity, in which the plan donated nebulizers to 35 local schools.
Transportation Summit		X		This was a one-time summit coordinated by the plan that has been completed.
Language Services Access Summit		X		The plan has completed this activity. The Robert Wood Johnson Foundation awarded a two (2) year grant to the plan to perform this activity. The grant funding was from December 2004 through April 2006.
24 Hour Billingual Spanish Nurse Advice Line-Telesalud	X			
Exceeding DHS Standards in Daily Um Activities:				
a) Member Data Base of carved out services	X			
b) ER Visit summaries to delegated entities	X			
c) Provide In-patient and Bed day summaries to delegated entities	X			

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
				The plan has modified this program, called the Motherhood Matters Program. The Plan sends trimester specific information including postpartum materials to members. The plan continues telephonic outreach to encourage members to complete their postpartum check up. Also, the plan coordinates home visits to members based upon medical need.
After delivery home visit	X			
Comprehensive CPSP Training	X			
				The plan has modified this program to provide focused discharge planning for those members requiring medically necessary follow-up care. The plan's case management staff perform outreach activities including placing phone calls directly to members to ensure complex medical needs and needs based upon social limitations are being addressed.
Hospital to Home Program	X			
Rural Transportation Program	X			
				DHS approves plan's request to remove this activity. The plan has discontinued the intended implementation of this initiative. The plan researched the application of this service for health plan members and determined that it was not an appropriate service to implement at the present time. The purpose of this initiative was to enable a treating PCP to consult about a member's condition/treatment with a specialist via telephone or video conference. The plan has instead focused on building up its specialist network to provide PCPs a network of qualified specialist providers with whom to consult on member conditions and treatment options.
Video Medical Conferencing			X	
9.e. Innovative Ideas/Practices				
Annual PCP and specialist appointment access and after hours instructions survey	X			
Requires Urgent Care pre-contractual facility site review	X			
Every six month analysis using qualifiable and measurable standards for PCP's (1:2000 members) and their geographic distribution	X			

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
Every six month analysis using qualifiable and measurable standards for high volume specialists for orthopedic surgeons, dermatologists, otolaryngologists, opthalmologists (1:5000 members) and OB-GYN's (1:1000 members)	X			The plan modified this activity to assess and identify high volume specialists on an annual basis.
Annual Analysis of geographic availability to members for the number of:				
a) PCP's	X			
b) Specialists	X			
c) Pharmacies	X			
d) Urgent Care Centers	X			
e) Facilities	X			
Access and Availability Committee	X			
Ask the Registered Dietician (web based)	X			
Breathe with Ease Program	X			
Disease Specific Member Newsletters	X			
Healthy Living with Diabetes	X			
Hablamos Juntos		X		The plan has completed this activity. The Robert Wood Johnson Foundation awarded a two (2) year grant to the plan to perform this activity. The grant funding was from December 2004 through April 2006.

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
Immunization Outreach Program (Home Verification)			X	DHS approves plan's request to remove this activity. The plan has discontinued this initiative. The plan researched ways to implement this activity and determined that it was not practical at the present time. The shortage of qualified nurses in California made this program very difficult to implement. To help achieve the original objective of increasing immunization rates for plan members, the plan has focused on performing outreach activities to members and their families to educate them about the importance of staying up-to-date with immunizations. The plan's "Healthy Baby Program" provides a car seat to a member's family when evidence is presented that the members immunizations are current and up-to-date. Another example of the plan's ongoing activities in this area is a flu shot campaign underway in which postcards are sent to members along with phone calls, reminding members and their families about scheduled immunizations. The plan also participates in community outreach events and other collaborative activities directed at increasing immunization rates
Interpreter Request Card Program	X			
Molina Appointment Access Survey	X			
Motherhood Matters Program	X			
Motherhood Matters Outreach	X			
Prenatal/Postpartum Reminders	X			
Community Based Organization Outreach	X			The plan's RFP response covered activities that occurred in 2003 and 2004. The plan continues to participate in a variety of community outreach activities. Including working with community based organizations ("CBOs") to facilitate outreach and coordination efforts.
Community Located Staff Model Offices	X			The plan continues to operate four (4) staff model offices ("SMOs") in San Bernardino, two (2) SMOs in Riverside and two (2) SMOs in east Los Angeles County that adjoin Riverside.
Transportation Assistance Program (New Innovation)	X			
Welcome Call Program	X			

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
13.d Innovative member Services Activities				
Customer telephone Service requires:				
a) Average speed of answer less that 30 seconds	X			
b) Abandonment Rate less than 5%	X			
Implemented new member welcome call to confirm new member understanding of health care benefits and how to access services	X			
Uses easy to understand language in member materials to advise members about protected health information and open communication with their PCP	X			
Measures numerous categories or reasons for member inquiries, complains and grievances and identifies systemic trends and acts on findings	X			
IHA Gift Incentive	X			
New member Outreach: Welcome Call	X			
Telephone Outreach	X			
Mail Outreach	X			
FAQ Sheet-Frequently Asked Questions and Answers	X			
Molina’s Ombudsman Program				
Cultural Training Assistance	X			The plan provides cultural competency training, assistance and resources to members; providers and community groups in a variety of settings.
Cultural Training and Assistance	X			
Cultural and Linguistic Advisory Committee	X			
Disenrollment Survey	X			
Education on IHA	X			

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
Hablamos Juntos		X		The plan has completed this activity. The Robert Wood Johnson Foundation awarded a two (2) year grant to the plan to perform this activity. The grant funding was from December 2004 through April 2006.
Interpreter Card Program	X			
“Motherhood Matters”	X			
Motherhood Matters Outreach	X			
Web Site Translation	X			
Wellness Mailing (Annual)	X			The plan has revised its member mailing activities to include member wellness information such as informative brochures and refrigerator magnets in new member enrollment mailing and annual member mailings. Health Education information, such as wellness materials, are routinely reviewed with the plan’s community advisory committees to receive feedback.
Collaborative Activities	X			Molina Healthcare participates in various ongoing projects and collaboratives
Birthday Card Program	X			
IHA Appointment Reminders	X			The plan has modified this activity to provide manual reminder calls to members about IHAs. The plan continues to consider new technological applications to more effectively notify member of IHAs.
Transportation	X			

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
Immunization Outreach Program (Home Verification)			X	DHS approves plan's request to remove this activity. The plan has discontinued this initiative. The plan research ways to implement this activity and determined that it was not practical at the present time. The shortage of qualified nurses in California made this program very difficult to implement. To help achieve the original objective of increasing immunization rates for plan members, the plan has focused on performing outreach activities to members and their families to educate them about the importance of staying up-to-date with immunizations. The plan's "Health Baby Program" provides a car seat to a member's family when evidence is presented that the member's immunizations are current and up-to-date. Another example of the plan's ongoing activities in this area is a flu short campaign underway in which postcards are sent to members along with phone calls, reminding members and their families about scheduled immunizations. The plan also participates in families about scheduled immunizations. The plan also participates in community outreach events and other collaborative activities directed at increasing immunization rates.
14.c Innovative Activities				
Customer Telephone Services requires:				
a) Average speed of answer less than 30 seconds	X			
b) Abandonment Rate less than 5%	X			
Implemented new member welcome call to confirm new member understanding of health care benefits and how to access services	X			
Uses easy to understand language in member materials to advise members about protected health information and open communication with their PCP	X			
Measures member understanding of plan Information to provide strategies for improvement	X			
Measures numerous categories of reasons for members inquiries, complains and grievances and identifies systemic trends and acts on finds	X			
Molina's Ombudsman Program	X			

Activity Name	Current Activity	Completed Activity	Discontinued Activity	Comments
Grievance Acknowledgement within 24 hours	X			
Grievance Closure TAT 15 days	X			
Member Participation Committee	X			
Disenrollment Survey				
Cultural training and Assistance	X			The plan provides cultural competency training, assistance and resources to members, providers and community groups in a variety of settings.
Interpreter Wallet Cards	X			
Ask the Anthropologist (web based)	X			The plan is revising this program to better serve members. A new initiative is being developed to allow members to contact the plan's cultural & linguistics staff to received answers about cultural and linguistic questions/issues.
Hablamos Juntos		X		The plan has completed this activity. The Robert Wood Johnson Foundation awarded a two (2) year grant to the plan to perform this activity. The grant funding was from December 2004 through April 2006.
New Member Outreach: Welcome Call	X			

Exhibit F

Contractor's Release

Instructions to Contractor:

With final invoice(s) submit one (1) original and one (1) copy. The original must bear the original signature of a person authorized to bind the Contractor. The additional copy may bear photocopied signatures.

Submission of Final Invoice

Pursuant to contract number _____ entered into between the State of California Department of Health Services (CDHS) and the Contractor (identified below), the Contractor does acknowledge that final payment has been requested via invoice number(s) _____, in the amount of $ _____ and dated _____ If necessary, enter "See Attached" in the appropriate blocks and attach a list of invoice numbers, dollar amounts and invoice dates.

Release of all Obligations

By signing this form, and upon receipt the amount specified in the invoice number(s) referenced above, the Contractor does hereby release and discharge the State, its offices, agents and employees of and from any and all liabilities, obligations, claims, and demands whatsoever arising from the above referenced contract.

Repayments Due to Audit Exceptions / Record Retention

By signing in this form, Contractor acknowledges that expenses authorized for reimbursement does not guarantee final allowability of said expenses. Contractor that the amount of any sustained audit exceptions resulting from any subsequent audit made after final payment will be refunded to the State.

All expense and accounting records related to the above referenced contract must be maintained for audit purposes for no less than three years beyond the date of final payment, unless a longer term is stated in said contract.

Recycled Product Use Certification

By signing this form, Contractor certifies under penalty of perjury that a minimum 0% unless otherwise specified in writing of post consumer material, as defined in the Public Contract Code Section 12200, in products, materials, goods, or supplies offered or sold to the State regardless of whether it meets the requirements of Public Contract Code Section 12209. Contractor specifies that printer or duplication cartridges offered or sold to the State comply with the requirements of Section 12516(e).

Reminder to Return State Equipment/Property (If Applicable)
(Applies only if equipment was provided by CDHS or purchased with or reimbursed by contract funds)

Unless CDHS has approved the continued use and possession of State equipment (as defined in the above referenced contract) for use in connection with another CDHS agreement, Contractor agrees to promptly initiate arrangements to account for and return said equipment to CDHS, at CDHS's expense, if said equipment has not passed its useful life expectancy as defined in the above referenced contract.

Patents / Other Issues

By signing this form, Contractor further agrees, in connection with patent matters and with any claims that are not specifically released as set forth above, that it will comply with all of the provisions contained in the above referenced contract, including, but not limited to, those provisions relating to notification to the State and related to the defense or prosecution of litigation.

ONLY SIGN AND DATE THIS DOCUMENT WHEN ATTACHING TO THE FINAL INVOICE

Contractor's Legal Name (as on contract): _____

Signature of Contractor or Official Designee: _____ Date: _____

Printed Name/Title of Person Signing: _____

CDHS Distribution: Accounting (Original) Program

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

1. Recitals

A. "Protected Health Information" or "PHI" means any information, whether oral or recorded in any form or medium that relates to the past, present, or future physical or mental condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual. PHI shall have the meaning given to such term under HIPAA and HIPAA regulations, as the same may be amended from time to time.

B. CDHS desires to protect the privacy and provide for the security of PHI disclosed, created or received on behalf of CDHS pursuant to this Contract.

IN THE USE OR DISCLOSURE OF INFORMATION PURSUANT TO THIS CONTRACT, THE PARTIES AGREE AS FOLLOWS:

2. Permitted Uses and Disclosures.

A. *Permitted Uses and Disclosures.* Except as otherwise required by law, Contractor may use or disclose PHI only to perform functions, activities or services specified in this Contract provided that such use or disclosure is for purposes directly connected with the administration of the Medi-Cal program. Those activities which are for purposes directly connected with the administration of the Medi-Cal program include, but are not limited to: establishing eligibility and methods of reimbursement; determining the amount of medical assistance; providing services for Members; conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the Medi-Cal program; and conducting or assisting a legislative investigation or audit related to the administration of the Medi-Cal program.

B. *Specific Use and Disclosure Provisions.* Except as otherwise indicated in this Contract, Contractor may:

1) *Use and disclose for management and administration.* Use and disclose PHI for the proper management and administration of the Contractor or to carry out the legal responsibilities of the Contractor, provided that disclosures are required by law, or the Contractor obtains reasonable assurances from the person to whom the information is disclosed that it will remain confidential and will be used or further disclosed only as required by law or for the purpose for which it was disclosed to the person, and the person notifies the Contractor of any instances of which it is aware that the confidentiality of the information has been breached.

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

2) *Provision of Data Aggregation Services.* Use PHI to provide data aggregation services to CDHS. Data aggregation means the combining of PHI created or received by the Contractor on behalf of CDHS with PHI received by the Contractor in its capacity as the Contractor of another covered entity, to permit data analyses that relate to the health care operations of CDHS.

C. *Prohibition of External Disclosures of Lists of Members.* A Contractor must provide CDHS' contract manager with a list of external entities, including persons, organizations, and agencies, other than those within its treatment network and other than CDHS, to which it discloses lists of Medi-Cal Member names and addresses. This list must be provided within 30 calendar days of the execution of this Contract and annually thereafter.

3. Responsibilities of Contractor.

Contractor agrees:

A. *Divulging Medi-Cal Status.* Not to divulge the Medi-Cal status of a Contractor's Members without CDHS's prior approval except for treatment, payment and operations.

B. *Safeguards.* To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the PHI, including electronic PHI, that it creates, receives, maintains or transmits on behalf of CDHS; and to prevent use or disclosure of PHI other than as provided for by this Contract. Contractor shall maintain a comprehensive written information privacy and security program that includes administrative, technical and physical safeguards appropriate to the size and complexity of the Contractor's operations and the nature and scope of its activities. Contractor will provide CDHS with information concerning such safeguards as CDHS may reasonably request.

C. *Security.* To take any and all steps necessary to ensure the continuous security of all computerized data systems containing PHI, and provide data security procedures for the use of CDHS at the end of the contract period. These steps shall include, at a minimum:

i. Complying with all of the data system security precautions listed in this Agreement or in an Exhibit attached to this Agreement;

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

ii. Achieving and maintaining compliance with the HIPAA Security Rule (45 CFR Parts 160 and 164), as necessary in conducting operations on behalf of CDHS under this Agreement;

iii. Providing a level and scope of security that is at least comparable to the level and scope of security established by the Office of Management and Budget in OMB Circular No. A-130, Appendix III- Security of Federal Automated Information Systems, which sets forth guidelines for automated information systems in Federal agencies; and

iv. Complying with the safeguard provisions in the Department's Information Security Policy, embodied in Health Administrative Manual (HAM), sections 6-1000 et seq. and in the Security and Risk Management Policy in the Information Technology Section of the State Administrative Manual (SAM), sections 4840 et seq., in so far as the security standards in these manuals apply to Business Associate's operations. In case of a conflict between any of the security standards contained in any of these four enumerated sources of security standards, the most stringent shall apply. The most stringent means that safeguard which provides the highest level of protection to PHI from unauthorized disclosure. Further, Business Associate must comply with changes to these standards that occur after the effective date of this Agreement.

Business Associate shall designate a Security Officer to oversee its data security program who shall be responsible for carrying out the requirements of this section and for communicating on security matters with CDHS.

D. *Contractor's Agents.* To ensure that any agents, including subcontractors but excluding providers of treatment services, to whom Contractor provides PHI received from or created or received by Contractor on behalf of CDHS, agree to the same restrictions and conditions that apply to Contractor with respect to such PHI; and to incorporate, when applicable, the relevant provisions of this Contract into each subcontract or subaward to such agents or subcontractors.

E. *Availability of Information to Members.* To provide access to members (upon reasonable notice and during Contractor's normal business hours) to their PHI in a Designated Record Set in accordance with 45 CFR 164.524. Designated Record Set means the group of records maintained for CDHS that includes medical and billing records about Members; enrollment, payment, claims adjudication, and case or medical management systems maintained for CDHS health plans; or those records used to make decisions about Members on behalf of CDHS.

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

F. *Internal Practices.* To make Contractor's internal practices, books and records relating to the use and disclosure of PHI received from CDHS, or created or received by Contractor on behalf of CDHS, available to CDHS for inspection and auditing in a time and manner designated by CDHS, for purposes of determining compliance with the provisions of this Exhibit.

G. *Documentation and Accounting of Disclosures.* To document and make available to CDHS and to a Member such disclosures of PHI, and information related to such disclosures, necessary to respond to a proper request by the subject Member for an accounting of disclosures of PHI, in accordance with 45 CFR 164.528.

H. ***Notification of Breach***. During the term of this Agreement:

i. ***Discovery of Breach***. To notify CDHS **immediately by telephone call plus e-mail or fax** upon the discovery of breach of security of PHI in computerized form if the PHI was, or is reasonably believed to have been, acquired by an unauthorized person; or **within 24 hours by e-mail or fax** of any suspected security incident, intrusion or unauthorized use or disclosure of PHI in violation of this Agreement and this Addendum, or potential loss of confidential data affecting this Agreement. Notification shall be provided to the CDHS contract manager, the CDHS Privacy Officer and the CDHS Information Security Officer. If the incident occurs after business hours or on a weekend or holiday and involves electronic PHI, notification shall be provided by calling the CDHS ITSD Help Desk. Business Associate shall take:

a. Prompt corrective action to mitigate any risks or damages involved with the breach and to protect the operating environment and

b. Any action pertaining to such unauthorized disclosure required by applicable Federal and State laws and regulations.

ii. ***Investigation of Breach***. To immediately investigate such security incident, breach, or unauthorized use or disclosure of PHI or confidential data. Within 72 hours of the discovery, to notify the CDHS contract manager, the SDHS Privacy Officer, and the CDHS Information Security Officer of:

1. What data elements were involved and the extent of the data involved in the breach,

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

2. A description of the unauthorized persons known or reasonably believed to have improperly used or disclosed PHI or confidential data,
3. A description of where the PHI or confidential data is believed to have been improperly transmitted, sent, or utilized,
4. A description of the probable causes of the improper use or disclosure; and
5. Whether Civil Code sections 1798.29 or 1798.82 or any other federal or state laws requiring individual notifications of breaches are triggered.

iii. ***CDHS Contact Information***. To direct communications to the above referenced SDHS staff, the Contractor shall initiate contact as indicated herein. SDHS reserves the right to make changes to the contact information below by giving written notice to the Contractor. Said changes shall not require an amendment to this Agreement or Addendum.

CDHS Contract Manager	**CDHS Privacy Officer**	**CDHS Information Security Officer**
See Provision 4 of Exhibit A for Contract Manager information???	Privacy Officer % Office of Legal Services California Department of Health Services P.O. Box 997413, MS 0011 Sacramento, CA 95899-7413 Telephone: (916) 440-7750 Email: privacyofficer@dhs.ca.gov	Information Security Officer Information Security Office P.O. Box 997413, MS 6302 Sacramento, CA 95899-7413 Email: dhsiso@dhs.ca.gov Telephone: ITSD Help Desk 916-440-7000 or 800-579-0874

I. *Notice of Privacy Practices.* To produce a Notice of Privacy Practices (NPP) in accordance with standards and requirements of HIPAA, the HIPAA regulations, applicable State and Federal laws and regulations, and Section 2.A. of this Exhibit. Such NPP's must include the CDHS Privacy Officer contact information included in part H. above of this Contract as an alternative means for Medi-Cal beneficiaries to lodge privacy complaints. All NPP's created or modified, must be submitted to the CDHS contract manager for review.

Exhibit G
Health Insurance Portability and Accountability Act (HIPAA)

4. Miscellaneous Provisions.

A. *Amendment.* The parties acknowledge that Federal and State laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Contract may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HIPAA regulations and other applicable laws relating to the security or privacy of PHI. Upon CDHS's request, Contractor agrees to promptly enter into negotiations with CDHS concerning an amendment to this Contract embodying written assurances consistent with the standards and requirements of HIPAA, the HIPAA regulations or other applicable laws. CDHS may terminate this Contract upon 30 calendar days written notice in the event (i) Contractor does not promptly enter into negotiations to amend this Contract when requested by CDHS pursuant to this Section or (ii) Contractor does not enter into an amendment providing assurances regarding the safeguarding of PHI that CDHS in its sole discretion, deems sufficient to satisfy the standards and requirements of HIPAA, the HIPAA regulations, and applicable laws.

B. *Assistance in Litigation or Administrative Proceedings.* Contractor shall make itself and its employees, and use all due diligence to make any subcontractors or agents assisting Contractor in the performance of its obligations under this Contract, available to CDHS at no cost to CDHS to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CDHS, its directors, officers or employees based upon claimed violation of HIPAA, the HIPAA regulations or other laws relating to security and privacy, except where Contractor or its subcontractor, employee or agent is a named adverse party.

Exhibit 10.21

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

OHIO MEDICAL ASSISTANCE PROVIDER AGREEMENT
FOR MANAGED CARE PLAN
CFC ELIGIBLE POPULATION

This provider agreement is entered into this first day of January, 2007, at Columbus, Franklin County, Ohio, between the State of Ohio, Department of Job and Family Services, (hereinafter referred to as ODJFS) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and Molina Healthcare of Ohio, Inc., Managed Care Plan (hereinafter referred to as MCP), an Ohio for-profit corporation, whose principal office is located in the city of Columbus, County of Franklin, State of Ohio.

MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751. of the Ohio Revised Code and is organized and agrees to operate as prescribed by Chapter 5101:3-26 of the Ohio Administrative Code (hereinafter referred to as OAC), and other applicable portions of the OAC as amended from time to time.

MCP is an entity eligible to enter into a provider agreement in accordance with 42 CFR 438.6 and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Covered Families and Children (CFC) eligible population described in OAC rule 5101:3-26-02 (B).

ODJFS, as the single state agency designated to administer the Medicaid program under Section 5111.02 of the Ohio Revised Code and Title XIX of the Social Security Act, desires to obtain MCP services for the benefit of certain Medicaid recipients. In so doing, MCP has provided and will continue to provide proof of MCP's capability to provide quality services, efficiently, effectively and economically during the term of this agreement.

This provider agreement is a contract between the ODJFS and the undersigned Managed Care Plan (MCP), provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide comprehensive medical services through the managed care program as provided in Chapter 5101:3-26 of the Ohio Administrative Code, assuming the risk of loss, and complying with applicable state statutes, Ohio Administrative Code, and Federal statutes, rules, regulations and other requirements, including but not limited to title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

ARTICLE I - GENERAL

A. MCP agrees to report to the Chief of Bureau of Managed Health Care (hereinafter referred to as BMHC) or their designee as necessary to assure understanding of the responsibilities and satisfactory compliance with this provider agreement.

B. MCP agrees to furnish its support staff and services as necessary for the satisfactory performance of the services as enumerated in this provider agreement.

C. ODJFS may, from time to time as it deems appropriate, communicate specific instructions and requests to MCP concerning the performance of the services described in this provider agreement. Upon such notice and within the designated time frame after receipt of instructions, MCP shall comply with such instructions and fulfill such requests to the satisfaction of the department. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this provider agreement, and are not intended to amend or alter this provider agreement or any part thereof.

If the MCP previously had a provider agreement with the ODJFS and the provider agreement terminated more than two years prior to the effective date of any new provider agreement, such MCP will be considered a new plan in its first year of operation with the Ohio Medicaid managed care program.

ARTICLE II - TIME OF PERFORMANCE

A. Upon approval by the Director of ODJFS this provider agreement shall be in effect from the date entered through June 30, 2007, unless this provider agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

ARTICLE III - REIMBURSEMENT

A. ODJFS will reimburse MCP in accordance with rule 5101:3-26-09 of the Ohio Administrative Code and the appropriate appendices of this provider agreement.

ARTICLE IV - MCP INDEPENDENCE

A. MCP agrees that no agency, employment, joint venture or partnership has been or will be created between the parties hereto pursuant to the terms and conditions of this agreement. MCP also agrees that, as an independent contractor, MCP assumes all responsibility for any federal, state, municipal or other tax liabilities, along with workers compensation and unemployment compensation, and insurance premiums which may accrue as a result of compensation received for services or deliverables rendered hereunder. MCP certifies that all approvals, licenses or other qualifications necessary to conduct business in Ohio have been obtained and are operative. If at any time during the period of this provider agreement MCP becomes disqualified from conducting business in Ohio, for whatever reason, MCP shall immediately notify ODJFS of the disqualification and MCP shall immediately cease performance of its obligation hereunder in accordance with OAC Chapter 5101:3-26.

ARTICLE V - CONFLICT OF INTEREST; ETHICS LAWS

A. In accordance with the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of MCP, the Chief of BMHC, or other ODJFS employee who exercises any functions or responsibilities in connection with the review or approval of this provider agreement or provision of services under this provider agreement shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, “members” does not include individuals whose sole connection with MCP is the receipt of services through a health care program offered by MCP.

B. MCP hereby covenants that MCP, its officers, members and employees of the MCP have no interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this provider agreement. MCP shall periodically inquire of its officers, members and employees concerning such interests.

C. Any person who acquires an incompatible, compromising or conflicting personal or business interest shall immediately disclose his or her interest to ODJFS in writing. Thereafter, he or she shall not participate in any action affecting the services under this provider agreement, unless ODJFS shall determine that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, Bureau of Managed Health Care, ODJFS.

D. No officer, member or employee of MCP shall promise or give to any ODJFS employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. No officer, member or employee of MCP shall solicit an ODJFS employee to violate any ODJFS rule or policy relating to the conduct of the parties to this agreement or to violate sections 102.03, 102.04, 2921.42 or 2921.43 of the Ohio Revised Code.

E. MCP hereby covenants that MCP, its officers, members and employees are in compliance with section 102.04 of the Revised Code and that if MCP is required to file a statement pursuant to 102.04(D)(2) of the Revised Code, such statement has been filed with the ODJFS in addition to any other required filings.

ARTICLE VI - EQUAL EMPLOYMENT OPPORTUNITY

A. MCP agrees that in the performance of this provider agreement or in the hiring of any employees for the performance of services under this provider agreement, MCP shall not by reason of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry, discriminate against any citizen of this state in the employment of a person qualified and available to perform the services to which the provider agreement relates.

B. MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the provider agreement on account of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.

C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5101:3-26, MCP agrees to hold all subcontractors and persons acting on behalf of MCP in the performance of services under this provider agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this provider agreement, in accordance with rule 5101:3-26-05 of the Ohio Administrative Code.

ARTICLE VII - RECORDS, DOCUMENTS AND INFORMATION

A. MCP agrees that all records, documents, writings or other information produced by MCP under this provider agreement and all records, documents, writings or other information used by MCP in the performance of this provider agreement shall be treated in accordance with rule 5101:3-26-06 of the Ohio Administrative Code. MCP must maintain an appropriate record system for services provided to members. MCP must retain all records in accordance with 45 CFR 74.

B. All information provided by MCP to ODJFS that is proprietary shall be held to be strictly

confidential by ODJFS. Proprietary information is information which, if made public, would put MCP at a disadvantage in the market place and trade of which MCP is a part [see Ohio Revised Code Section 1333.61(D)]. MCP is responsible for notifying ODJFS of the nature of the information prior to its release to ODJFS. ODJFS reserves the right to require reasonable evidence of MCP's assertion of the proprietary nature of any information to be provided and ODJFS will make the final determination of whether this assertion is supported. The provisions of this Article are not self-executing.

C. MCP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this provider agreement. MCP agrees to be bound by the same standards of confidentiality that apply to the employees of the ODJFS and the State of Ohio. The terms of this section shall be included in any subcontracts executed by MCP for services under this provider agreement. MCP must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

ARTICLE VIII - SUSPENSION AND TERMINATION

A. This provider agreement may be canceled by the department or MCP upon written notice in accordance with the applicable rule(s) of the Ohio Administrative Code, with termination to occur at the end of the last day of a month.

B. MCP, upon receipt of notice of suspension or termination, shall cease provision of services on the suspended or terminated activities under this provider agreement; suspend, or terminate all subcontracts relating to such suspended or terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and furnish a report, as of the date of receipt of notice of suspension or termination describing the status of all services under this provider agreement.

C. In the event of suspension or termination under this Article, MCP shall be entitled to reconciliation of reimbursements through the end of the month for which services were provided under this provider agreement, in accordance with the reimbursement provisions of this provider agreement.

D. ODJFS may, in its judgment, suspend, terminate or fail to renew this provider agreement if the MCP or MCP's subcontractors violate or fail to comply with the provisions of this agreement or other provisions of law or regulation governing the Medicaid program. Where ODJFS proposes to suspend, terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the Ohio Administrative Code with respect to ODJFS' suspension, termination or refusal to enter into a provider agreement shall apply, including the MCP's right to request a public hearing under Chapter 119. of the Revised Code.

E. When initiated by MCP, termination of or failure to renew the provider agreement requires written notice to be received by ODJFS at least 75 days in advance of the termination or renewal date, provided, however, that termination or non-renewal must be effective at the end of the last day of a calendar month. In the event of non-renewal of the provider agreement with ODJFS, if MCP is unable to provide notice to ODJFS 75 days prior to the date when the provider agreement expires, and if, as a result of said lack of notice, ODJFS is unable to disenroll Medicaid enrollees prior to the expiration date, then the provider agreement shall be deemed extended for up to two calendar months beyond the expiration date and both parties shall, for that time, continue to fulfill their duties and obligations as set forth herein. If an MCP wishes to terminate or not renew their provider agreement for a specific region(s), ODJFS reserves the right to initiate a procurement process to select additional MCPs to serve Medicaid consumers in that region(s).

ARTICLE IX - AMENDMENT AND RENEWAL

A. This writing constitutes the entire agreement between the parties with respect to all matters herein. This provider agreement may be amended only by a writing signed by both parties. Any written amendments to this provider agreement shall be prospective in nature.

B. This provider agreement may be renewed one or more times by a writing signed by both parties for a period of not more than twelve months for each renewal.

C. In the event that changes in State or Federal law, regulations, an applicable waiver, or the terms and conditions of any applicable federal waiver, require ODJFS to modify this agreement, ODJFS shall notify MCP regarding such changes and this agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this provider agreement.

ARTICLE X - LIMITATION OF LIABILITY

A. MCP agrees to indemnify the State of Ohio for any liability resulting from the actions or omissions of MCP or its subcontractors in the fulfillment of this provider agreement.

B. MCP hereby agrees to be liable for any loss of federal funds suffered by ODJFS for enrollees resulting from specific, negligent acts or omissions of the MCP or its subcontractors during the term of this agreement, including but not limited to the nonperformance of the duties and obligations to which MCP has agreed under this agreement.

C. In the event that, due to circumstances not reasonably within the control of MCP or ODJFS, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection occurs, neither ODJFS nor MCP will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered

services; provided that so long as MCP's certificate of authority remains in full force and effect, MCP shall be liable for the covered services required to be provided or arranged for in accordance with this agreement.

ARTICLE XI - ASSIGNMENT

A. ODJFS will not allow the transfer of Medicaid members by one MCP to another MCP unless this membership has been obtained as a result of an MCP selling their entire Ohio corporation to another health plan. MCP shall not assign any interest in this provider agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODJFS and subject to such conditions and provisions as ODJFS may deem necessary. Any such assignments shall be submitted for ODJFS' review 120 days prior to the desired effective date. No such approval by ODJFS of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODJFS in addition to the total agreed-upon reimbursement in accordance with this agreement.

B. MCP shall not assign any interest in subcontracts of this provider agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODJFS and subject to such conditions and provisions as ODJFS may deem necessary. Any such assignments of subcontracts shall be submitted for ODJFS' review 30 days prior to the desired effective date. No such approval by ODJFS of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODJFS in addition to the total agreed-upon reimbursement in accordance with this agreement.

ARTICLE XII - CERTIFICATION MADE BY MCP

A. This agreement is conditioned upon the full disclosure by MCP to ODJFS of all information required for compliance with federal regulations as requested by ODJFS.

B. By executing this agreement, MCP certifies that no federal funds paid to MCP through this or any other agreement with ODJFS shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. MCP further certifies compliance with the lobbying restrictions contained in Section 1352, Title 31 of the U.S. Code, Section 319 of Public Law 101-121 and federal regulations issued pursuant thereto and contained in 45 CFR Part 93, Federal Register, Vol. 55, No. 38, February 26, 1990, pages 6735-6756. If this provider agreement exceeds $100,000, MCP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this provider agreement was entered into.

C. By executing this agreement, MCP certifies that neither MCP nor any principals of MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal

agency. The MCP also certifies that the MCP has no employment, consulting or any other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCP's contractual obligation with ODJFS. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into. If it is ever determined that MCP knowingly executed this certification erroneously, then in addition to any other remedies, this provider agreement shall be terminated pursuant to Article VII, and ODJFS must advise the Secretary of the appropriate Federal agency of the knowingly erroneous certification.

D. By executing this agreement, MCP certifies compliance with Article V as well as agreeing to future compliance with Article V. This certification is a material representation of fact upon which reliance was placed when this contract was entered into.

E. By executing this agreement, MCP certifies compliance with the executive agency lobbying requirements of sections 121.60 to 121.69 of the Ohio Revised Code. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

F. By executing this agreement, MCP certifies that MCP is not on the most recent list established by the Secretary of State, pursuant to section 121.23 of the Ohio Revised Code, which identifies MCP as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

G. By executing this agreement MCP agrees not to discriminate against individuals who have or are participating in any work program administered by a county Department of Job and Family Services under Chapters 5101 or 5107 of the Revised Code.

H. By executing this agreement, MCP certifies and affirms that, as applicable to MCP, no party listed in Division (I) or (J) of Section 3517.13 of the Ohio Revised Code or spouse of such party has made, as an individual, within the two previous calendar years, one or more contributions in excess of $1,000.00 to the Governor or to his campaign committees. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into. If it is ever determined that MCP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, MCP shall return to ODJFS all monies paid to MCP under this provider agreement. The provisions of this section shall survive the expiration or termination of this provider agreement.

I. By executing this agreement, MCP certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, etc. of MCP.

J. By executing this agreement, MCP agrees to comply with the false claims recovery requirements of Section 6032 of The Deficit Reduction Act of 2005 (also see Section 5111.101 of the Revised Code).

ARTICLE XIII - CONSTRUCTION

A. This provider agreement shall be governed, construed and enforced in accordance with the laws and regulations of the State of Ohio and appropriate federal statutes and regulations. If any portion of this provider agreement is found unenforceable by operation of statute or by administrative or judicial decision, the operation of the balance of this provider agreement shall not be affected thereby; provided, however, the absence of the illegal provision does not render the performance of the remainder of the provider agreement impossible.

ARTICLE XIV - INCORPORATION BY REFERENCE

A. Ohio Administrative Code Chapter 5101:3-26 (Appendix A) is hereby incorporated by reference as part of this provider agreement having the full force and effect as if specifically restated herein.

B. Appendices B through P and any additional appendices are hereby incorporated by reference as part of this provider agreement having the full force and effect as if specifically restated herein.

C. In the event of inconsistence or ambiguity between the provisions of OAC 5101:3-26 and this provider agreement, the provision of OAC 5101:3-26 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of this provider agreement, in which case such federal or state law shall be determinative of the obligations of the parties. In the event OAC 5101:3-26 is silent with respect to any ambiguity or inconsistency, the provider agreement (including Appendices B through P and any additional appendices), shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the provider agreement and the budgetary and statutory constraints of ODJFS.

Covered Families and Children (CFC) population

The parties have executed this agreement the date first written above. The agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

MOLINA HEALTHCARE OF OHIO, INC.:

BY: _____ DATE: _____
JESSE THOMAS, PRESIDENT & CEO

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES:

BY: _____ DATE: _____
BARBARA E. RILEY, DIRECTOR

CFC PROVIDER AGREEMENT INDEX
JANUARY 1, 2007

APPENDIX A

OAC RULES 5101:3-26

The managed care program rules can be accessed electronically through the BMHC page of the ODJFS website.

APPENDIX B

SERVICE AREA SPECIFICATIONS
ABD ELIGIBLE POPULATION

MCP : Molina Healthcare of Ohio, Inc.

The MCP agrees to provide services to Aged, Blind or Disabled (ABD) members residing in the following service area(s):

Service Area: Southwest Region: Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren counties.

Service Area: West Central Region: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby counties.

Service Area: Southeast Region: Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Vinton, and Washington counties.

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.
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 their Contract Administrator of the termination of an MCP panel provider that is designated as the primary care physician for >500 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 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 that **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 adhere 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 (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 or other staff. Furthermore, MCPs are prohibited from offering gifts of nominal value (i.e. clipboards, pens, coffee mugs, etc.) to CDJFS offices or SSE 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 its receipt prior to the member's effective date of coverage. No other materials may be included with this mailing.

c. The member handbook, provider directory and advance directives information must be mailed 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 MCP is unable to mail the materials within twenty-four (24) hours, the materials must be mailed via a method that will ensure receipt by no later than the 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 a.m to 7:00 p.m 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 (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:
    - Eligible for Supplemental Security Income under title XVI;
    - In foster care or other out-of-home placement;
    - Receiving foster care of adoption assistance;
    - 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 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 selection services contractor (SSC) 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 SSC-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.

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 Deferment Requests: When the MCP learns of a new member's hospitalization that is eligible for deferment prior to that member's discharge, the MCP shall notify the hospital and treating providers of the potential that the MCP may not be the payer. The MCP shall work with hospitals, 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 MCP learns of a deferment-eligible hospitalization, the MCP shall make every effort to notify the ODJFS and request the deferment as soon as possible. When the MCP is notified by ODJFS of a potential hospital deferment, the MCP must make every effort to respond to ODJFS within ten (10) business days of the receipt of the deferment information.

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 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, 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.

i. Transition of Fee-For-Service Members

Providing care coordination for prescheduled health services 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 authorized representative contacts the MCP to discuss the scheduled health services in advance of the service date and one of the following applies:

a. The member has been approved to receive an organ, bone marrow, or hematapoietic stem cell transplant pursuant to OAC rule 5101:3-2-07.1.

b. The member is in her third trimester of pregnancy and has an established relationship with an obstetrician and/or delivery hospital;

c. 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);

d. 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

e. The member is receiving ongoing chemotherapy or radiation treatment.

ii. Reimburse out-of-panel providers that agree to provider the transition services identified in this section at 100% of the current Medicaid fee-for-service provider rate for the service(s).

iii. Document the provision of transition of services as follows:

a. As expeditiously as the situation warrants, contact the provider’s office via telephone to confirm that the service(s) meet(s) the above criteria.

b. For services that meet the above criteria, inform the provider the MCP is sending a form for signature to document that they accept/do not accept the terms for the provision of the services and copy the member on the form.

c. If the provider agrees to the terms, notify the member and provider of the authorization and ensure that the claims processing system will not deny the claim payment because the provider is out-of-panel. MCPs must include their non-contracting provider materials as outlined in Appendix G.4.e.with the provider notice.

d. If the provider does not agree to the terms, notify the member and assist the member with locating a provider as expeditiously as the member's condition warrants.

e. Use the ODJFS-specified model language for the provider and member notices.

f. Maintain documentation of all member and/or provider contacts relating to such out-of-panel services, including but not limited to telephone calls and letters.

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:

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; and
Standard code sets.

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 submit written verification to ODJFS for transaction standards and code sets specified in 45 CFR Part 162 – Health Insurance Reform: Standards for Electronic Transactions (HIPAA regulations), that the MCP has established the capability of sending and receiving applicable transactions in compliance with the HIPAA regulations. The written verification shall specify the date that the MCP has: 1) achieved capability for sending and/or receiving the following transactions, 2) entered into the appropriate trading partner agreements, and 3) 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.

No more than two production files in the ODJFS-specified medium per format (e.g., NSF) should be submitted each month. If it is necessary for an MCP to submit more than two production files in the ODJFS-specified medium for a particular format in a month, they must request and receive permission to do so from their designated Contract Administrator.

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

Every two (2) years, and before ODJFS enters into a provider agreement with a new MCP, ODJFS or designee may review the information system capabilities of each MCP. Each MCP must participate in the review, except as specified below. 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.

As noted above, the information system review may be performed every two years. However, if ODJFS or its designee identifies significant information system problems, then ODJFS or its designee may conduct, and the MCP must participate in, a review the following year or in such a timeframe as ODJFS, in their sole discretion, deems appropriate to ensure accuracy and efficiency of the MCP health information system.

If an MCP had an assessment performed of its information system through a private sector accreditation body or other independent entity within the two years preceding the time when ODJFS or its designee will be conducting its review, and has not made significant changes to its information system since that time, and the information gathered is the same as or consistent with the ODJFS or its designee's proposed review, as determined by the ODJFS, then the MCP will not required to undergo the IS review. The MCP must provide ODJFS or its designee with a copy of the review that was performed so that ODJFS can determine whether or not the MCP will be required to participate in the IS review.

MCPs who are determined to be exempt from the IS review must participate in subsequent information system reviews, as determined by ODJFS.

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).

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 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 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 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 36(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; and (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 member materials designated specifically for CFC and/or ABD consumers are clearly labeled as such. 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.

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.
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 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 Selection Services Entity (SSE) also known as Selection Services Contractor (SSC): The ODJFS-contracted SSC will provide unbiased education, selection services, and community outreach for the Medicaid managed care program. The SSC shall operate a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

The SSC 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 SSC-initiated MCP assignment processed through the SSC. 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 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.

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.

APPENDIX E

RATE METHODOLOGY
CFC ELIGIBLE POPULATION

MERCER
Government Human Services Consulting

333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427
www.mercerHR.com

October 20, 2006

Mr. Jon Barley
State of Ohio
Bureau of Managed Health Care
Ohio Department of Job and Family Services
255 East Main Street, 2nd Floor
Columbus, OH 43215-5222

Subject:

Calendar Year 2007 Rate-Setting Methodology: Healthy Families and Healthy Start

Dear Jon:

The Ohio Department of Job and Family Services (State) contracted with Mercer Government Human Services Consulting (Mercer) to develop actuarially sound capitation rates for Calendar Year (CY) 2007 for the Healthy Families and Healthy Start (CFC) managed care populations. Mercer developed CY 2007 capitation rates for the following seven managed care regions: Central, East Central, Northeast, Northwest, Southeast, Southwest, and West Central. At this time, Mercer has not developed rates for the eighth region, Northeast Central, because managed care implementation has been put on hold for this region. Once the implementation date is determined for Northeast Central, a supplemental certification with the Northeast Central rates will be provided.

The basic rate-setting methodology is similar to the county-specific rate methodology used in previous years. This methodology letter outlines the rate-setting process, provides information on data adjustments, and includes a final rate summary.

The key components in the CY 2007 rate-setting process are:

- Base data development,
- Managed care rate development, and
- Centers for Medicare and Medicaid Services (CMS) documentation requirements.

Each of these components is described further throughout the document and is depicted in the flowchart included as Appendix A.

Base Data Development

The major steps in the development of the base data are similar to previous years. Mercer and the State have discussed the available data sources for rate development and the applicability of these data sources for each region.

The data sources used for CY 2007 rate setting were:

- Ohio historical FFS data,
- MCP encounter data, and
- MCP financial cost report data.

Validation Process

As part of the rate-setting process, Mercer validated each of the data sources that were used to develop rates. The validations included a review of the data to be used in the rate setting process. During the validation process, Mercer adjusted the data for any data miscodes (e.g., males in the delivery rate cohort) that were found.

Data Sources

As Ohio's Medicaid program matures, the rate-setting methodology for those counties within each region with stable managed care programs can focus more on plan-reported managed care data, including encounter data and cost reports. For counties within each region without established managed care programs, Mercer continued to use the FFS data as a direct data source. The data sources used in each region depended on the most credible data sources available within the region. In regions where there are stable managed care programs, managed care data for those counties was combined with the FFS data for those counties without established managed care programs. The process to prepare these three data sources for rate-setting is detailed below.

Appendix B includes a chart detailing how each region's counties have been bucketed into mandatory, Preferred Option, voluntary, or new based on the delivery system in place during the base period. This determined which data sources were used in determining regional CY 2007 rates. Also included in Appendix B is a map that shows the counties included within each region.

Other sources of information that were used, as necessary, included state enrollment reports, state financial reports, projected managed care penetration rates, information from prior MCP surveys, encounter data issues log, and other ad hoc sources.

Fee-for-Service Data

FFS experience from the base time period of State Fiscal Year (SFY) 2004 (July 1, 2003-June 30, 2004) and SFY 2005 (July 1, 2004-June 30, 2005) was used as a direct data source for the counties described below:

- Those that had a voluntary managed care program during the base time period, and
- Those that did not have a managed care program during the base time period.

In addition to the SFY 2004 and SFY 2005 data, SFY 2003 data supplemented the FFS base data development as a reasonability measure. For the above counties, the FFS data was considered the most credible data source and, in some cases, was the only data available for rate setting.

As in previous years, adjustments were applied to the FFS data to reflect the actuarially equivalent claims experience for the population that will be enrolled in the managed care program. The State Medicaid Management Information System (MMIS) includes data for populations and/or services excluded from managed care and the actual FFS paid claims may be net or gross of certain factors (e.g., gross adjustments or third party liability (TPL)). As a result, it is necessary to make adjustments to the FFS base data as documented in Appendix C and outlined in Appendix A.

Encounter Data

MCP encounter experience from the base time period of SFY 2004 and SFY 2005 was used as a direct data source for the counties described below:

- Those that had a mandatory managed care program during the base time period, and
- Those that had a Preferred Option managed care program during the base time period.

For the above counties, the encounter data was considered a credible data source and was used along with the financial cost report data as a direct data source.

Although encounter data is generally reflective of the populations and services that are the responsibility of the MCPs, adjustments were applied to the encounter data, as appropriate. Those adjustments, and other considerations, include the following items:

- Claims completion factors,

- Program changes in the historical base time period (SFY 2004-SFY 2005), and
- Other actuarially appropriate adjustments, as needed, and according to the State's direction to reflect such things as incomplete encounter reporting or other known data issues.

The adjustments to the encounter data are further documented in Appendix C and outlined in Appendix A.

During the rate setting process, shadow pricing was used to assign unit costs to the encounter data. This process was necessary since, during the base period, paid amounts were not a required field for reporting encounters. Additional information on shadow pricing is presented on page six of this letter.

Financial Cost Reports

MCP-submitted financial cost reports from the base time period CY 2004 and CY 2005 were used as a direct data source for the counties described below:

- Those that had a mandatory managed care program during the base time period, and
- Those that had a Preferred Option managed care program during the base time period.

For all of the above counties, except Mahoning and Trumbull who entered into managed care on October 1, 2005, the cost reports were considered a credible data source. In addition, for counties with voluntary managed care programs during the base time period, the cost reports were taken into consideration when setting rates, although not used as a direct data source.

As with the encounter data, the cost report data typically reflects the populations and services that are the responsibility of the MCPs. However, adjustments were applied to the cost report data, as appropriate. Those adjustments, and other considerations, include the following items:

- Program changes in the historical base time period (CY 2004-CY 2005),
- Incurred claims estimates based on review of claims lag triangles, and
- Other actuarially appropriate adjustments, as needed, to reflect such things as incomplete reporting or other known data issues.

Mercer considered the CY 2004 and CY 2005 cost reports both in the development of completion factors for the base time period (CY 2004-CY 2005) and in the development of the final rate.

The adjustments for the cost report data are further documented in Appendix C and outlined in Appendix A.

Managed Care Rate Development

This section explains how Mercer developed the final capitation rates paid to contracted MCPs after the base data was developed and multiple years of data were blended for each data source. First, Mercer applied trend, programmatic changes and other adjustments to each data source to project the program cost into the contract year. Next, the various data sources were blended into a single managed care rate and an administrative component was applied. Finally, relational modeling was used to smooth the results within each region. Appendix A outlines the managed care rate development process. Appendix D provides more detail behind each of the following adjustments.

Blending Multiple Years of Data

As the programs have matured, we have collected multiple years of FFS and managed care data. In order to utilize all available current information, Mercer combined the yearly data within each data source using a weighted average methodology similar to that used in previous years. Prior to blending these years of data, the base time period experience was trended to a common time period of CY 2005. Mercer applied greater credibility on the most recent year of data to reflect the expectation that the most recent year may be more reflective of future experience and to reflect that fewer adjustments are needed to bring the data to the effective contract period.

Managed Care Assumptions for the FFS Data Source

In developing managed care savings assumptions, Mercer applied generally accepted actuarial principles that reflect the impact of MCP programs on FFS experience. Mercer reviewed Ohio's historical FFS experience, CY 2004 and CY 2005 cost report data, SFY 2004 and SFY 2005 encounter data, and other state Medicaid managed care experience to develop managed care savings assumptions. These assumptions have been applied to the FFS data to derive managed care cost levels. The assumptions are consistent with an economic and efficiently operated Medicaid managed care plan. The managed care savings assumptions vary by region, rate cohort and category of service (COS).

Specific adjustments were made in this step to reflect the differences between pharmacy contracting for the State and contracting obtained by the MCPs. Mercer reviewed information related to discount rates, dispensing fees, rebates, encounter data and MCP cost report data to make these adjustments. The rates are reflective of MCP contracting for these services.

Shadow Pricing

During our base period, MCPs were not required to report the amount paid for a particular service in their encounter submissions. Therefore, Mercer developed assumed unit costs that were applied to encounter utilization data. For the inpatient category of service, unit costs were calculated by region based on the average daily cost for each hospital peer group. Unit costs for other COSs were calculated based on Ohio Medicaid FFS reimbursement levels. The unit costs were then adjusted by rate cohort to reflect the age/sex unit cost differential apparent in the statewide FFS data. In addition, a unit cost managed care assumption was applied in the shadow pricing step for the pharmacy COS.

Prospective Policy Changes

CMS also requires that the rate-setting methodology incorporates the impact of any programmatic changes that have taken place, or are anticipated to take place, between the base period (CY 2005) and the contract period (CY 2007).

The State provided Mercer with a detailed list of program changes that may have a material impact on the cost, utilization, or demographic structure of the program prior to, or within, the contract period and whose impact was not included within the base period data. In addition, other potential program changes are being discussed in the current legislative session. Final programmatic changes approved for SFY 2007 are reflected in the CY 2007 rates, as appropriate. Please refer to Appendix D for more information on these programmatic changes.

Clinical Measures/Incentives

Per Appendix M of the Provider Agreement, the State expects the MCPs to reach certain performance levels for selected clinical measures. Mercer reviewed the impact of these standards and incentives on the managed care rates and developed a set of adjustments based upon the State's expected improvement rates. These utilization targets were built into the capitation rates. The individual measures/incentives are outlined in Appendix D.

Caseload

Historically, the State has experienced significant changes in its Medicaid caseload. These shifts in caseload have affected the demographics of the remaining Medicaid population. Mercer

evaluated recent and expected caseload variations to determine if an adjustment was necessary to account for demographic changes. Based on the data provided by the State, Mercer determined no adjustments were necessary for either the non-delivery or delivery rate cells.

Selection Issues

There are two selection adjustments that were made in the development of the rates. The first is adverse selection, which accounts for the "missing" managed care data and is applied to historical FFS data. This adjustment is explained in more detail in Appendix C.

The second selection adjustment is voluntary selection, which accounts for the fact that costs associated with individuals who elect to participate in managed care are generally lower than the remaining FFS population. Therefore, the voluntary selection adjustment adjusts for the risk of only those members selecting managed care.

Both selection adjustments are reductions to paid claims and utilization for non-delivery data. Appendix D provides more detail around the voluntary selection adjustment.

Non-State Plan Services

According to the CMS Final Medicaid Managed Care Rule that was implemented August 13, 2003, non-state plan services may not be included in the base data for rate-setting. The CY 2004 and 2005 cost reports contain information from the MCPs that was used to adjust the base data for non-state plan services reported in the cost reports and the encounter data. Please refer to Appendix D for more information concerning this adjustment.

Prospective Trend Development

Trend is an estimate of the change in the overall cost of providing a specific benefit service over a finite period of time. A trend factor is necessary to estimate the expenses of providing health care services in some future year, based on expenses incurred in prior years. Trend was applied by COS to the blended base data costs for CY 2005 to project the data forward to the CY 2007 contract period.

Cost report data was reviewed for overall per member per month (PMPM) trend levels while the FFS data continued to be a primary source in projecting trend. Because of its role in the rate-setting process, the encounter data was available to study utilization trend drivers. Mercer integrated the specific data sources' trend analysis with a broader analysis of other trend resources. These resources included health care economic factors (e.g., as Consumer Price Index

(CPI) and Data Resource Inc. (DRI)), trends in neighboring states, the State FFS trend expectations and any Ohio market changes. Moreover, the trend component was comprised of both unit cost and utilization components.

As in the past, Mercer discussed all trend recommendations with the State. We reviewed the potential impact of initiatives targeted to slow or otherwise affect the trends in the program. Final trend amounts were determined from the many trend resources and this additional program information. Appendix D provides more information on trend.

Credibility Assignment

For regions composed of only new and voluntary counties, 100% credibility was placed on the FFS data. For regions with available FFS and managed care data, the FFS, encounter and cost report data was blended together.

Cesarean Delivery Rate

Mercer reviewed historical FFS delivery data, recent MCP delivery data, and other program experience to determine an expected cesarean delivery rate under the managed care program. Please refer to Appendix D for additional information on cesarean delivery rates.

Relational Modeling

Relational modeling was used to adjust the premiums by rate cohort to produce a relatively consistent age/sex slope among the regions. The relational modeling adjustments shift dollars across rate cohorts within a region but do not change the composite results by region or in aggregate. Through the use of the adjustments, the range of variances among the regions and rate cohorts was reduced while maintaining budget neutrality.

The relational modeling adjustments were applied to the net medical rates in the Capitation Rate Calculation Sheets (CRCS) to develop new adjusted medical rates. An administration load factor was then applied as a percent of premium.

Administration/Contingencies

Mercer reviewed the components of the administration/contingencies allowance and evaluated the administration/contingencies rates paid to the MCPs. Factors that were taken into consideration in determining the final administration/contingencies percentages included the State's expectations, Ohio health plan experience, other Medicaid program

administration/contingencies allowances, and Ohio health plans' lengths of participation in the program. In addition, the MCP franchise fee of 4.5% was incorporated into the final capitation rate.

Certification of Final Rates

The following capitation rates were developed for each of the seven regions for the CY 2007 contract period:

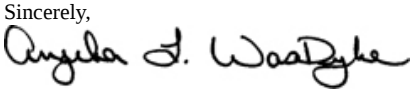
- Healthy Families/Healthy Start, Less Than 1, Male & Female,
- Healthy Families/Healthy Start, 1 Year Old, Male & Female,
- Healthy Families/Healthy Start, 2-13 Years Old, Male & Female,
- Healthy Families/Healthy Start, 14-18 Years Old, Female,
- Healthy Families/Healthy Start, 14-18 Years Old, Male,
- Healthy Families, 19-44 Years Old, Female,
- Healthy Families, 19-44 Years Old, Male,
- Healthy Families, 45 and Over, Male & Female,
- Healthy Start, 19-64 Years Old, Female, and
- Delivery Payment.

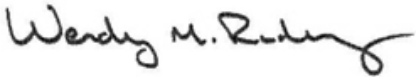
A summary of the rates is included in Appendix E.

Mercer certifies the above rates were developed in accordance with generally accepted actuarial practices and principles by actuaries meeting the qualification standards of the American Academy of Actuaries for the populations and services covered under the managed care contract. Rates developed by Mercer are actuarial projections of future contingent events. Actual MCP costs will differ from these projections. Mercer developed these rates on behalf of the State to demonstrate compliance with the CMS requirements under 42 CFR 438.6(c) and to demonstrate that rates are in accordance with applicable law and regulations.

MCPs are advised that the use of these rates may not be appropriate for their particular circumstance and Mercer disclaims any responsibility for the use of these rates by MCPs for any purpose. Mercer recommends any MCP considering contracting with the State should analyze its own projected medical expense, administrative expense, and any other premium needs for comparison to these rates before deciding whether to contract with the State. Use of these rates for purposes beyond those stated may not be appropriate.

Sincerely,



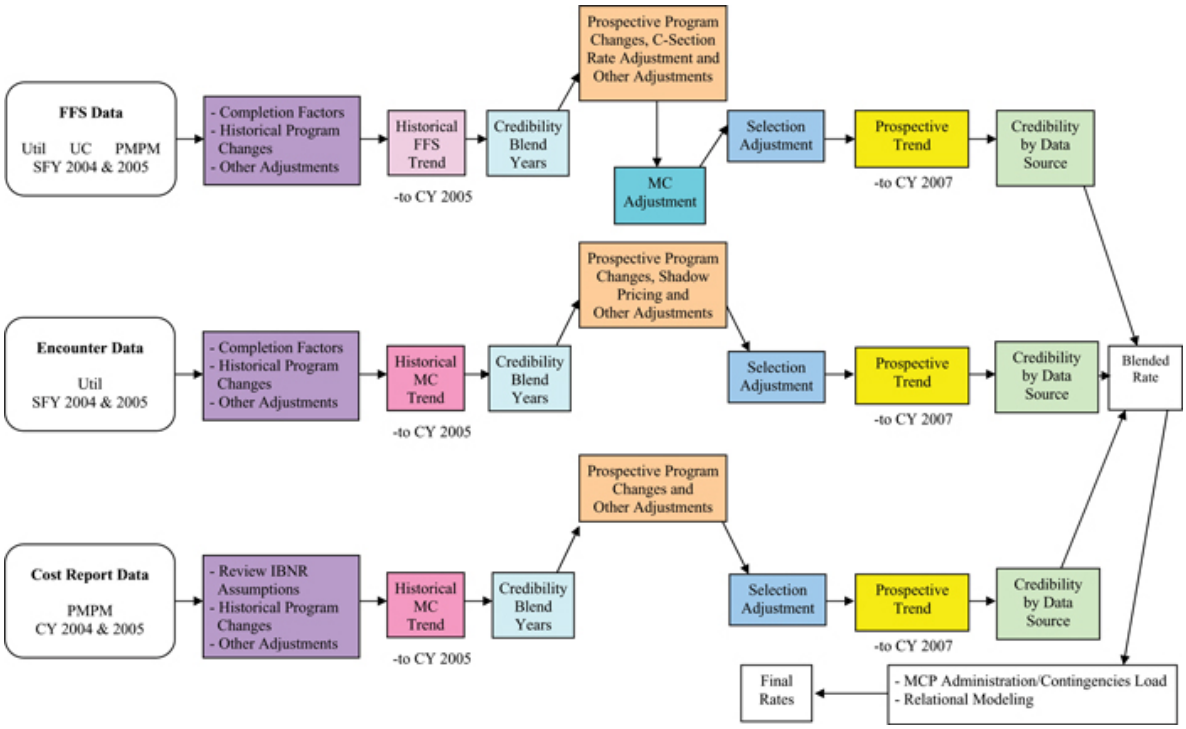


Angela WasDyke, MAAA, ASA

Wendy Radunz, MAAA, FSA

Copy:
Chuck Betley, Mitali Ghatak, Tracy Williams – State of Ohio
Katie Olecik, Jon Rasmussen – Mercer

Appendix A – CY 2007 Rate-Setting Methodology



Appendix B – Regional Delivery System Definition

Regional Delivery System Definitions

For regional rate development, counties were bucketed into mandatory, Preferred Option, voluntary, or new as outlined below. The data for all counties within the region was used to develop the regional rate. Please see page B-2 for a map defining the counties within each region.

Mandatory and Preferred Option Counties

Encounter and cost report data was used for counties that were either mandatory or Preferred Option during the base data period*. These counties include:

Mandatory:	Preferred Option:
Cuyahoga	Butler
Lucas	Clark
Stark	Franklin
Summit	Hamilton
	Lorain
	Montgomery

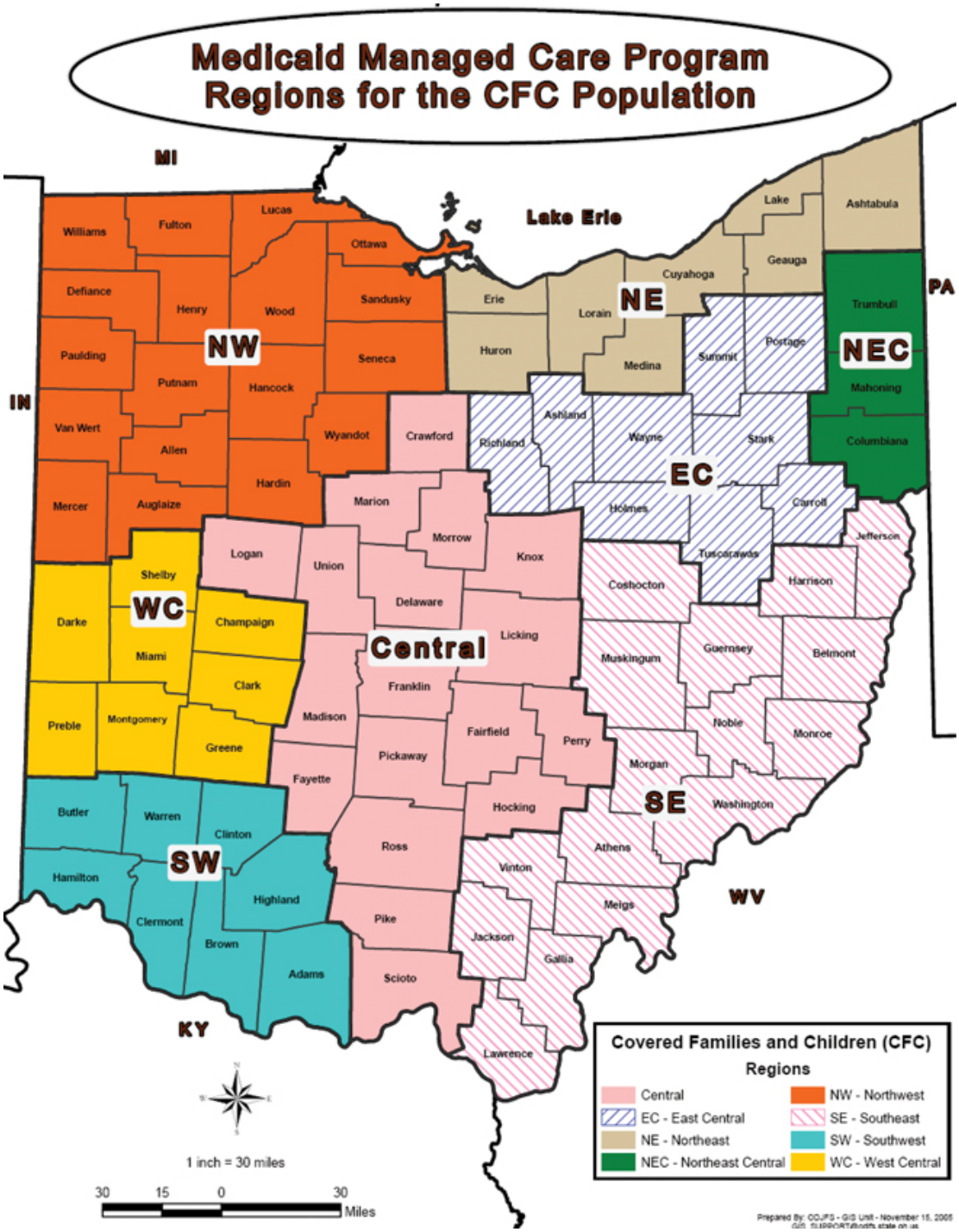
* *Please note Mahoning and Trumbull are not included in the above table due to a lack of credible data. Both counties entered into managed care in October of 2005.*

Voluntary Counties

FFS data was used for voluntary counties during the base period and new counties entering the managed care program since the time of the base data. The voluntary counties include:

Voluntary:
Clermont
Greene
Pickaway
Warren
Wood

New counties include all counties that were not mandatory, Preferred Option or voluntary during the base data period.


Medicaid Managed Care Program
Regions for the CFC Population
MI
Lake Erie
PA
IN
KY
WV
NW
NE
NEC
EC
WC
Central
SW
SE
Williams
Fulton
Lucas
Ottawa
Defiance
Henry
Wood
Sandusky
Paulding
Putnam
Hancock
Seneca
Van Wert
Allen
Wyandot
Crawford
Mercer
Auglaize
Hardin
Marion
Logan
Union
Morrow
Knox
Shelby
Darke
Champaign
Delaware
Licking
Miami
Clark
Franklin
Preble
Montgomery
Greene
Madison
Fairfield
Perry
Pickaway
Fayette
Hocking
Butler
Warren
Clinton
Ross
Hamilton
Highland
Vinton
Clermont
Brown
Pike
Jackson
Adams
Scioto
Gallia
Lawrence
Lake
Ashtabula
Geauga
Cuyahoga
Erie
Lorain
Huron
Medina
Summit
Portage
Trumbull
Mahoning
Ashland
Richland
Wayne
Stark
Columbiana
Holmes
Carroll
Jefferson
Tuscarawas
Coshocton
Harrison
Muskingum
Guernsey
Belmont
Noble
Monroe
Morgan
Washington
Athens
Meigs
Covered Families and Children (CFC) Regions
Central
EC - East Central
NE - Northeast
NEC - Northeast Central
NW - Northwest
SE - Southeast
SW - Southwest
WC - West Central
1 inch = 30 miles
30 15 0 30
Miles

Appendix C – FFS Data Adjustments

This section lists adjustments made to the FFS claims and eligibility information received from the State.

Completion Factors

The claims data was adjusted to account for the value of claims incurred but unpaid on a COS basis. Mercer used claims for SFY 2004 and SFY 2005 that reflect payments through the dates included in the following table.

SFY	Paid Through
2004	03/31/05
2005	12/31/05

The value of the claims incurred during each of these years, but unpaid, was estimated using completion factor analysis.

Gross Adjustment File (GAF)

To account for gross debit and credit amounts not reflected in the FFS data, adjustments were applied to the FFS paid claims.

Historical Policy Changes

As part of the rate-setting process, Mercer must account for policy changes that occurred during the base data time period. Changes only reflected in a portion of the data must be applied to the remaining data so that all base data reflects the policy changes. All policy changes implemented during SFY 2004 and SFY 2005 were applied to the FFS data.

The following table shows the specific policy changes for which Mercer adjusted the SFY 2004 and SFY 2005 delivery (where applicable) and non-delivery data. Mercer calculated the adjustments based on information supplied by the State.

Policy Changes	Effective Date	Category of Service Affected	Rate Cohorts Affected
Independently-practicing psychologist services eliminated for adults (>21) and pregnant women	1/1/2004	PCP, OB/GYN and Specialists	Ages 19+, including delivery
All chiropractic services eliminated for adults (>21) and pregnant women	1/1/2004	Other	HF, Age 19-44, M HF, Age 19-44, F HF, Age 45+, M & F HST, Age 19-64, F
Implementation of $3.00 Copay on Prior-Authorized Drugs	1/1/2004	Pharmacy	All

Third Party Liability Recoveries

TPL can be identified with two components: “cost-avoidance” and “pay and chase” type actions. “Cost-avoidance” occurs when the State initially denies paying a claim because another payer is the primary payer. The State may then pay a residual portion of the charged amount. Only the residual portion of the claim will be included in the FFS data. The portion of the claim paid by another payer has been avoided and not included in reported claim payments. Participating MCPs are expected to pay in a similar fashion and therefore, no adjustment to the FFS data will be required.

In a “pay and chase” scenario, the State pays the claim as though it were the primary payer. Subsequent to payment, the State makes recovery from a third party. These TPL recoveries are not reflected in the FFS MMIS data. Since MCPs are also expected to take similar recovery actions, the FFS experience was adjusted to reflect “pay and chase” recoveries. Mercer made adjustments to both the paid claims and utilization for all non-delivery and delivery COS. Since MCPs do not collect tort recoveries, the data excludes tort collections.

Hospital Cost Settlements

The State provided Mercer with SFY 2004 and SFY 2005 interim cost settlements for Diagnosis Related Group (DRG) and DRG-exempt hospitals. The DRG-exempt hospital information included inpatient and outpatient settlements. However, the DRG hospitals only include capital settlements, which were incorporated into the adjustment. Therefore, an adjustment has been applied to non-delivery and delivery inpatient, outpatient, and emergency room (ER) claims to remove these additional costs.

Fraud and Abuse

The State does pursue recoveries from fraud and abuse cases. The dollars recovered are accounted for outside of the State’s MMIS system and are not included in the FFS data. Since the MCPs are required to pursue fraud and abuse cases, an adjustment was applied to the FFS claims and utilization in both the delivery and non-delivery data.

Excluded Time Periods

The capitation rates paid to the MCPs reflect the risk of serving the eligible enrollees from the date of health plan enrollment forward. Therefore, the non-delivery FFS data has been adjusted to reflect only the time periods for which the MCPs are at risk. Since newborns are automatically eligible for the Medicaid program and are enrolled into their mother’s MCP at birth, no adjustment will be applied to the “Less Than 1” age group.

Adverse Selection

An adverse selection adjustment was applied to the historical FFS data to account for the “missing” managed care data. The adverse selection factor adjusts the associated risk of the FFS members to the entire Medicaid population’s risk by accounting for the cost of the managed care population. This adjustment varies by historical managed care penetration and includes a credibility factor which accounts for differences in State enrollment patterns and data sources. It has been applied to the paid claims and utilization for non-delivery FFS base data.

Dual Eligibles

Dual eligible persons are not enrolled in managed care and, therefore, are not included in the managed care rates. Their experience has been excluded from the base FFS data used to develop the rates.

Catastrophic Claims

Since the State does not provide reinsurance to the MCPs, the MCPs are expected to purchase reinsurance on their own. To reflect these costs, all claims, including claims above the reinsurance threshold, were included in the base FFS data. The final rates Mercer calculated reflect the total risk associated with the covered population and are expected to be sufficient to cover the cost of the required stop-loss provision.

DSH Payments

DSH payments are made by the State to providers and are not the responsibility of the MCPs; therefore, the information for these payments was excluded from the FFS data used to develop the rates. No rate adjustment was necessary.

Spend Down

Persons Medicaid eligible due to spend down are not enrolled in managed care and therefore not included in the managed care rates. The base FFS data is net of recipient spend down. Therefore, no additional adjustment was needed for the rate computations.

Graduate Medical Education (GME)

The State does not make supplemental GME payments for services delivered to individuals covered under the managed care program. Rather, the MCPs negotiate specific rates with the individual teaching hospitals for the daily cost of care. Therefore, the GME payments are included in the capitation rates paid to the MCPs.

Appendix C – Encounter Data Adjustments

Claims Completion

Mercer used CY 2005 cost report lag triangles to complete the MCP encounter utilization data.

Historical Policy Changes

As part of the rate-setting process, the data must reflect any policy changes that occurred during the base data time period. Changes only reflected in a portion of the base data must be applied to the remaining base data to keep the data similar. Mercer made adjustments to the encounter data to include consideration for the following policy changes.

Policy Change	Effective Date	Category of Service Affected	Rate Cohorts Affected
Independently-practicing psychologist services eliminated for adults (>21) and pregnant women	1/1/2004	PCP, OB/ GYN and Specialists	Ages 19+, including delivery
All chiropractic services eliminated for adults (>21) and pregnant women	1/1/2004	Other	HF, Age 19-44, M HF, Age 19-44, F HF, Age 45+, M & F HST, Age 19-64, F

The adjustment for the $3.00 copay on Prior-Authorization Drugs cannot be directly applied to the encounter data because it only contains utilization. The unit cost reduction was, however, reflected in the encounter data shadow prices.

Data Anomaly Corrections

As directed by the State, Mercer made adjustments to the encounter data to account for incomplete reporting or other known data issues.

Non-State Plan Services

Mercer reviewed NSPS information included in the MCP cost reports. This information was used to calculate an adjustment for NSPS, including eye examinations, chiropractic and psychological services, and routine transportation. The adjustment was applied to the Specialists, Dental and Other categories of service in the encounter data, as appropriate.

Third Party Liability Recoveries

Mercer reviewed TPL recoveries information contained in Report I of the cost reports to remove these from the encounters reported by each health plan. Mercer made MCP specific adjustments to the data.

Appendix C – Cost Report Data Adjustments

IBNR Review/Adjustment

Mercer used CY 2005 cost report claims restatement Report IV and lag triangles to adjust the MCP IBNR estimates in the CY 2004 and CY 2005 financial experience.

Historical Policy Changes

As part of the rate-setting process, the data must reflect any policy changes that occurred during the base data time period. Changes only reflected in a portion of the base data must be applied to the remaining base data to keep the data similar. There were no rate-impacting policy changes implemented after 1/1/2004 and before 12/31/05. Therefore, no policy change adjustments were applied to the cost report data.

Data Anomaly Corrections

Mercer made cost-neutral adjustments to the CY 2004 cost report data to account for recoding of expenses by category of service. For example, the delivery costs associated with the “Other” COS in report III-A were shifted to the non-delivery “Other” COS.

Non-State Plan Services

Mercer reviewed NSPS information included in the MCP cost reports. This information was used to calculate an adjustment for NSPS, including eye examinations, chiropractic and psychological services, and routine transportation. The adjustment was applied to the Specialists, Dental and Other categories of service in the cost report data, as appropriate.

Third Party Liability Recoveries

Mercer reviewed TPL recoveries information contained in Report I of the cost reports to remove these from the medical costs reported by each health plan.

Appendix D – Calendar Year 2007 CFC Rate Development

Credibility By Year

Mercer placed more credibility on the most recent year of data for each data source.

FFS Historical and Managed Care Historical/Prospective Trend

Historical FFS trend assumptions were used to trend SFY 2004 and SFY 2005 FFS data to the base period (CY 2005) for voluntary and new counties. Credibility was then applied to blend together the trended SFY 2004 and the SFY 2005 FFS data.

Managed care historical trend was used to trend SFY 2004 and SFY 2005 encounter data and CY 2004 cost report data to the base period (CY 2005) for Preferred Option and mandatory counties. Credibility was then applied to blend together the trended SFY 2004 and the SFY 2005 encounter data and the trended CY 2004 and CY 2005 cost report data.

Prospective managed care trend assumptions were then applied to the blended FFS, cost report, and encounter data to develop the CY 2007 regional rates.

Prospective Policy Changes

The following items are considered prospective policy changes. These changes were not reflected in the base data, but were implemented prior to the contract period. Therefore, Mercer made rate-setting adjustments for each item in the following table.

Adjustments Affecting Unit Cost

Policy Change	Effective Date	Category of Service Affected	Rate Cohorts Affected
Implementation of $2 copay for trade-name preferred drugs for adults ([3]21)	1/1/2006	Pharmacy	HF, Age 19-44, F HF, Age 19-44, M HF, Age 45+, M & F
Implementation of $3 copay for each dental date of service for adults ([3]21)	1/1/2006	Dental	HF, Age 19-44, F HF, Age 19-44, M HF, Age 45+, M & F
Implementation of $2 copay for vision exams and $ 1 copay for dispensing services for adults ([3]21)	1/1/2006	Other	HF, Age 19-44, F HF, Age 19-44, M HF, Age 45+, M&F HST, Age 19-64, F
Inpatient recalibration and outlier policies	1/1/2006	Inpatient	All
Inpatient rate freeze	1/1/2006	Inpatient	All

Adjustments Affecting Utilization

Policy Change	Effective Date	Category of Service Affected	Rate Cohorts Affected
Reduction in coverage of dental services for adults (³21)	1/1/2006	Dental	HF, Age 19-44, F HF, Age 19-44, M HF, Age 45+, M & F HST, Age 19-64, F

The 1/1/2006 policy change in the Federal Poverty Level (FPL) from 100% to 90% did not have an impact on the rates.

Clinical Measures/Incentives

Since the State requires the plans to reach, at minimum, the performance standard for each of the indicators from Appendix M of the SFY 2007 Provider Agreement, Mercer built this expectation into the capitation rates. To calculate the adjustments, Mercer reviewed MCP clinical measures percentages for the CY 2005 base year and projected these rates forward by building in the State's expected improvement rate for counties in managed care as of January 1, 2006. Mercer then calculated the percent change from base year to the rating period, and applied the adjustment as a portion of COS. The following chart provides additional detail on each clinical measure.

Clinical Measure	Rate Cohort	Category of Service Affected
Prenatal Care – Frequency of Ongoing Prenatal Care Target: 80% of eligible population must receive 81% or more of expected number of prenatal visits.	HF/HST, 14-18 F HST, 19-64 F HF, 19-44 F	OB/GYN Physician
Prenatal Care – Post Partum Visits Target: 80% of the eligible population must receive a post partum visit.	HF/HST, 14-18 F HST, 19-64 F HF, 19-44 F	OB/GYN
Preventive Care for Children – Well-Child Visits Target: 80% of children receive expected number of visits: Children who turn 15 mos. old; 6+ visits. Children who were 3-6 years old; 1+ visit. Children who were 12-21 years old; 1+ visit.	HF/HST, <1 M&F HF/HST, 1 M&F HF/HST, 2-13 M&F HF/HST, 14-18 M HF/HST, 14-18 F	Physician
Use of Appropriate Medications for People with Asthma Target: 95% of eligible Asthma members receive prescribed medications acceptable as primary therapy for long-term control of asthma.	HF/HST, 2-13 M&F HF/HST, 14-18 M HF/HST, 14-18 F HF, 19-44 M HF, 19-44 F HF, 45+ M&F HST, 19-64 F	Pharmacy
Annual Dental Visits Target: 60% of enrolled children age 4-21 receive 1 dental visit.	HF/HST, 2-13 M&F HF/HST, 14-18 M HF/HST, 14-18 F	Dental
Lead Screening Target: 80% of children age 1-2 receive a blood lead screening.	HF/HST, 1 M&F HF/HST, 2-13 M&F	Physician

Voluntary Selection

As a result of the adverse selection adjustment that was applied in the FFS Data Summaries, the FFS data already reflects the risk of the entire Medicaid program (i.e., FFS and managed care individuals). To solely reflect the risk of the managed care program, Mercer modified the FFS data based on the projected managed care penetration levels for CY 2007. This voluntary selection adjustment modifies the FFS data to reflect the risk to the MCPs (i.e., only those individuals who enroll in a health plan).

For the encounter and cost report data, the original base data reflects the historical penetration levels in SFY 2004-SFY 2005 and CY 2004-CY 2005, respectively. Where projected managed

care penetration levels differ from the historical values, the data was brought back to reflect the risk of the entire Medicaid program, and then adjusted forward (as the FFS data was) to reflect projected managed care levels.

Credibility by Data Source

For regions composed of only new and voluntary counties, 100% credibility was placed on the FFS data. For regions with available FFS and managed care data, the FFS data was used for the new and voluntary counties within the region, while the encounter and cost report data were used for the mandatory and Preferred Option counties within the region.

C-Section/Vaginal Percent

Mercer received MCP cesarean and vaginal rates from CY 2005 encounter data. Based on the analysis for all MCPs combined, Mercer determined C-section and vaginal rate assumptions.

MCP Administration/Contingencies

Based on a review of MCP reported administration expenses, the MCP administration/ contingencies allowance will remain at 12% of premium prior to the franchise fee. For existing health plans, 1% of the pre-franchise fee capitation rate will be put at risk, contingent upon MCPs meeting performance requirements for counties with managed care enrollment as of January 1, 2006. The at-risk amount for counties entering managed care after January 1, 2006 will be 0% for the first two plan years.

For plans new to managed care in Ohio, the administration schedule will be as follows.

	Admin	At-Risk
Plan Year 1 (months 1-12)	13%	0%
Plan Year 2 (months 13-24)	12%	0%
Plan Year 3 (months 25-36)	12%	1%

For plans entering Ohio through the acquisition of another Ohio health plan’s membership, the administration schedule will continue as outlined above based on the plan year of the acquired health plan membership. The administration schedule will not revert back to the Plan Year 1 schedule due to the membership acquisition.

In addition, the total capitation rate was adjusted to incorporate the 4.5% MCP franchise fee requirement.

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 on Medicaid-covered services, MCPs must refer to the ODJFS website. The following is a 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 services
- Podiatry
- Chiropractic services [not covered for adults age twenty-one (21) and older]
- 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

- Short-term rehabilitative stays in a nursing facility
- Hospice care
- Behavioral health services (see section G.2.b.iii of this appendix). Note: Independent psychologist services not covered for adults age twenty-one (21) and older.

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
- Sex change surgery and related services
- Sexual or marriage counseling

- Court ordered testing
- 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.

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* 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 "Annual Opportunity" 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 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 must provide 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 various Medicaid-covered mental health (MH) services available through the 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 free-standing psychiatric hospital.

Substance Abuse Services: There are a number of various 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: MCPs are responsible for the payment of Medicaid-covered prescription drugs prescribed by a CMHC or ODADAS-certified provider when obtained through an MCP's panel pharmacy. MCPs are also responsible for the payment of Medicaid-covered services provided by an MCP's panel laboratory when referred by a CMHC or ODADAS-certified provider. Additionally, MCPs are responsible for the payment of all other behavioral health services obtained through providers other than those who are CMHC or ODADAS-certified providers when arranged/authorized by the MCP. MCPs are not responsible for paying for behavioral health services provided through CMHCs and ODADAS-certified Medicaid providers. MCPs are also not required to cover the payment of partial hospitalization (mental health), inpatient psychiatric care in a free-standing inpatient psychiatric hospital, outpatient detoxification, or methadone maintenance.

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 §5111.72, 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 hematapoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the "Ohio Hematapoietic 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 (Modification) Programs

General Provisions - Pursuant to OAC rule 5101:3-26-03.1(A)(7), MCPs must implement the ODJFS-required emergency department diversion (EDD) utilization management program to maximize the effectiveness of the care provided to members and may develop other utilization management programs, subject to prior approval by ODJFS. For the purposes of this requirement, the specific utilization management programs which require ODJFS prior-approval are those programs designed by the MCP with the purpose of redirecting or restricting access to a particular service or service location. These programs are referred to as utilization modification programs. MCP care coordination and disease management activities which are designed to enhance the services provided to members with specific health care needs would not be considered utilization management programs nor would the designation of specific services requiring prior approval by the MCP or the member's PCP. 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 approval.

Pharmacy Programs - Pursuant to ORC Sec. 5111.172 and OAC rule 5101:3-26-03(A) and (B), MCPs subject to ODJFS prior-approval, may implement strategies, including prior authorization and limitations on the type of provider and locations where certain medications may be administered, for the management of pharmacy utilization.

Prior Authorizations: MCPs must receive prior approval from ODJFS on the types of medication that they wish to cover through prior authorizations. MCPs must establish their prior authorization system so that it does not unnecessarily impede member access to medically-necessary Medicaid-covered services.

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.

MCPs may also, with ODJFS prior approval, implement pharmacy utilization modification programs designed to address members demonstrating high or inappropriate utilization of specific prescription drugs.

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

In accordance with 5101:3-26-03.1(A)(8), MCPs must offer and provide case management services which coordinate and monitor the care of members with specific diagnoses, or who require high-cost and/or extensive services.

i. Each MCP must inform all members and contracting providers of the MCP's case management services.

ii. The MCP's case management system must include, at a minimum, the following components:

a. specification of the criteria used by the MCP to identify those potentially eligible for case management services, including diagnosis, cost threshold and/or amount of service utilization, and the methodology or process (e.g. administrative data, provider referrals, self-referrals) used to identify the members who meet the criteria for case management;

b. a process for comprehensive assessment of the member's health condition to confirm the results of a positive identification, and determine the need for case management, including information regarding the credentials of the staff performing the assessments of CSHCN;

c. 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;

d. the procedure by which the MCP will assure the timely development of a care treatment plan for any member receiving case management services; offer both the member and the member's PCP/specialist the opportunity to participate in the care treatment plan's development based on the health needs assessment; and provide for the

periodic review of the member's need for case management and updating of the care treatment plan;

e. a process to facilitate, maintain, and coordinate communication between service providers, and member/family, including an accountable point of contact to help obtain medically necessary care, and assist with health-related services and coordinate care needs.

iii. MCPs 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*." The CAMS files are due the 10th business day of each month.

iv. MCPs must have an ODJFS-approved case management system which includes the items in Section G.3.b.i. and Section G.3.b.ii. of this Appendix. 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 system description must be submitted to ODJFS in writing for review and approval prior to implementation.

c. Children with Special Health Care Needs

Children with special health care needs (CSHCN) are a particularly vulnerable population which often have chronic and complex medical health care conditions. In order to ensure state compliance with the provisions of 42 CFR 438.208, ODJFS has implemented program requirements for the identification, assessment, and case management of CSHCN.

Each MCP must establish a CSHCN program with the goal of conducting timely identification and screening, assuring a thorough and comprehensive assessment, and providing appropriate and targeted case management services for any CSHCN.

i. Definition of 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 need or 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

ii. Identification of CSHCN

All MCPs must implement mechanisms to identify CSHCN.

MCPs are expected to use a variety of mechanisms to identify children that meet the definition of CSHCN and are in need of a follow-up assessment including: MCP administrative review; information as reported by the SSC during membership selection; PCP referrals; outreach; and contacting newly-enrolled children. The MCP must annually submit the process used to identify and assess CSHCN for review and approval by ODJFS as part of their CSHCN program.

iii. Assessment of CSHCN

All MCPs must implement mechanisms to assess children with a positive identification as a CSHCN. A positive assessment confirms the results of the positive identification and should assist the MCP in determining the need for case management.

This assessment mechanism must include, at a minimum:

- The use of the *ODJFS CSHCN Standard Assessment Tool* to assess all children with a positive identification using the methods described in Section 2.c., Children with Special Health Care Needs, of this appendix as having a condition that may warrant case management.

See ODJFS CSHCN Program Requirements for a description of the *ODJFS CSHCN Standard Assessment Tool*.

- Completion of the assessment by a physician, physician assistant, RN, LPN, licensed social worker, or a graduate of a two or four year allied health program.
- The oversight and monitoring by either a registered nurse or a physician, if the assessment is completed by another medical professional.

iv. Case Management of CSHCN

All MCPs must implement mechanisms to provide case management services for all CSHCN with a positive assessment, including those children with an ODJFS mandated condition. The ODJFS mandated conditions for case management are HIV/AIDS, asthma, and pregnant teens as specified by the ODJFS methods outlined in Appendix M Case Management System Performance Measures. This case management mechanism must include, at a minimum:

- The components required in Section 3. b., Case Management, of this Appendix.
- Case management of CSHCN must include at a minimum, the elements listed in the *Minimum Case Management Components* document. See *ODJFS CSHCN Program Requirements* for a description of the *Minimum Case Management Components*.

v. Access to Specialists for CSHCN

All MCPs must implement mechanisms to notify all CSHCN with a positive assessment and determined to need case management 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.

vi. Submission of Data on CSHCN

MCPs must submit to ODJFS all case management records as specified by the ODJFS Case Management File and Submission Specifications.

vii. MCPs must have an ODJFS-approved CSHCN system which includes the items specified in Section G.3.c.ii-vi of this Appendix. Each MCP should implement an evaluation process to review, revise and/or update the CSHCN program. The MCP must annually submit its CSHCN program for review and approval by ODJFS. Any subsequent changes to an approved CSHCN system description must be submitted to ODJFS in writing for review and approval prior to implementation.

d. 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 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;
- 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).

The MCP must notify ODJFS when this requirement has been fulfilled.

e. 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 tha**t** 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.i.c. of Appendix C.

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 that **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). 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.

3. PROVIDER PANEL REQUIREMENTS

The provider network criteria that must be met by each MCP are as follows:

a. Primary Care Physicians (PCPs)

Primary Care Physicians (PCPs) may be individuals or group practices/clinics [Primary Care Clinics (PCCs)]. Acceptable specialty types for PCPs are family/general practice, internal medicine, pediatrics and obstetrics/gynecology(OB/GYNs). 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, and to be included in the MCP's total PCP capacity calculation. 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 physician 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). ODJFS may also compare a PCP's capacity against the number of members assigned to that PCP, and/or the number of patient encounters attributed to that PCP to determine if the reported capacity number reasonably reflects a PCP's expected caseload for a specific MCP. 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 physicians 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 and therefore may not appear as PCPs in the MCP's provider directory. Also, no PCP capacity will be counted for these providers. 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 55% of the eligibles in the region. At a, 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.

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 (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 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. All MCP-contracting OB/GYNs must have current hospital delivery privileges at a hospital under contract with the MCP in the region.

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.

Contracting CNMs must have hospital delivery privileges at a hospital under contract to the MCP in the region. 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. 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. Contracting general surgeons, orthopedists and otolaryngologists must have admitting privileges at a hospital under contract with the MCP in the region.

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.

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 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 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.

MCPs are to follow the procedures specified in the current *MCP PVS Instructional Manual*, posted on the ODJFS website, in order to comply with these federal access requirements.

North East Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required Hospitals: Out-of-Region
General Hospital[3]	8 [4]	1	1 [4]	1	1	1	1	1	1	
Hospital System	1		1							

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospitals cannot be included under any subcontract used to meet the minimum required provider panel requirements.
3 These hospitals must provide obstetrical services if such a hospital is available in the county/region.
4 The Cuyahoga hospital requirement may be met by either contracting with **(1)** a single hospital system that includes fifty (50) pediatric beds and five (5) pediatric intensive care unit (PICU) beds **OR (2)** a single general hospital that includes fifty (50) pediatric beds and five (5) pediatric intensive care unit (PICU) beds and a hospital system.

As of November 20, 2006

North East Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Columbiana	Mahoning	Trumbull	Additional Required Hospitals: Out-of-Region
General Hospital[3]	3	1	1[4]	1	
Hospital System					

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospitals cannot be included under any subcontract used to meet the minimum required provider panel requirements.
3 These hospitals must provide obstetrical services if such a hospital is available in the county/region, except where a hospital must meet the criteria specified in footnote #4 below.
4 Must be a hospital that includes thirty (30) pediatric beds and five (5) pediatric intensive care unit (PICU) beds.

East Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required Hospitals: Out-of-Region
General Hospital[3]	8	1		1	1	1	1	1 [4]	1	1	
Hospital System	1							1			

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospitals cannot be included under any subcontract used to meet the minimum required provider panel requirements.
3 These hospitals must provide obstetrical services if such a hospital is available in the county/region, except where a hospital must meet the criteria specified in footnote #4 below.
4 Must be a hospital that includes one hundred (100) pediatric beds and five (5) pediatric intensive care unit (PICU) beds.

South East Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Athens	Belmont	Coshocton	Gallia	Guernsey	Harrison	Jackson	Jefferson	Lawrence	Meigs	Monroe	Morgon	Muskingum	Noble	Vinton	Washington	Additional Required Hospitals: Out-of-Region
General Hospital[3]	11	1	1	1	1	1			1					1			1	Cabell **AND** King's Daughter AND Children's Hospital Columbus
Hospital System																		

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospitals cannot be included under any subcontract used to meet the minimum required provider panel requirements.
3 These hospitals must provide obsetrical services if such a hospital is available in the county/region.

Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Crawford	Delaware	Fairfield	Fayette	Franklin	Hocking	Knox	Licking	Logan	Madison	Marion	Morrow	Perry	Pickaway	Pike	Ross	Scioto	Union	Additional Required Hospitals: Out-of-Region
General Hospital[3]	14	1		1	1	1[4]		1	1	1	1	1			1		1	1	1	Genesis Health Care System, Inc.
Hospital System	2					2														

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospitals cannot be included under any subcontract used to meet the minimum required provider panel requirements.
3 These hospitals must provide obstetrical services if such a hospital is available in the county/region, except where a hospital must meet the criteria specified in footnote #4 below.
4 Must be a hospital that includes one hundred fifty (150) pediatric beds and twenty-five (25) pediatric intensive care unit (PICU) beds.

South West Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required Hospitals: Out-of-Region
General Hospital[3]	6		1	1		1	1 [4]	1		Grandview **or** Miami Valley
Hospital System	2						2			

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospitals cannot be included under any subcontract used to meet the minimum required provider panel requirements.
3 These hospitals must provide obstetrical services if such a hospital is available in the county/region, except where a hospital must meet the criteria specified in footnote #4 below.
4 Must be a hospital that includes two-hundred (200) pediatric beds and thirty-five (35) pediatric intensive care unit (PICU) beds.

West Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required Hospitals: Out-of-Region
General Hospital[3]	6		1	1	1	1	1 [4]		1	
Hospital System	1						1			

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospital cannot be included under any subcontract used to meet the minimum required provider panel requirements.
3 These hospitals must provide obsetrical services if such a hospital is available in the county/region, except where a hospital must meet the criteria specified in footnote #4 below.
4 Must be a hospital that includes seventy-five (75) pediatric beds and ten (10) pediatric intensive care unit (PICU) beds.

North West Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Allen	Auglaize	Defiance	Fulton	Hancock	Hardin	Henry	Lucas	Mercer	Ottawa	Paulding	Putnam	Sandusky	Seneca	Van Wert	Williams	Wood	Wyandot	Additional Required Hospitals: Out-of-Region
General Hospital[3]	10	1		1	1	1				1				1		1	1		1	Bellevue Hospital Association
Hospital System	1								1 [4]											

1 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
2 These hospitals cannot be included under any subcontract used to meet minimum required provider panel requirements.
3 These hospitals must provide obsetrical services if such a hospital is available in the county/region.
4 Must be a hospital system that includes forty-five (45) pediatric beds and ten (10) pediatric intensive care unit (PICU) beds.

North East Region - PCP Capacity

Minimum PCP Capacity Requirements

PCPs	Total Required	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required: In-Region *
Capacity [1]	**146,000**	6,560	111,520	3,680	2,080	3,960	3,680	11,320	3,200	
FTEs	**73.00**	3.28	55.76	1.84	1.04	1.98	1.84	5.66	1.60	

[1] Based on an FTE of 2000 members

* Must be located within the region.

North East Central Region - PCP Capacity

Minimum PCP Capacity Requirements

PCPs	Total Required	Columbiana	Mahoning	Trumbull	Additional Required: In-Region *
Capacity [1]	**39,140**	6,440	16,340	11,360	5,000
FTEs	**19.57**	3.22	8.17	5.68	2.50

[1] Based on an FTE of 2000 members
* Must be located within the region.

East Central Region - PCP Capacity

Minimum PCP Capacity Requirements

PCPs	Total Required	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required: In-Region *
Capacity [1]	**84,000**	2,940	2,000	2,000	4,520	7,400	22,660	33,560	4,360	4,560	
FTEs	**42.00**	1.47	1.00	1.00	2.26	3.70	11.33	16.78	2.18	2.28	

[1] Based on an FTE of 2000 members

* Must be located within the region.

South East Region - PCP Capacity

County	Capacity [1]	FTEs
Total Required	**53,000**	**26.50**
Athens	5,000	2.50
Belmont	2,880	1.44
Coshocton	2,400	1.20
Gallia	7,220	3.61
Guernsey	3,820	1.91
Harrison	940	0.47
Jackson	1,000	0.50
Jefferson	4,340	2.17
Lawrence	4,020	2.01
Meigs	700	0.35
Monroe	780	0.39
Morgon	1,260	0.63
Muskingum	7,400	3.70
Noble	600	0.30
Vinton	820	0.41
Washington	2,820	1.41
Additional Required:		
In-Region *	7,000	3.50

[1] Based on an FTE of 2000 members

* Must be located within the region.

Central Region - PCP Capacity

County	Capacity [1]	FTEs
Total Required	**138,000**	**69.00**
Crawford	2,720	1.36
Delaware	1,900	0.95
Fairfield	5,660	2.83
Fayette	1,320	0.66
Franklin	84,200	42.10
Hocking	1,860	0.93
Knox	2,800	1.40
Licking	6,740	3.37
Logan	2,380	1.19
Madison	980	0.49
Marion	4,080	2.04
Morrow	1,620	0.81
Perry	2,200	1.10
Pickaway	2,000	1.00
Pike	2,400	1.20
Ross	6,620	3.31
Scioto	6,940	3.47
Union	1,580	0.79

Additional Required:
In-Region *

[1] Based on an FTE of 2000 members
* Must be located within the region.

South West Region - PCP Capacity

Minimum PCP Capacity Requirements

PCPs	Total Required	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required: In Region *
Capacity [1]	**88,000**	2,420	2,540	12,500	2,860	2,940	59,680	2,620	2,440	
FTEs	**44.00**	1.21	1.27	6.25	1.43	1.47	29.84	1.31	1.22	

1 Based on an FTE of 2000 members

* Must be located within the region.

West Central Region - PCP Capacity

Minimum PCP Capacity Requirements

PCPs	Total Required	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required: In-Region *
Capacity [1]	**59,600**	1,140	9,360	1,320	4,700	4,020	35,660	1,400	2,000	
FTEs	**29.80**	0.57	4.68	0.66	2.35	2.01	17.83	0.70	1.00	

[1] Based on an FTE of 2000 members

* Must be located within the region.

North West Region - PCP Capacity

County	Capacity [1]	FTEs
Total Required	**90,860**	**45.43**
Allen	7,780	3.89
Auglaize	1,260	0.63
Defiance	2,600	1.30
Fulton	1,300	0.65
Hancock	3,620	1.81
Hardin	1,220	0.61
Henry	1,200	0.60
Lucas	38,620	19.31
Mercer	1,080	0.54
Ottawa	1,200	0.60
Paulding	900	0.45
Putnam	960	0.48
Sandusky	2,700	1.35
Seneca	2,340	1.17
Van Wert	1,020	0.51
Williams	1,900	0.95
Wood	2,000	1.00
Wyandot	960	0.48
Additional Required:		
In-Region *	18,200	9.10

1 Based on an FTE of 2000 members

* Must be located within the region.

As of November 20, 2006

North East Region - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required Providers[2]
Pediatricians[4]	**90**	1	66	2			3	8	3	7
OB/GYNs	**25**	1	16	1		1	1	2	1	2
Vision	**33**	1	25	1			1	2	1	2
General Surgeons	**20**		12	1		1	1	2	1	2
Otolaryngologist	**6**		2					1		3
Allergists	**5**		2					1		2
Orthopedists	**16**		8	1			1	2	1	3
Dentists[5]	**90**	3	65	1	1	1	5	10	3	1

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

North East Central - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Columbiana	Mahoning	Trumbull	Additional Required Providers[2]
Pediatricians[4]	**23**	2	10	6	5
OB/GYNs	**7**	1	3	2	1
Vision	**7**		3	2	2
General Surgeons	**6**	1	3	1	1
Otolaryngologist	**2**		1		1
Allergists	**1**				1
Orthopedists	**4**		2	1	1
Dentists[5]	**23**	2	11	8	2

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

East Central - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required Providers[2]
Pediatricians[4]	**49**	1			2	3	14	20	2	2	5
OB/GYNs	**17**					1	5	8		1	2
Vision	**18**					1	5	8			4
General Surgeons	**13**				1	2	3	4	1	1	1
Otolaryngologist	**7**						2	2			3
Allergists	**3**						1	1			1
Orthopedists	**9**					1	2	2		1	3
Dentists[5]	**48**	2			3	5	13	17	3	3	2

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

South East - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Athens	Belmont	Coshocton	Gallia	Guernsey	Harrison	Jackson	Jefferson	Lawrence	Meigs	Monroe	Morgon	Muskingum	Noble	Vinton	Washington	Additional Required Providers[2]
Pediatricians[4]	**31**	1	1		2	1			1					2			1	22
OB/GYNs	**9**	1				1			1					1			1	4
Vision	**13**	1	1		1	1		1	1	1				2			1	3
General Surgeons	**8**		1		1	1			1					1			1	2
Otolaryngologist	**3**				1									1				1
Allergists	**1**																	1
Orthopedists	**5**				1									1			1	2
Dentists[5]	**30**	2	3	1	1	3		1	3	2				3			2	9

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

Central - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Crawford	Delaware	Fairfield	Fayette	Franklin	Hocking	Knox	Licking	Logan	Madison	Marion	Morrow	Perry	Pickaway	Pike	Ross	Scioto	Union	Additional Required Providers[2]
Pediatricians[4]	**86**		4	3		55		1	2	1	1	2			1		2	2	1	11
OB/GYNs	**24**		2	2		12		1	1			1					1	1		3
Vision	**31**	1	2	2		15		1	1	1		1			1		1	1	1	3
General Surgeons	**22**	1	1	1		10		1	1	1		1					1	1	1	2
Otolaryngologist	**6**		1			4														1
Allergists	**4**					2														2
Orthopedists	**13**			1		7			1			1					1			2
Dentists[5]	**77**	1	2	3	1	45	1	2	3	1	1	2	1	1	1	1	3	2	1	5

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

South West - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required Providers[2]
Pediatricians[4]	**59**			7	2	1	39			10
OB/GYNs	**16**		1	2	1	1	9		1	1
Vision	**21**			3	1	1	11	1	1	3
General Surgeons	**13**			2	1	1	7		1	1
Otolaryngologist	**6**			1			3		1	1
Allergists	**7**						4			3
Orthopedists	**9**			2			5			2
Dentists[5]	**50**	1	1	10	4	1	26	2	2	3

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

West Central - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required Providers[2]
Pediatricians[4]	**36**		2		3	1	22			8
OB/GYNs	**12**		2		1	1	6		1	1
Vision	**20**		2	1	2	2	10		1	2
General Surgeons	**10**		2		2	1	3			2
Otolaryngologist	**7**		1				3			3
Allergists	**4**						2			2
Orthopedists	**6**				2		2			2
Dentists[5]	**39**	1	5	1	3	3	20	1	1	4

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

North West - Practitioners

Minimum Provider Panel Requirements

Provider Types	Total Required Providers[1]	Allen	Auglaize	Defiance	Fulton	Hancock	Hardin	Henry	Lucas	Mercer	Ottawa	Paulding	Putnam	Sandusky	Seneca	Van Wert	Williams	Wood	Wyandot	Additional Required Providers[2]
Pediatricians[4]	**45**	4				1			23					1			1	2		13
OB/GYNs	**13**	2				1			5					1	1			1		2
Vision	**18**	2	1	1		1			7	1				1			1	2		1
General Surgeons	**13**	2				1			4					1			1	2		2
Otolaryngologist	**7**	1				1			2											3
Allergists	**3**	1							1											1
Orthopedists	**7**	2				1			2					1				1		
Dentists[5]	**45**	4	1	1	1	2	1	1	20	1	1		1	2	2	1	1	2	1	2

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.
3 Preferred Providers are the additional provider contracts that must be secured in order for the MCP to receive bonus points.
4 Half of this number must be certified by the American Board of Pediatrics.
5 No more than two-thirds of this number can be pediatric dentists.

As of November 20, 2006

APPENDIX I

PROGRAM INTEGRITY
CFC ELIGIBLE POPULATION

MCPs must comply with all applicable program integrity requirements, including those specified in 42 CFR 455 and Subpart H.

1. Fraud and Abuse Program:

In addition to the specific requirements of OAC rule 5101:3-26-06, MCPs must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan to guard against fraud and abuse. The MCP's compliance plan must designate staff responsibility for administering the plan and include clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the MCP will determine the compliance plan's effectiveness.

In addition to the requirements in OAC rule 5101:3-26-06, the MCP's compliance program which safeguards against fraud and abuse must, at a minimum, specifically address the following:

a. Employee education about false claims recovery: In order to comply with Section 6032 of the Deficit Reduction Act of 2005 MCPs must, as a condition of Medicaid participation, do the following:

i. establish and make available to all employees through the MCP's employee handbook the following written materials regarding false claims recovery:

a. policies that provide detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties;

b. policies and procedures for detecting and preventing fraud, waste, and abuse; and

c. the laws governing the rights of employees to be protected as whistleblowers.

ii. establish written policies for subcontractors that provide detailed information about the federal False Claims Act and other state and federal laws related to the prevention and detection of fraud, waste, and abuse, including administrative remedies for false claims and statements as well as civil or criminal penalties, and the MCP's policies and procedures for detecting and preventing fraud, waste, and abuse. MCPs must make such information available to their subcontractors.

b. Monitoring for fraud and abuse: The MCP's program which safeguards against fraud and abuse must specifically address the MCP's prevention, detection, investigation, and reporting strategies in at least the following areas:

i. Embezzlement and theft – MCPs must monitor activities on an ongoing basis to prevent and detect activities involving embezzlement and theft (e.g., by staff, providers, contractors, etc.) and respond promptly to such violations.

ii. Underutilization of services – MCPs must monitor for the potential underutilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any underutilized services are identified, the MCP must immediately investigate and, if indicated, correct the problem(s) which resulted in such underutilization of services.

The MCP's monitoring efforts must, at a minimum, include the following activities: a) an annual review of their prior authorization procedures to determine that they do not unreasonably limit a member's access to Medicaid-covered services; b) an annual review of the procedures providers are to follow in appealing the MCP's denial of a prior authorization request to determine that the process does not unreasonably limit a member's access to Medicaid-covered services; and c) ongoing monitoring of MCP service denials and utilization in order to identify services which may be underutilized.

iii. Claims submission and billing – On an ongoing basis, MCPs must identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and bundling.

c. Reporting MCP fraud and abuse activities: Pursuant to OAC rule 5101:3-26-06, MCPs are required to submit annually to ODJFS a report which summarizes the MCP's fraud and abuse activities for the previous year in each of the areas specified above. The MCP's report must also identify any proposed changes to the MCP's compliance plan for the coming year.

d. Reporting fraud and abuse: MCPs are required to promptly report all instances of provider fraud and abuse to ODJFS and member fraud to the CDJFS. The MCP, at a minimum, must report the following information on cases where the MCP's investigation has revealed that an incident of fraud and/or abuse has occurred:

i. provider's name and Medicaid provider number or provider reporting number (PRN);

ii. source of complaint;

iii. type of provider;

iv. nature of complaint;

v. approximate range of dollars involved, if applicable; vi. results of MCP's investigation and actions taken;

vii. name(s) of other agencies/entities (e.g., medical board, law enforcement) notified by MCP; and

viii. legal and administrative disposition of case, including actions taken by law enforcement officials to whom the case has been referred.

e. Monitoring for prohibited affiliations: The MCP's policies and procedures for ensuring that, pursuant to 42 CFR 438.610, the MCP will not knowingly have a relationship with individuals debarred by Federal Agencies, as specified in Article XII of the Agreement.

2. Data Certification:

Pursuant to 42 CFR 438.604 and 42 CFR 438.606, MCPs are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODJFS which may affect MCP payment.

a. MCP Submissions: MCPs must submit the appropriate ODJFS-developed certification concurrently with the submission of the following data or documents:

i. Encounter Data [as specified in the Data Quality Appendix (Apendix L)]

ii. Prompt Pay Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

iii. Cost Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

b. Source of Certification: The above MCP data submissions must be certified by one of the following:

i. The MCP's Chief Executive Officer;

ii. The MCP's Chief Financial Officer, or

iii. An individual who has delegated authority to sign for, or who reports directly to, the MCP's Chief Executive Officer or Chief Financial Officer.

ODJFS may also require MCPs to certify as to the accuracy, completeness, and truthfulness of additional submissions.

APPENDIX J

FINANCIAL PERFORMANCE
ABD ELIGIBLE POPULATION

MCP : Molina Healthcare of Ohio, Inc.

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. 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);

f. Reinsurance agreements, as outlined in OAC rule 5101:3-26-09(C);

g. 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;

h. 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;

i. 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);

j. 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 2007, a minimum net worth per member of $155.00, 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 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 $150,000 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 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
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.

In addition, as noted in Appendix M, if an MCP fails to meet the Minimum Performance Standard for selected Clinical Performance Measures, the MCP will be required to complete a PIP.

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, beginning in SFY 2005, 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. Comprehensive Diabetes Care

ii. Child Immunization Status

iii. Adolescent 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.

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 REVIEW AND NON-DUPLICATION OF MANDATORY ACTIVITIES

The EQRO will conduct administrative compliance assessments for each MCP every three (3) years. The review will include, but not be limited to, the following domains as specified by ODJFS: member rights and services, QAPI program, access standards, provider network, grievance system, case management, coordination and continuity of care, and utilization management. 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 07.

b. ANNUAL REVIEW OF QAPI AND CASE MANAGEMENT PROGRAM

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.

The annual QAPI and case management/CSHCN (refer to Appendix G) program submissions are subject to an administrative review by the EQRO. If the EQRO identifies deficiencies during its review, the MCP must develop and implement Corrective Action Plan(s) that are prior approved by ODJFS. Serious deficiencies may result in immediate termination or non-renewal of the provider agreement.

c. EXTERNAL QUALITY REVIEW PERFORMANCE

In accordance with OAC rule 5101:3-26-07, each MCP must participate in clinical or non-clinical focused quality of care studies as part of the annual external quality review survey. If the EQRO cites a deficiency in clinical or non-clinical performance, the MCP will be required to complete a Corrective Action Plan (e.g., ODJFS technical assistance session), Quality Improvement Directives or Performance Improvement Projects 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.

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 1 below, is the rate of utilization (e.g., discharges, visits) per 1,000 member months (MM).

Report Period: The report periods for the SFY 2007 and SFY 2008 contract periods are listed in the table below.

Table 1. Report Periods for the SFY 2007 and 2008 Contract Periods

Quarterly Report Periods	Data Source: Estimated Encounter Data File Update	Quarterly Report Estimated Issue Date	Contract Period
Qtr 3 & Qtr 4 2003, 2004, 2005 Qtr 1 2006	July 2006	August 2006	SFY 2007
Qtr 3 & Qtr 4 2003, 2004, 2005 Qtr 1, Qtr 2 2006	October 2006	November 2006	
Qtr 4 2003, 2004, 2005 Qtr 1 thru Qtr 3 2006	January 2007	February 2007	
Qtr 1 thru Qtr 4: 2004, 2005, 2006	April 2007	May 2007	
Qtr 2 thru Qtr 4 2004, Qtr 1 thru Qtr4: 2005, 2006 Qtr 1 2007	July 2007	August 2007	
Qtr 3, Qtr 4: 2004, Qtr 1 thru Qtr 4: 2005, 2006 Qtr 1, Qtr 2 2007	October 2007	November 2007	SFY 2008
Qtr 4: 2004, Qtr 1 thru Qtr 4: 2005, 2006 Qtr 1 thru Qtr 3 2007	January 2008	February 2008	
Qtr 1 thru Qtr 4: 2005, 2006, 2007	April 2008	May 2008	

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)

Category	Measure per 1,000/MM	Standard for Dates of Service 7/1/2003 thru 6/30/2004	Standard for Dates of Service 7/1/2004 thru 6/30/2006	Standard for Dates of Service on or after 7/1/2006	Description
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.]

Data Quality Standard, County-Based Approach: The standards in Table 2 apply to the MCP's county-based results (see *County-Based Approach* above). 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.

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)

Category	Measure per 1,000/MM	Standard for Dates of Service on or after 7/1/2006	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 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. Encounter Data Omissions

Omission studies will evaluate the completeness of the encounter data.

Measure: This study will compare the medical records of members during the time of membership to the encounters submitted. Omission rates will be calculated per MCP (i.e., to include all counties serviced by the MCP).

The encounters documented in the medical record that do not appear in the encounter data 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.

Medical records retrieval from the provider and submittal to ODJFS or its designee is an integral component of the omission measure. 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: The data quality standard is a maximum omission rate of 15% for studies with time periods ending in the CY 2006 and CY 2007 contract periods.

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.iii. 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 (i.e., to include all counties serviced by the MCP).

Report Period: For the SFY 2007 and SFY 2008 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. If the standard is not met in all report periods, then the MCP will be determined to be noncompliant.

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.iv. 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 all counties in which the MCP has CFC membership).

Report Period: 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.

Data Quality Standard: The data quality standard is 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.v. 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.

<u>Measure 1 only applies to MCPs that have had Medicaid membership for more than one year.</u>

Measure 1: The percentage of encounters submitted to ODJFS that are rejected. The measure will be calculated per MCP (i.e., to include all counties serviced by the MCP).

Report Period: For the SFY 2007 contract period, performance will be evaluated using the following report periods: April—June 2006; July—September 2006; October—December 2006 and January—March 2007. For the SFY 2008 contract period, performance will be evaluated using the following report periods: April—June 2007; July—September 2007; October—December 2007 and January—March 2008.

Data Quality Standard 1: Data Quality Standard 1 is a maximum encounter data rejection rate of 10% for each file in the ODJFS-specified medium per format for encounters submitted in SFY 2004 and thereafter. The measure will be calculated per MCP (i.e., to include all counties serviced by the 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 Data Quality Standard 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 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 (i.e., to include all counties serviced by the 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 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 months with membership:	50%
Seventh through twelfth month with membership:	25%

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 Data Quality Standard 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 only once per measure 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.vi. 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 (i.e., to include all counties serviced by the 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 only once per measure 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.

1.a.vii. Incomplete Birth Weight Data

Measure: The percentage of newborn delivery inpatient encounters during the report period which contained a birth weight. If a value of "88" through "96" is found on any of the five condition code fields on the UB-92 inpatient claim format, then the encounter will be considered to have a birth weight. The condition code fields are described in Items 24-30 of the "Inpatient Hospital, UB-92 Claim Form Instructions." The measure will be calculated per MCP (i.e., to include all counties in which the MCP has CFC membership).

Report Period: 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.

Data Quality Standard: The data quality standard is 90%.

Penalty for noncompliance: If an MCP is 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. 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 all counties serviced by the MCP).

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 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 for Measure 2: 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 (i.e., to include all counties serviced by the 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 based on study conducted in SFY 2007

Penalty for Noncompliance: Does not apply for SFY 2006 or SFY 2007. 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 (i.e., to include all counties serviced by the 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 2007 and SFY 2008 contract periods, performance will be evaluated using the report periods listed in 1.a.i., Table 1.

Data Quality Standard: A maximum generic provider usage rate of 10%.

Determination of Compliance: Performance is monitored once every quarter for all report periods. If the standard is not met in all report periods, then the MCP will be determined to be noncompliant.

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

MCP submissions of encounter data files in the ODJFS-specified medium per format to ODJFS are limited to two per format per month. Should an MCP wish to send additional files in the ODJFS-specified medium per format, permission to do so must be obtained by contacting BMHC.

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

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 SFY 2007 contract period, July – September 2006, October – December 2006, January – March 2007, and 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.

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 the clinical 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.

If an MCP does not complete a study because either their encounter data is of insufficient quality or too few medical records are submitted, accurate evaluation of clinical quality in the study area cannot be determined for the individual MCP and the assurance of adequate clinical quality for the program as a whole is jeopardized.

3.a. Independent External Quality Review

Measure: The independent external quality review covers both administrative and clinical focus areas of study.

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 1: Sufficient encounter data quality in each study area to draw a sample as determined by the external quality review organization

Penalty for noncompliance with Data Quality Standard 1: 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.

Data Quality Standard 2: A minimum record submittal rate of 85% for each clinical measure.

Penalty for noncompliance for Data Quality Standard 2: 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 physician 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; however, no CFC member may have more than one PCP identified.

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

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 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, October – December 2007, January – March 2008 and April – June 2008 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 1 and quarter 2 of SFY 2008. A minimum rate of 85% of new members with PCP designation by their effective date of enrollment for quarter 3 and quarter 4 of SFY 2008.

Statewide Approach: MCPs will be evaluated using a statewide result, including all regions 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 physician (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 G*rievance 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.v., and 1.a.vi., 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. The Ohio Medicaid managed care program will transition to a regional-based system as managed care expands statewide, beginning in SFY 2007. Evaluation of performance will transition to a regional-based approach after completion of the statewide expansion. If statewide expansion is 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. Due to differences in data and reporting requirements, transition to the regional-based approach will vary by performance measure. Unless otherwise noted, performance measures and standards (see Sections 1, 2, 3 and 4) will be applicable for all counties in which the MCP has membership as of February 1, 2006, until the regional-based approach is developed.

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.i Independent External Quality Review [Only use in SFY2006 Incentive System; *only applicable for MCPs with membership as of February 1, 2006*]

In accordance with federal law and regulations state Medicaid agencies must annually provide for an external 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 both an administrative component and clinical focus areas of study. The overall score is weighted to emphasize clinical performance.

Report Period: For the SFY 2006 contract period, performance will be evaluated using the reviews that are finalized during SFY 2006.

Minimum Performance Standard 1: A minimum score of 75% for each clinical study and the administrative component.

Action Required for Noncompliance with the Minimum Performance Standard 1: For all studies that are finalized during this contract period, if an MCP is noncompliant with the standard, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K,

Quality Assessment and Performance Improvement Program, to address the area(s) of noncompliance.

Minimum Performance Standard 2: Each MCP must achieve an overall score of at least 75%.

Penalty for Noncompliance with the Minimum Performance Standard 2: A serious deficiency may result in immediate termination or nonrenewal of the provider agreement. (Examples of an external quality review serious deficiency are a score of less than 75 percent for each clinical study or a score of less than 75 percent for the administrative component with a score of less than 75 percent on the preponderance of clinical studies).

1.a.ii Independent External Quality Review [Effective SFY 2007]

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 both an administrative review and focused quality of care studies as outlined in Appendix K.

Report Period: Performance will be evaluated using the reviews conducted during SFY 2007.

Action Required for Deficiencies: For all reviews conducted during the contract period, if the EQRO cites a deficiency in the administrative review or quality of care studies, the MCP will be required to complete a Corrective Action Plan, Quality Improvement Directive, or Performance Improvement Project as outlined in Appendix K. 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 *(Use in SFY2006 Incentive System; only applicable for MCPs with membership as of January 1, 2006)*

Measure: The average monthly case management rate for children 6 months and over and under 21 years of age.

Report Period: For the SFY 2006 contract period, performance will be evaluated using the January - June 2005 and July - December 2005 report periods. For the SFY 2007 contract period, performance will be evaluated using the January - June 2006 report period.

Performance Target: A minimum case management rate of 5.0%.

Minimum Performance Standard: For results that are below the performance target the performance standard is an improvement level that results in a 20% decrease between the target and the previous reporting period's results. For MCPs that reach or surpass the performance target, then the standard is to keep the results at or above the performance target.

Penalty for Noncompliance: The first time an MCP is noncompliant with the 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 semi-annual measurements of performance, if an MCP is again determined to be noncompliant with the standard for this measure. ODJFS will impose a monetary sanction (see Section 5) of one half of one percent of the current month's premium payment. Once the MCP is performing at standard levels and the violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded.

1.b.ii. Case Management of Children

Measure: The average monthly case management rate for children under 21 years of age.

Report Period: For the SFY 2007 contract period, July - September 2006, October - December 2006, January - March 2007, and 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.

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.

Minimum Performance Standard: For the first and second quarters of SFY 2007, a case management rate of 4.5%. For the third and fourth quarters of SFY 2007, a case management rate of 5.0%. For SFY 2008, a case management rate of 6.0%.

Penalty for Noncompliance: The first time an MCP is noncompliant with the 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 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 new member selection freeze/reduction of assignments will be lifted.

1.b.iii. Case Management of Children with an ODJFS-Mandated Condition *(only applicable for MCPs with membership as of January 1, 2006)*

Measure 1: The percent of children 6 months and over and 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.

Report Period: For the SFY 2006 contract period, performance will be evaluated using the July - September 2005 and January - March 2006 report periods.

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.

Report Period: For the SFY 2006 contract period, performance will be evaluated using the - January - June 2005 and July - December 2005 report periods. For the SFY 2007 contract period, performance will be evaluated using the January - June 2006 report period.

Measure 3: The percent of children 6 months and over and 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 Period: For the SFY 2006 contract period, performance will be evaluated using the July - September 2005 and January - March 2006 report periods.

Performance Target for Measures 1, 2, and 3: A minimum case management rate of 80%.

Minimum Performance Standard for Measures 1, 2, and 3: For results that are below the performance target the performance standard is an improvement level that results in a 20% decrease between the target and the previous reporting period's results. For MCPs that reach or surpass the performance target, then the standard is to keep the results at or above the performance target.

Penalty for Noncompliance for Measures 1 and 2: The first time an MCP is noncompliant with the 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 semi-annual measurements of performance, if an MCP is again determined to be noncompliant with the standard (see Section 5) for measures 1 or 2, 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 the violations/deficiencies are resolved to the satisfaction of ODJFS, the money will be refunded. Note: For SFY 2006, measure 3 is a reporting-only measure.

1.b.iv. Case Management of Children with an ODJFS-Mandated Condition

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, July – September 2006, October – December 2006, January – March 2007, and 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.

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.

Minimum Performance Standard for Measures 1 and 3: For the first and second quarters of SFY 2007, a case management rate of 65%. For the third and fourth quarters of SFY 2007, a case management rate of 70%. For SFY 2008, a case management rate of 80%.

Minimum Performance Standard for Measure 2: For the first and second quarters of SFY 2007, a case management rate of 55%. For the third and fourth quarters of SFY 2007, a case management rate of 60%. For SFY 2008, a case management rate of 70%.

Penalty for Noncompliance for Measures 1 and 2: The first time an MCP is noncompliant with the 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 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 new member selection freeze/reduction of assignments will be lifted. 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 both SFY 2007 and 2008, measure 3 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 were 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 2003 results (the baseline period) and calendar year 2004 results. The methods will be updated and a new baseline will be created during 2005 for calendar year 2004 results. These results will then serve as the baseline to evaluate whether improvement occurred from calendar year 2004 to calendar year 2005. 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 Medicaid 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: Prior to the transition to the regional-based approach, MCP performance will be evaluated using an MCP's 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 approach for any active region in which the MCP had membership.

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region. CY 2008 will be the first reporting year that MCPs will be held accountable to the performance standards for an active region, and penalties will be applied for noncompliance. CY 2007 will be the first baseline reporting year for an active region.

ODJFS will use a sufficient amount of data needed per performance measure from all MCPs serving an active region to determine performance standards and targets for that region. For example, should a measure call for one calendar year of baseline data, first full calendar year data will be used. CY 2008 will be the first reporting year for measures that call for one year of baseline data. Should a measure call for two calendar years of baseline data, the first two full calendar years of data will be used. CY 2009 will be the first reporting year for measures that call for two years of baseline data.

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 2006 contract period, performance will be evaluated using the January - December 2005 report period. 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.

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.

Target: 80% of the eligible population must receive 81% or more of the expected number of prenatal visits.

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.)

Action Required for Noncompliance: If the standard is not met and the results are below 42%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program,* to address the area of noncompliance.

If the standard is not met and the results are at or above 42%, then 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.

Target: 90% of the eligible population initiate prenatal care within the specified time.

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.

Action Required for Noncompliance: If the standard is not met and the results are below 71%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program,* to address the area of noncompliance. If the standard is not met and the results are at or above 71%, then 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.

Target: At least 80% of the eligible population must receive a postpartum visit.

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.

Action Required for Noncompliance: If the standard is not met and the results are below 48%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program,* to address the area of noncompliance. If the standard is not met and the results are at or above 48%, then 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.

Target: At least 80% of the eligible children receive the expected number of well-child visits.

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.

Action Required for Noncompliance (15 month old age group): If the standard is not met and the results are below 34%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above 34%, then 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): If the standard is not met and the results are below 50%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above 50%, then 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): If the standard is not met and the results are below 30%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above 30%, then 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.

Target: 95% of the eligible population must receive the recommended medications.

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.

Action Required for Noncompliance: If the standard is not met and the results are below 83%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above 83%, then 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.

Target: At least 60% of the eligible population receive a dental visit.

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.

Action Required for Noncompliance: If the standard is not met and the results are below 40%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above 40%, then 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.

Target: At least 80% of the eligible population receive a blood lead screening.

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.

Action Required for Noncompliance (1 year olds): If the standard is not met and the results are below 45% then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above 45%, then 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): If the standard is not met and the results are below 28% then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance.

If the standard is not met and the results are at or above 28%, then 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 Physician (PCP) Turnover, Children's Access to Primary Care, and Adults' Access to Preventive/Ambulatory Health Services. For a comprehensive description of the access performance measures below, see *ODJFS Methods for Access Performance Measures for the Medicaid 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 physicians 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 physicians 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: Prior to the transition to the regional-based approach, MCP performance will be evaluated using an MCP's statewide result for the counties in which the MCP had membership as of February 1, 2006. The minimum performance standard in the *Appendix (2.a)* will be applicable to the MCP's statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting year using the MCP's 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 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 approach for any active region in which the MCP had membership.

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region. ODJFS will use the first full calendar year of data (which may be adjusted based on the number of months of managed care membership). from all MCPs serving an active region to determine a minimum performance standard for that region. CY 2008 will be the first reporting year that MCPs will be held accountable to the performance standards for an active region, 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 2006 contract period, performance will be evaluated using the January - December 2005 report period. 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.

Minimum Performance Standard: A maximum PCP Turnover rate of 18%.

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 an 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: Prior to the transition to the regional-based approach, MCP performance will be evaluated using an MCP's statewide result for the counties in which the MCP had membership as of February 1, 2006. The minimum performance standard in the *Appendix (2.b)* will be applicable to the MCP's statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting year using the MCP's 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 approach for any active region in which the MCP had membership.

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region. ODJFS will use the first two full calendar years of data (which may be adjusted based on the number of months of managed care membership) from all MCPs serving an active region to determine a minimum performance standard for that region. CY 2009 will be the first reporting year that MCPs will be held accountable to the performance standards for an active region, and penalties will be applied for noncompliance. Performance measure results for that region 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 2006 contract period, performance will be evaluated using the January-December 2005 report period. 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.

Minimum Performance Standards:

CY 2005 report period – 70% of the children must receive a visit.
CY 2006 report period – 70% of the children must receive a visit.
CY 2007 report period – 71% of the children must receive a visit.

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: Prior to the transition to the regional-based approach, MCP performance will be evaluated using an MCP's statewide result for the counties in which the MCP had membership as of February1, 2006. The minimum performance standard in the *Appendix (2.c)* will be applicable to the MCP's statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting year using the MCP's statewide result for the counties in which the MCP had membership as of February 1, 2006 for performance evaluation is CY2007; the last reporting year using the MCP's 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 approach for any active region in which the MCP had membership.

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region. ODJFS will use the first full calendar year of data (which may be adjusted based on the number of months of managed care membership) from all MCPs serving an active region to determine a minimum performance standard for that region. CY 2008 will be the first reporting year that MCPs will be held accountable to the performance standards for an active region, and penalties will be applied for noncompliance. Performance measure results for that region 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 2006 contract period, performance will be evaluated using the January - December 2005 report period. 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.

Minimum Performance Standards: 63% of the adults must receive a visit.

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. Adults' Access to Designated PCP (new measure pending review)

The MCP must encourage and assist CFC members without a designated primary care physician (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 Approach: MCPs will be evaluated by region, using results for all counties included in the region. ODJFS will use the first full calendar year of data as a baseline from all MCPs serving CFC membership to determine a minimum performance standard for that region. CY 2008 will be the first reporting year that MCPs will be held accountable to the performance standards for an active region and penalties will be applied for noncompliance. Performance measure results for that region 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: For the SFY 2009 contract period, performance will be evaluated using the January - December 2008 report 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

The regional approach for this measure is to be determined for SFY 2008. The county-based approach remains effective in SFY 2007; the county-based approach is only applicable for MCPs with membership as of February1, 2006 and for the counties in which the MCPs had membership as of February1, 2006.

In accordance with federal requirements and in the interest of assessing enrollee satisfaction with MCP performance, ODJFS periodically 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. 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 Consumer Satisfaction Performance Measures for the Medicaid CFC Managed Care 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.

Report Period: For the SFY 2006 contract period, performance will be evaluated using the results from the most recent consumer satisfaction survey completed prior to the end of the SFY 2006. For the SFY 2007 contract period, performance will be evaluated using the results from the most recent consumer satisfaction survey completed prior to the end of the SFY 2007. For the SFY 2008 contract period, the measure is under review and the report period has not been determined.

Minimum Performance Standard: An average score of no less than 7.0.

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 Administrative Capacity Performance Measures for the Medicaid CFC Managed Care Program*.

4.a. Compliance Assessment System

Measure: The number of points accumulated for one contract year (one state fiscal year) through the Compliance Assessment System.

Report Period: For the SFY 2005 contract period, performance will be evaluated using the July 2004 - June 2005 report period. For the SFY 2006 contract period, performance will be evaluated using the July 2005 - June 2006 report period.

Minimum Performance Standard: No more than 25 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 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: Prior to the transition to the regional-based approach, MCP performance will be evaluated using an MCP's statewide result for the counties in which the MCP had membership as of February1, 2006. The minimum performance standard and the target in the *Appendix (4.b)* will be applicable to the MCP's statewide result for the counties in which the MCP had membership as of February 1, 2006. The last reporting period using the MCP's 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 statewide result for the counties in which the MCP had membership as of February 1, 2006 for P4P (*Appendix O*) is July-December 2008.

For any MCP which did not have membership as of February 1, 2006: Performance will be evaluated using a regional-based approach for any active region in which the MCP had membership.

Regional-Based Approach: MCPs will be evaluated by region, using results for all counties included in the region. The reporting period will be a full calendar year. ODJFS will use the first full calendar year of data, which may be adjusted based on the number of months of managed care membership, as a baseline from all MCPs serving an active region to determine a minimum performance standard and a target for that region. CY 2008 will be the first reporting year that MCPs will be held accountable to the performance standards for an active region, and penalties will be applied for noncompliance. Performance measure results for that region 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.

Regional-Based Measure: The percentage of members who had TBD or more ED visits during the 12 month reporting period.

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 2006 contract period, a baseline level of performance will be set using the
January - June 2005 report period. Results will be calculated for the reporting period of July-December 2005 and compared to the baseline results to determine if the minimum performance standard is met. 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 (which may be adjusted based on the number of months of managed care membership). 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. SFY 2008 is also the first year for regional based reporting, using January - December 2007 as a baseline.

Target: A maximum of 0.70% of the eligible population will have four or more ED visits during the reporting period.

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.

5. NOTES

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 compliance is 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 contact, 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, *Termination*s, of the provider agreement.

APPENDIX N

COMPLIANCE ASSESSMENT SYSTEM (CAS)
CFC ELIGIBLE POPULATION

The Compliance Assessment System (CAS) is designed to improve the quality of each MCP's performance through actions taken by ODJFS to address identified failures to meet certain program requirements. The CAS assesses progressive remedies with specified values (occurrences or points) assigned for certain documented failures to satisfy the deliverables required by the Agreement. Remedies are progressive based upon the severity of the violation, or a repeated pattern of violations. The CAS does not include categories which require subjective assessments or which are not within the MCPs control. CAS allows the accumulated point total to reflect both patterns of less serious violations as well as less frequent, more serious violations.

The CAS focuses on clearly identifiable deliverables and occurrences/points are only assessed in documented and verified instances of noncompliance. 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 Ohio Administrative Code (OAC) rule 5101:3-26-10, including the proposed termination, amendment, or nonrenewal of the MCP's provider agreement.

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.

Corrective Action Plans (CAPs) - MCPs may be required to develop CAPs for any instance of noncompliance, and CAPs are not limited to actions taken under the CAS. All CAPs requiring ongoing activity on the part of an MCP to ensure their compliance with a program requirement remain in effect for the next provider agreement period. 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 an ODJFS-approvable CAP, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" CAP.

Occurrences and Points - Occurrences and points are defined and applied as follows:

Occurrences — Failures to meet program requirements, including but not limited to, noncompliance with administrative requirements.

Examples include:
- Use of unapproved marketing materials.
- Failure to attend a required meeting.
- Second failure to meet a call center standard.

5 Points — Failures to meet program requirements, including but not limited to, actions which could impair the member's ability to access information regarding services in a timely manner or which could impair a member's rights.

Examples include:
- 24-hour call-in system is not staffed by medical personnel.
- Failure to notify a member of their right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to appropriately notify ODJFS of provider panel terminations.

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 member to access covered services.

Examples include:
- Failure to comply with the minimum provider panel requirements specified in Appendix H of the Agreement.
- Failure to provide medically-necessary Medicaid covered services to members.
- Failure to meet the electronic claims adjudication requirements.

Failure to submit or comply with CAPs will result in the assessment of occurrences or points based on the nature of the violation under correction.

Notwithstanding the assessment of occurrences and/or points as a result of individual events, the following cumulative actions will be imposed for repeated violations.

After accumulating a total of three occurrences within a contract term, all subsequent occurrences during the period will be assessed as 5-point violations, regardless of the number of 5-point violations which have been accrued by the MCP.

After accumulating a total of three 5-point violations within a contract term, all subsequent 5-point violations during the period will be assessed as 8-point violations, except as specified above.

After accumulating a total of two 10-point violations within a contract term, all subsequent 10-point violations during the period will be assessed as 15-point violations.

Occurrences and points will accumulate over the contract term of the Agreement. Upon the beginning of a new Agreement, the MCP will begin the new contract term with a score of zero unless the MCP has accrued a total of 55 points or more during the prior provider agreement period. Those MCPs who have accrued a total of 55 points or more during the contract term of a prior provider agreement will carry these points over for the first three (3) months of their next provider agreement. If the MCP does not accrue any additional points during this three (3) month period the MCP will then have their point total reduced to zero and continue on in the new contract term. If the MCP does accrue additional points during this three-month period, the MCP will continue to carry the points accrued from the prior provider agreement plus any additional points accrued during the new provider agreement contract term.

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 provider agreement period will be subject to remedial action under CAS at the time that ODJFS first becomes aware of this noncompliance.

In cases where an MCP subcontracting provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, unapprovable billing of members, etc.), ODJFS will not assess occurrences or 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, occurrences or points may be assessed, as determined by ODJFS.

All required submissions to be received by their specified deadline. Unless otherwise specified, late submissions will initially be addressed through CAPs, with repeated instances of untimely submissions resulting in escalating penalties, as may be determined by ODJFS.

If an MCP determines that they will be unable to meet a program deadline, the MCP must verbally inform the designated ODJFS contact person (or their supervisor) of such and submit a written request (by facsimile transmission) 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 arisen which make it impossible for the MCP to meet an ODJFS-stipulated deadline and all such requests will be evaluated upon the basis and with that in mind. Only written approval as may be granted by ODJFS of a deadline extension will preclude the assessment of a CAP, occurrence or points for untimely submissions.

No points or occurrences 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.).

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 issued under the CAS are nonrefundable.

1-9 Points Corrective Action Plan (CAP)

10-19 Points CAP + $5,000 fine

20-29 Points CAP + $10,000 fine

30-39 Points CAP + $20,000 fine

40-69 Points CAP + $30,000 fine

70+ Points Proposed Contract Termination

New Member Selection Freezes:

Notwithstanding any other penalty, occurrence or point assessment that ODJFS may impose on MCP under this Appendix, ODJFS may prohibit an MCP from receiving new membership through consumer initiated selection or the assignment process (selection freeze) in one or more counties if : (1) the MCP has accumulated a total of 20 or more points during a contract term; (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 is denied by CMS in accordance with the requirements in 42 CFR 438.730.

Reduction of Assignments

ODJFS may reduce the number of assignments an MCP receives if ODJFS, in its sole discretion, determines that the MCP lacks sufficient administrative capacity to meet the needs of the increased volume in membership. Examples of circumstances which ODJFS may determine demonstrate a lack of sufficient administrative capacity include, but are not limited to an MCP's failure to: 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.

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 10-point penalty and a monetary sanction of $20,000 per day for the period of noncompliance. ODJFS may assess additional penalty points based on the length of noncompliance, as it may determine in its sole discretion.

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.

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 the contract term will result in the assessment of 5 points, quarterly prompt pay reporting, and submission of monthly status reports to ODJFS until the next quarterly report is due. The second and any subsequent violation during the contract term will result in the submission of monthly status reports, assessment of 10 points 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.

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 a selection freeze of not less than three (3) months duration.

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.
- A 10 point penalty assessment for the period of noncompliance.

- 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.

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.

Noncompliance with Encounter Data Submissions:

Submission of unpaid encounters (except for immunization services as specified in Appendix L) will result in the assessment of a nonrefundable $1,000 fine for each violation.

Noncompliance with Abortion and Sterilization Payment

Noncompliance with abortion and sterilization requirements as specified by ODJFS will result in the assessment of a nonrefundable $1,000 fine for each documented violation. Additionally, MCPs must take all appropriate action to correct each such ODJFS-documented violation.

Negligent Breach of Protected Health Information (PHI) Standards

Non-compliance with the HIPAA Privacy Regulations and negligent breach of protected health information (PHI) standards will be assessed in accordance with Appendix C.27. Therefore, the progressive remedies specified under Appendix N, Compliance Assessment System will not be utilized for assessing non-compliance with the HIPAA Privacy Regulations and negligent breach of PHI.

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.

General Provisions:

All notifications of the imposition by ODJFS of a fine or freeze will be made via certified or overnight mail to the identified MCP Medicaid Coordinator.

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.

Refundable monetary sanctions/assurances applied by ODJFS will be based on the premium payment for the month in which the MCP was cited for the deficiency. Any monies collected through the imposition of such a 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. 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.

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.

In addition, 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.

In addition to the remedies imposed under the CAS, remedies related to areas of data quality and financial performance may also be imposed pursuant to Appendices J, L, and M respectively, of the Agreement.

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, the ODJFS may, pursuant to the provisions of OAC rule 5101:3-26-10(A): (1) notify the MCP's members that they may terminate from the MCP without cause; and/or (2) suspend any further new member selections.

REQUESTS FOR RECONSIDERATIONS

Requests for reconsiderations of remedial action taken under the CAS shall be submitted to ODJFS as follows:

- MCPs notified of ODJFS' imposition of remedial action taken under the CAS (i.e., occurrences, points, fines, assignment reductions and selection freezes), will have five (5) working days from the date of receipt to request reconsideration, although ODJFS will impose selection freezes based on an access to care concern concurrent with initiating notification to the MCP. (All notifications of the imposition of a fine or a freeze will be made via certified or overnight mail to the identified MCP Contact.) 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.
- 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 fifth business day after receipt of notification of the imposition of the remedial action by ODJFS.

  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.
- Final decisions or requests for additional information will be made by ODJFS within five (5) business days of receipt of the request for reconsideration.

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.

- 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.

POINT COMPLIANCE SYSTEM - POINT VALUES

OCCURRENCES: Failures to meet program requirements, including but not limited to, noncompliance with administrative requirements, as determined by ODJFS. Examples include, but are not limited to, the following:

- Unapproved use of marketing/member materials.
- Failure to attend ODJFS-required meetings or training sessions.
- Failure to maintain ODJFS-required documentation.
- Use of unapproved subcontracting providers where prior approval is required by ODJFS.
- Use of unapprovable subcontractors (e.g., not in good standing with Medicaid and/or Medicare programs, provider listed in directory but no current contract, etc.) where prior-approval is not required by ODJFS.
- Failure to provide timely notification to members, as required by ODJFS (e.g., notice of PCP or hospital termination from provider panel).
- Participation in a prohibited or unapproved marketing activity.
- Second failure to meet the monthly call-center requirements for either the member services or 24-hour call-in system lines.
- Failure to submit and/or comply with a Corrective Action Plan (CAP) requested by ODJFS as the result of an occurrence, or when no occurrence was designated for the precipitating violation of OAC rules or provider agreement
- Failure to comply with the physician incentive plan requirements, except for noncompliance where member rights are violated (i.e, failure to complete required patient satisfaction surveys or to provide members with requested physician incentive information) or where false, misleading or inaccurate information is provided to ODJFS.

5 POINTS: Failures to meet program requirements, including but not limited to, actions which could impair the member's ability to access information regarding services in a timely manner or which could impair a consumer's or member's rights, as determined by ODJFS. Examples include, but are not limited to, the following:

- Violations which result in selection or termination counter to the recipient's preference (e.g., a recipient makes a selection decision based on inaccurate provider panel information from the MCP).
- Any violation of a member's rights.
- Failure to provide member materials to new members in a timely manner.
- Failure to comply with appeal, grievance**,** or state hearing requirements, including timely submission to ODJFS.
- Failure to staff 24-hour call-in system with appropriate trained medical personnel.
- Third failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Failure to submit and/or comply with a CAP as a result of a 5-point violation.
- Failure to meet the prompt payment requirements (first violation).
- Provision of false, inaccurate or materially misleading information to health care providers, the MCP's members, or any eligible individuals.
- Failure to submit a required monthly CAMS file (as specified in Appendix L of the Agreement) by the end of the month the submission was required.
- Failure to submit a required monthly Members' Designated PCP file (as specified in Appendix L of the Agreement) by the end of the month the submission was required.

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:

- Failure to meet any of the provider panel requirements as specified in Appendix H of the Agreement.
- 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 process prior authorization requests within prescribed time frame.
- Failure to remit any ODJFS-required payments within the specified time frame.
- Failure to meet the electronic claims adjudication requirements.
- Failure to submit and/or comply with a CAP as a result of a 10-point violation.
- Failure to meet the prompt payment requirements (second and subsequent violations).
- Fourth and any subsequent failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Failure to provide ODJFS with a required submission after ODJFS has notified the MCP that the prescribed deadline for that submission has passed.
- Failure to submit a required monthly appeal or grievance file (as specified in Appendix L of the Agreement) by the end of the month the submission was required.
- Misrepresentation or falsification of information that the MCP furnishes to the ODJFS or to the Centers for Medicare and Medicaid Services.

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 the Emergency Department Diversion and 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 P4P system (SFY 2006 through SFY 2009), the county-based 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 P4P system.

1. SFY 2006 P4P

1.a. Qualifying Performance Levels

To qualify for consideration of the SFY 2006 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 2006 established in Appendix M, *Performance Evaluation*, must be met to qualify for consideration of P4P are as follows:

1. Independent External Quality Review (Appendix M, Section 1.a.i. – Minimum Performance Standard 2)

Report Period: The most recent Independent External Quality Review completed prior to the end of the SFY 2006 contract period.

2. PCP Turnover (Appendix M, Section 2.a.)

Report Period: CY 2005

3. Children's Access to Primary Care (Appendix M, Section 2.b.)

Report Period: CY 2005

4. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

Report Period: CY 2005

5. Overall Satisfaction with MCP (Appendix M, Section 3.)

Report Period: The most recent consumer satisfaction survey completed prior to the end of the SFY 2006 contract period.

For the EDD performance measure, the MCP must meet the P4P standard for the report period of July - December, 2005 to be considered for SFY 2006 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 2006 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.

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	59%
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.

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: July - December 2005

   Excellent Standard: 2.5%

   Superior Standard: 3.8%

2. Use of Appropriate Medications for People with Asthma (Appendix M, Section 1.c.vi.)

   Report Period: CY 2005

   Excellent Standard: 59%

   Superior Standard: 68%

3. Adults' Access to Preventive/Ambulatory Health Services (Appendix M, Section 2.c.)

   Report Period: CY 2005

   Excellent Standard: 76%

   Superior Standard: 83%

1.c. Determining SFY 2006 P4P

MCP's reaching the minimum performance standards described in Section 2.a. 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. 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., 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 amount, among all MCPs' Aged, Blind or Disabled (ABD) and/or Covered Families and Children (CFC) receiving additional P4P. The maximum amount to be awarded to a single plan P4P additional to the at- risk amount is $250,000 per contract year. 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 2007 P4P

2.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%

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.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%

2.c. Determining SFY 2007 P4P

MCP's reaching the minimum performance standards described in Section 2.a. 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. 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., 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 amount, among all MCPs' Aged, Blind or Disabled (ABD) and/or Covered Families and Children (CFC) receiving additional P4P. The maximum amount to be awarded to a single plan P4P additional to the at-risk amount is $250,000 per contract year. 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. Initiation of the P4P System

For MCPs in their first twenty-four months of Ohio Medicaid 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.

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. Transition from a county-based to a regional-based P4P system.

The current county-based P4P system will transition to a regional-based system as managed care expands statewide. The regional-approach will be fully phased in no later than SFY 2010. The regional-based P4P system will be modeled after the county-based system with adjustments to performance standards where appropriate to account for regional differences.

3.c.i. County-based P4P system

During the transition to a regional-based system (SFY 2006 through SFY 2009), MCPs with membership as of February 1, 2006 will continue in the county-based 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.c.ii. Regional-based P4P system

All MCPs will be included in the regional-based 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 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. If statewide expansion is 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 P4P system for the SFY 2009 P4P determination, will be excluded from the at-risk dollars included in the first regional P4P determination.

3.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.

3.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 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.

APPENDIX P

MCP TERMINATIONS/NONRENEWALS/AMENDMENTS
CFC ELIGIBLE POPULATION

Upon termination either by the MCP or ODJFS, nonrenewal or denial of an MCP's provider agreement, all previously collected refundable monetary sanctions will be retained by ODJFS.

MCP-INITIATED TERMINATIONS/NONRENEWALS

If an MCP provides notice of the termination/nonrenewal of their provider agreement to ODJFS, pursuant to Article VIII of the agreement, the MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODJFS until such time that the MCP has submitted all outstanding monies owed and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP=s provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODJFS in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must also return to ODJFS the at-risk amount paid to the MCP under the current provider agreement. The amount to be returned will be based on actual MCP membership for preceding months and estimated MCP membership through the end date of the contract. MCP membership for each month between the month the termination/nonrenewal is issued and the end date of the provider agreement will be estimated as the MCP membership for the month the termination/nonrenewal is issued. Any over payment will be determined by comparing actual to estimated MCP membership and will be returned to the MCP following the end date of the provider agreement.

The MCP must remit the monetary assurance and the at-risk amount in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State*, *State of Ohio (ODJFS)*. The MCP should contact their Contract Administrator to verify the correct amounts required for the monetary assurance and the at-risk amount and obtain an invoice number prior to submitting the monetary assurance and the at-risk amount. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODJFS Fund account. In addition, the MCP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance and the at-risk amount are not received as specified above, ODJFS will withhold the MCP's next month's capitation payment until such time that ODJFS receives documentation that the monetary assurance and the at-risk amount are received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

ODJFS-INITIATED TERMINATIONS

If ODJFS initiates the proposed termination, nonrenewal or amendment of an MCP=s provider agreement pursuant to OAC rule 5101:3-26-10 and the MCP appeals that proposed action, the MCP's provider agreement will be extended through the duration of the appeals process.

During this time, the MCP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation under Appendix N of the provider agreement. If the MCP exceeds 69 points, each subsequent point accrual will result in a $15,000 nonrefundable fine.

Pursuant to OAC rule 5101:3-26-10(H), if ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODJFS may notify the MCP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCP without cause. If ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODJFS may propose to terminate the membership of all of the MCP's members. The appeal process for reconsideration of either of these proposed actions is as follows:

- All notifications of such a proposed MCP membership termination will be made by ODJFS via certified or overnight mail to the identified MCP Contact.
- MCPs notified by ODJFS of such a proposed MCP membership termination will have three working days from the date of receipt to request reconsideration.
- All reconsideration requests must be submitted by either facsimile transmission or overnight mail to the Deputy Director, Office of Ohio Health Plans, and received by 3PM on the third working day following receipt of the ODJFS notification of termination. The address and fax number to be used in making these requests will be specified in the ODJFS notification of termination document.
- The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCP membership termination is not justified. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP.

- A final decision or request for additional information will be made by the Deputy Director within three working days of receipt of the request for reconsideration. Should the Deputy Director require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.
- The proposed MCP membership termination will not occur while an appeal is under review and pending the Deputy Director's decision. If the Deputy Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODJFS determines that it would be in the best interest of the members.

Aged, Blind or Disabled (ABD) Population

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES

OHIO MEDICAL ASSISTANCE PROVIDER AGREEMENT
FOR MANAGED CARE PLAN
ABD ELIGIBLE POPULATION

This provider agreement is entered into this first day of January, 2007, at Columbus, Franklin County, Ohio, between the State of Ohio, Department of Job and Family Services, (hereinafter referred to as ODJFS) whose principal offices are located in the City of Columbus, County of Franklin, State of Ohio, and Molina Healthcare of Ohio, Inc., Managed Care Plan (hereinafter referred to as MCP), an Ohio for-profit corporation, whose principal office is located in the city of Columbus, County of Franklin, State of Ohio.

MCP is licensed as a Health Insuring Corporation by the State of Ohio, Department of Insurance (hereinafter referred to as ODI), pursuant to Chapter 1751. of the Ohio Revised Code and is organized and agrees to operate as prescribed by Chapter 5101:3-26 of the Ohio Administrative Code (hereinafter referred to as OAC), and other applicable portions of the OAC as amended from time to time.

MCP is an entity eligible to enter into a provider agreement in accordance with 42 CFR 438.6 and is engaged in the business of providing prepaid comprehensive health care services as defined in 42 CFR 438.2 through the managed care program for the Aged, Blind or Disabled (ABD) eligible population described in OAC rule 5101:3-26-02 (B).

ODJFS, as the single state agency designated to administer the Medicaid program under Section 5111.02 of the Ohio Revised Code and Title XIX of the Social Security Act, desires to obtain MCP services for the benefit of certain Medicaid recipients. In so doing, MCP has provided and will continue to provide proof of MCP's capability to provide quality services, efficiently, effectively and economically during the term of this agreement.

This provider agreement is a contract between the ODJFS and the undersigned Managed Care Plan (MCP), provider of medical assistance, pursuant to the federal contracting provisions of 42 CFR 434.6 and 438.6 in which the MCP agrees to provide comprehensive medical services through the managed care program as provided in Chapter 5101:3-26 of the Ohio Administrative Code, assuming the risk of loss, and complying with applicable state statutes, Ohio Administrative Code, and Federal statutes, rules, regulations and other requirements, including but not limited to title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

ARTICLE I—GENERAL

A. MCP agrees to report to the Chief of Bureau of Managed Health Care (hereinafter referred to as BMHC) or their designee as necessary to assure understanding of the responsibilities and satisfactory compliance with this provider agreement.

B. MCP agrees to furnish its support staff and services as necessary for the satisfactory performance of the services as enumerated in this provider agreement.

C. ODJFS may, from time to time as it deems appropriate, communicate specific instructions and requests to MCP concerning the performance of the services described in this provider agreement. Upon such notice and within the designated time frame after receipt of instructions, MCP shall comply with such instructions and fulfill such requests to the satisfaction of the department. It is expressly understood by the parties that these instructions and requests are for the sole purpose of performing the specific tasks requested to ensure satisfactory completion of the services described in this provider agreement, and are not intended to amend or alter this provider agreement or any part thereof.

If the MCP previously had a provider agreement with the ODJFS and the provider agreement terminated more than two years prior to the effective date of any new provider agreement, such MCP will be considered a new plan in its first year of operation with the Ohio Medicaid managed care program.

ARTICLE II—TIME OF PERFORMANCE

A. Upon approval by the Director of ODJFS this provider agreement shall be in effect from the date entered through June 30, 2007, unless this provider agreement is suspended or terminated pursuant to Article VIII prior to the termination date, or otherwise amended pursuant to Article IX.

ARTICLE III—REIMBURSEMENT

A. ODJFS will reimburse MCP in accordance with rule 5101:3-26-09 of the Ohio Administrative Code and the appropriate appendices of this provider agreement.

ARTICLE IV—MCP INDEPENDENCE

A. MCP agrees that no agency, employment, joint venture or partnership has been or will be created between the parties hereto pursuant to the terms and conditions of this agreement. MCP also agrees that, as an independent contractor, MCP assumes all responsibility for any federal, state, municipal or other tax liabilities, along with workers compensation and unemployment compensation, and insurance premiums which may accrue as a result of compensation received for services or deliverables rendered hereunder. MCP certifies that all approvals, licenses or other qualifications necessary to conduct business in Ohio have been obtained and are operative. If at any time during the period of this provider agreement MCP becomes disqualified from conducting business in Ohio, for whatever reason, MCP shall immediately notify ODJFS of the disqualification and MCP shall immediately cease performance of its obligation hereunder in accordance with OAC Chapter 5101:3-26.

ARTICLE V—CONFLICT OF INTEREST; ETHICS LAWS

A. In accordance with the safeguards specified in section 27 of the Office of Federal Procurement Policy Act (41 U.S.C. 423) and other applicable federal requirements, no officer, member or employee of MCP, the Chief of BMHC, or other ODJFS employee who exercises any functions or responsibilities in connection with the review or approval of this provider agreement or provision of services under this provider agreement shall, prior to the completion of such services or reimbursement, acquire any interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with, or would compromise in any manner or degree the discharge and fulfillment of his or her functions and responsibilities with respect to the carrying out of such services. For purposes of this article, “members” does not include individuals whose sole connection with MCP is the receipt of services through a health care program offered by MCP.

B. MCP hereby covenants that MCP, its officers, members and employees of the MCP have no interest, personal or otherwise, direct or indirect, which is incompatible or in conflict with or would compromise in any manner of degree the discharge and fulfillment of his or her functions and responsibilities under this provider agreement. MCP shall periodically inquire of its officers, members and employees concerning such interests.

C. Any person who acquires an incompatible, compromising or conflicting personal or business interest shall immediately disclose his or her interest to ODJFS in writing. Thereafter, he or she shall not participate in any action affecting the services under this provider agreement, unless ODJFS shall determine that, in the light of the personal interest disclosed, his or her participation in any such action would not be contrary to the public interest. The written disclosure of such interest shall be made to: Chief, Bureau of Managed Health Care, ODJFS.

D. No officer, member or employee of MCP shall promise or give to any ODJFS employee anything of value that is of such a character as to manifest a substantial and improper influence upon the employee with respect to his or her duties. No officer, member or employee of MCP shall solicit an ODJFS employee to violate any ODJFS rule or policy relating to the conduct of the parties to this agreement or to violate sections 102.03, 102.04, 2921.42 or 2921.43 of the Ohio Revised Code.

E. MCP hereby covenants that MCP, its officers, members and employees are in compliance with section 102.04 of the Revised Code and that if MCP is required to file a statement pursuant to 102.04(D)(2) of the Revised Code, such statement has been filed with the ODJFS in addition to any other required filings.

ARTICLE VI—EQUAL EMPLOYMENT OPPORTUNITY

A. MCP agrees that in the performance of this provider agreement or in the hiring of any employees for the performance of services under this provider agreement, MCP shall not by reason of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry, discriminate against any citizen of this state in the employment of a person qualified and available to perform the services to which the provider agreement relates.

B. MCP agrees that it shall not, in any manner, discriminate against, intimidate, or retaliate against any employee hired for the performance or services under the provider agreement on account of race, color, religion, sex, sexual orientation, age, disability, national origin, veteran's status, health status, or ancestry.

C. In addition to requirements imposed upon subcontractors in accordance with OAC Chapter 5101:3-26, MCP agrees to hold all subcontractors and persons acting on behalf of MCP in the performance of services under this provider agreement responsible for adhering to the requirements of paragraphs (A) and (B) above and shall include the requirements of paragraphs (A) and (B) above in all subcontracts for services performed under this provider agreement, in accordance with rule 5101:3-26-05 of the Ohio Administrative Code.

ARTICLE VII—RECORDS, DOCUMENTS AND INFORMATION

A. MCP agrees that all records, documents, writings or other information produced by MCP under this provider agreement and all records, documents, writings or other information used by MCP in the performance of this provider agreement shall be treated in accordance with rule 5101:3-26-06 of the Ohio Administrative Code. MCP must maintain an appropriate record system for services provided to members. MCP must retain all records in accordance with 45 CFR 74.

B. All information provided by MCP to ODJFS that is proprietary shall be held to be strictly

confidential by ODJFS. Proprietary information is information which, if made public, would put MCP at a disadvantage in the market place and trade of which MCP is a part [see Ohio Revised Code Section 1333.61(D)]. MCP is responsible for notifying ODJFS of the nature of the information prior to its release to ODJFS. ODJFS reserves the right to require reasonable evidence of MCP's assertion of the proprietary nature of any information to be provided and ODJFS will make the final determination of whether this assertion is supported. The provisions of this Article are not self-executing.

C. MCP shall not use any information, systems, or records made available to it for any purpose other than to fulfill the duties specified in this provider agreement. MCP agrees to be bound by the same standards of confidentiality that apply to the employees of the ODJFS and the State of Ohio. The terms of this section shall be included in any subcontracts executed by MCP for services under this provider agreement. MCP must implement procedures to ensure that in the process of coordinating care, each enrollee's privacy is protected consistent with the confidentiality requirements in 45 CFR parts 160 and 164.

ARTICLE VIII—SUSPENSION AND TERMINATION

A. This provider agreement may be canceled by the department or MCP upon written notice in accordance with the applicable rule(s) of the Ohio Administrative Code, with termination to occur at the end of the last day of a month.

B. MCP, upon receipt of notice of suspension or termination, shall cease provision of services on the suspended or terminated activities under this provider agreement; suspend, or terminate all subcontracts relating to such suspended or terminated activities, take all necessary or appropriate steps to limit disbursements and minimize costs, and furnish a report, as of the date of receipt of notice of suspension or termination describing the status of all services under this provider agreement.

C. In the event of suspension or termination under this Article, MCP shall be entitled to reconciliation of reimbursements through the end of the month for which services were provided under this provider agreement, in accordance with the reimbursement provisions of this provider agreement.

D. ODJFS may, in its judgment, suspend, terminate or fail to renew this provider agreement if the MCP or MCP's subcontractors violate or fail to comply with the provisions of this agreement or other provisions of law or regulation governing the Medicaid program. Where ODJFS proposes to suspend, terminate or refuse to enter into a provider agreement, the provisions of applicable sections of the Ohio Administrative Code with respect to ODJFS' suspension, termination or refusal to enter into a provider agreement shall apply, including the MCP's right to request a public hearing under Chapter 119. of the Revised Code.

E. When initiated by MCP, termination of or failure to renew the provider agreement requires written notice to be received by ODJFS at least 75 days in advance of the termination or renewal date, provided, however, that termination or non-renewal must be effective at the end of the last day of a calendar month. In the event of non-renewal of the provider agreement with ODJFS, if MCP is unable to provide notice to ODJFS 75 days prior to the date when the provider agreement expires, and if, as a result of said lack of notice, ODJFS is unable to disenroll Medicaid enrollees prior to the expiration date, then the provider agreement shall be deemed extended for up to two calendar months beyond the expiration date and both parties shall, for that time, continue to fulfill their duties and obligations as set forth herein. If an MCP wishes to terminate or not renew their provider agreement for a specific region(s), ODJFS reserves the right to initiate a procurement process to select additional MCPs to serve Medicaid consumers in that region(s).

ARTICLE IX—AMENDMENT AND RENEWAL

A. This writing constitutes the entire agreement between the parties with respect to all matters herein. This provider agreement may be amended only by a writing signed by both parties. Any written amendments to this provider agreement shall be prospective in nature.

B. This provider agreement may be renewed one or more times by a writing signed by both parties for a period of not more than twelve months for each renewal.

C. In the event that changes in State or Federal law, regulations, an applicable waiver, or the terms and conditions of any applicable federal waiver, require ODJFS to modify this agreement, ODJFS shall notify MCP regarding such changes and this agreement shall be automatically amended to conform to such changes without the necessity for executing written amendments pursuant to this Article of this provider agreement.

ARTICLE X—LIMITATION OF LIABILITY

A. MCP agrees to indemnify the State of Ohio for any liability resulting from the actions or omissions of MCP or its subcontractors in the fulfillment of this provider agreement.

B. MCP hereby agrees to be liable for any loss of federal funds suffered by ODJFS for enrollees resulting from specific, negligent acts or omissions of the MCP or its subcontractors during the term of this agreement, including but not limited to the nonperformance of the duties and obligations to which MCP has agreed under this agreement.

C. In the event that, due to circumstances not reasonably within the control of MCP or ODJFS, a major disaster, epidemic, complete or substantial destruction of facilities, war, riot or civil insurrection occurs, neither ODJFS nor MCP will have any liability or obligation on account of reasonable delay in the provision or the arrangement of covered services; provided that so long as MCP’s certificate of authority remains in full force and effect, MCP shall be liable for the covered services required to be provided or arranged for in accordance with this agreement.

ARTICLE XI—ASSIGNMENT

A. ODJFS will not allow the transfer of Medicaid members by one MCP to another MCP unless this membership has been obtained as a result of an MCP selling their entire Ohio corporation to another health plan. MCP shall not assign any interest in this provider agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODJFS and subject to such conditions and provisions as ODJFS may deem necessary. Any such assignments shall be submitted for ODJFS' review 120 days prior to the desired effective date. No such approval by ODJFS of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODJFS in addition to the total agreed-upon reimbursement in accordance with this agreement.

B. MCP shall not assign any interest in subcontracts of this provider agreement and shall not transfer any interest in the same (whether by assignment or novation) without the prior written approval of ODJFS and subject to such conditions and provisions as ODJFS may deem necessary. Any such assignments of subcontracts shall be submitted for ODJFS' review 30 days prior to the desired effective date. No such approval by ODJFS of any assignment shall be deemed in any event or in any manner to provide for the incurrence of any obligation by ODJFS in addition to the total agreed-upon reimbursement in accordance with this agreement.

ARTICLE XII—CERTIFICATION MADE BY MCP

A. This agreement is conditioned upon the full disclosure by MCP to ODJFS of all information required for compliance with federal regulations as requested by ODJFS.

B. By executing this agreement, MCP certifies that no federal funds paid to MCP through this or any other agreement with ODJFS shall be or have been used to lobby Congress or any federal agency in connection with a particular contract, grant, cooperative agreement or loan. MCP further certifies compliance with the lobbying restrictions contained in Section 1352, Title 31 of the U.S. Code, Section 319 of Public Law 101-121 and federal regulations issued pursuant thereto and contained in 45 CFR Part 93, Federal Register, Vol. 55, No. 38, February 26, 1990, pages 6735-6756. If this provider agreement exceeds $100,000, MCP has executed the Disclosure of Lobbying Activities, Standard Form LLL, if required by federal regulations. This certification is material representation of fact upon which reliance was placed when this provider agreement was entered into.

C. By executing this agreement, MCP certifies that neither MCP nor any principals of MCP (i.e., a director, officer, partner, or person with beneficial ownership of more than 5% of the MCP's equity) is presently debarred, suspended, proposed for debarment, declared ineligible, or otherwise excluded from participation in transactions by any Federal agency. The MCP also certifies that the MCP has no employment, consulting or any

other arrangement with any such debarred or suspended person for the provision of items or services or services that are significant and material to the MCP's contractual obligation with ODJFS. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into. If it is ever determined that MCP knowingly executed this certification erroneously, then in addition to any other remedies, this provider agreement shall be terminated pursuant to Article VII, and ODJFS must advise the Secretary of the appropriate Federal agency of the knowingly erroneous certification.

D. By executing this agreement, MCP certifies compliance with Article V as well as agreeing to future compliance with Article V. This certification is a material representation of fact upon which reliance was placed when this contract was entered into.

E. By executing this agreement, MCP certifies compliance with the executive agency lobbying requirements of sections 121.60 to 121.69 of the Ohio Revised Code. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

F. By executing this agreement, MCP certifies that MCP is not on the most recent list established by the Secretary of State, pursuant to section 121.23 of the Ohio Revised Code, which identifies MCP as having more than one unfair labor practice contempt of court finding. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into.

G. By executing this agreement MCP agrees not to discriminate against individuals who have or are participating in any work program administered by a county Department of Job and Family Services under Chapters 5101 or 5107 of the Revised Code.

H. By executing this agreement, MCP certifies and affirms that, as applicable to MCP, no party listed in Division (I) or (J) of Section 3517.13 of the Ohio Revised Code or spouse of such party has made, as an individual, within the two previous calendar years, one or more contributions in excess of $1,000.00 to the Governor or to his campaign committees. This certification is a material representation of fact upon which reliance was placed when this provider agreement was entered into. If it is ever determined that MCP's certification of this requirement is false or misleading, and not withstanding any criminal or civil liabilities imposed by law, MCP shall return to ODJFS all monies paid to MCP under this provider agreement. The provisions of this section shall survive the expiration or termination of this provider agreement.

I. By executing this agreement, MCP certifies and affirms that HHS, US Comptroller General or representatives will have access to books, documents, etc. of MCP.

J. By executing this agreement, MCP agrees to comply with the false claims recovery requirements of Section 6032 of The Deficit Reduction Act of 2005 (also see Section 5111.101 of the Revised Code).

ARTICLE XIII—CONSTRUCTION

A. This provider agreement shall be governed, construed and enforced in accordance with the laws and regulations of the State of Ohio and appropriate federal statutes and regulations. If any portion of this provider agreement is found unenforceable by operation of statute or by administrative or judicial decision, the operation of the balance of this provider agreement shall not be affected thereby; provided, however, the absence of the illegal provision does not render the performance of the remainder of the provider agreement impossible.

ARTICLE XIV—INCORPORATION BY REFERENCE

A. Ohio Administrative Code Chapter 5101:3-26 (Appendix A) is hereby incorporated by reference as part of this provider agreement having the full force and effect as if specifically restated herein.

B. Appendices B through P and any additional appendices are hereby incorporated by reference as part of this provider agreement having the full force and effect as if specifically restated herein.

C. In the event of inconsistence or ambiguity between the provisions of OAC 5101:3-26 and this provider agreement, the provision of OAC 5101:3-26 shall be determinative of the obligations of the parties unless such inconsistency or ambiguity is the result of changes in federal or state law, as provided in Article IX of this provider agreement, in which case such federal or state law shall be determinative of the obligations of the parties. In the event OAC 5101:3-26 is silent with respect to any ambiguity or inconsistency, the provider agreement (including Appendices B through P and any additional appendices), shall be determinative of the obligations of the parties. In the event that a dispute arises which is not addressed in any of the aforementioned documents, the parties agree to make every reasonable effort to resolve the dispute, in keeping with the objectives of the provider agreement and the budgetary and statutory constraints of ODJFS.

Aged, Blind or Disabled (ABD) Population

The parties have executed this agreement the date first written above. The agreement is hereby accepted and considered binding in accordance with the terms and conditions set forth in the preceding statements.

MOLINA HEALTHCARE OF OHIO, INC.:

BY: _____ DATE: _____

JESSE THOMAS, PRESIDENT & CEO

OHIO DEPARTMENT OF JOB AND FAMILY SERVICES:

BY: _____ DATE: _____

BARBARA E. RILEY, DIRECTOR

ABD PROVIDER AGREEMENT INDEX
December 1, 2006

APPENDIX A

OAC RULES 5101:3-26

The managed care program rules can be accessed electronically through the BMHC page of the ODJFS website.

APPENDIX B

SERVICE AREA SPECIFICATIONS
ABD ELIGIBLE POPULATION

MCP : Molina Healthcare of Ohio, Inc.

The MCP agrees to provide services to Aged, Blind or Disabled (ABD) members residing in the following service area(s):

ServiceArea: Southwest Region: Adams, Brown, Butler, Clermont, Clinton, Hamilton, Highland, and Warren counties.

ServiceArea: West Central Region: Champaign, Clark, Darke, Greene, Miami, Montgomery, Preble, and Shelby counties.

ServiceArea: Southeast Region : Athens, Belmont, Coshocton, Gallia, Guernsey, Harrison, Jackson, Jefferson, Lawrence, Meigs, Monroe, Morgan, Muskingum, Noble, Vinton, and Washington counties.

ServiceArea: Central Region—Crawford, Delaware, Fairfield, Fayette, Franklin, Hocking, Knox, Licking, Logan, Madison, Marion, Montgomery, Morrow, Perry, Pickaway, Pike, Ross, and Scioto counties.

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.
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 their Contract Administrator of the termination of an MCP panel provider that is designated as the primary care physician for >100 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.
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 that **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 adhere 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 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 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 or other staff. Furthermore, MCPs are prohibited from offering gifts of nominal value (i.e. clipboards, pens, coffee mugs, etc.) to CDJFS offices or SSE 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 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 its receipt prior to the member's effective date of coverage. No other materials may be included with this mailing.

c. The member handbook, provider directory and advance directives information must be mailed 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 five (5) days. If the MCP is unable to mail the materials within twenty-four (24) hours, the materials must be mailed via a method that will ensure receipt by no later than the 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.

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 selection services contractor (SSC) 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 SSC-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.

    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 Deferment Requests: When the MCP learns of a new member's hospitalization that is eligible for deferment prior to that member's discharge, the MCP shall notify the hospital and treating providers of the potential that the MCP may not be the payer. The MCP shall work with hospitals, providers and 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 MCP learns of a

deferment-eligible hospitalization, the MCP shall make every effort to notify ODJFS and request the deferment as soon as possible. When the MCP is notified by ODJFS of a potential hospital deferment, the MCP must make every effort to respond to ODJFS within ten (10) business days of the receipt of the deferment information.

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. 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 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, 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.

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:

i. Develop a transition plan that outlines how the MCP will effectively address the unique care coordination issues for members in their first three months of MCP membership that includes at a minimum:

ii. 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 sub-recipient agencies [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);

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, approved home health care, scheduled lab/radiology tests, necessary/approved durable medical equipment, supplies and needed/approved transportation arrangements.

iii. Strategies for how each new member will obtain care therapies from appropriate sources of care as an MCP member including reported scheduled health services as described in Section 28.i.(ii-iv) of this Appendix.

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

a. The member has appointments within the initial three months of the MCP membership with a primary physician or specialty physicians that were scheduled prior to the effective date of the MCP membership;

b. The member has been approved to receive an organ, bone marrow, or hematapoietic stem cell transplant pursuant to OAC rule 5101:3-2-07.1;

c. The member is in her third trimester of pregnancy and has an established relationship with an obstetrician and/or delivery hospital;

d. 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);

e. The member is receiving ongoing chemotherapy or radiation treatment;

f. The member has been released from the hospital within the last thirty (30) days and is following a treatment plan;

g. The member has been pre-certified to receive durable medical equipment (DME) which has not yet been received.

v. Reimburse out-of-panel providers that agree to provide the transition services identified in section 28.i.section ii at 100% of the current Medicaid fee-for-service provider rate for the service(s).

vi. Document the provision of transition services as follows:

a. As expeditiously as the situation warrants, contact the provider's offices via telephone to confirm that the service(s) meets the above criteria.

b. For services that meet the above criteria, inform the provider that the MCP is sending a form for signature to document that they accept/do not accept the terms for the provision of the services and copy the member on the form.

c. If the provider agrees to the terms, notify the member and provider of the MCP's authorization and ensure that the MCP's claims processing system will not deny the claim payment because the provider is out-of-panel. MCPs must include their non-contracting provider materials as outlined in Appendix G.4.e with the provider notice.

d. If the provider does not agree to the terms, notify the member and assist the member with locating a provider as expeditiously as the member's condition warrants.

e. Use the ODJFS-specified model language for the provider and member notices.

f. Maintain documentation of all member and/or provider contacts relating to such out-of-panel services, including but not limited to telephone calls and letters.

vii. Not require prior-authorization of any prescription drug that does not require prior authorization by Medicaid fee-for-service for the initial three months of a member's MCP membership. Additionally, all a typical anti- psychotic drugs, that do not require prior authorization by Medicaid fee-for-service, must be exempted from prior authorization requirements for all MCP ABD members through December 2007, after which time ODJFS will re-evaluate the continuation of this pharmacy utilization strategy.

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:

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; and

Standard code sets.

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 submit written verification to ODJFS for transaction standards and

code sets specified in 45 CFR Part 162 – Health Insurance Reform: Standards for Electronic Transactions (HIPAA regulations), that the MCP has established the capability of sending and receiving applicable transactions in compliance with the HIPAA regulations. The written verification shall specify the date that the MCP has: 1) achieved capability for sending and/or receiving the following transactions, 2) entered into the appropriate trading partner agreements, and 3) 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.

No more than two production files in the ODJFS-specified medium per format (e.g., NSF) should be submitted each month. If it is necessary for an MCP to submit more than two production files in the ODJFS-specified medium for a particular format in a month, they must request and receive permission to do so from their designated Contract Administrator.

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

Every two (2) years, and before ODJFS enters into a provider agreement with a new MCP, ODJFS or designee may review the information system capabilities of each MCP. Each MCP must participate in the review, except as specified below. 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.

As noted above, the information system review may be performed every two years. However, if ODJFS or its designee identifies significant information system problems, then ODJFS or its designee may conduct, and the MCP must participate in, a review the following year, or in such a timeframe as ODJFS, in their sole discretion, deems appropriate to ensure accuracy and efficiency of the MCP health information system.

If an MCP had an assessment performed of its information system through a private sector accreditation body or other independent entity within the two years preceding the time when ODJFS or its designee will be conducting its review, and has not made significant changes to its information system since that time, and the information gathered is the same as or consistent with the ODJFS or its designee's proposed review, as determined by the ODJFS, then the MCP will not required to undergo the IS review. The MCP must provide ODJFS or its designee with a copy of the review that was performed so that ODJFS can determine whether or not the MCP will be required to participate in the IS review. MCPs who are determined to be exempt from the IS review must participate in subsequent information system reviews, as determined by ODJFS.

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.

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 4 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.

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), 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 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 36(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; and (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. ODJFS may require MCPs to include additional information on the provider website, as needed.

37. MCPs must provide members with a printed version of their PDL and PA lists, upon request.

38. MCPs must not use, or propose to use , any offshore programming or call center services in fulfilling the program requirements.

39. 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 physician performance improvement projects that include incentive programs or the development of quality improvement programs.

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.
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 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 Selection Services Entity (SSE) also known as Selection Services Contractor (SSC): The ODJFS-contracted SSC will provide unbiased education, selection services, and community outreach for the Medicaid managed care program. The SSC shall operate a statewide toll-free telephone center to assist eligible individuals in selecting an MCP or choosing a health care delivery option.

The SSC 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 SSC-initiated MCP assignment processed through the SSC. 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.

APPENDIX E

RATE METHODOLOGY
ABD ELIGIBLE POPULATION

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 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). Note: Independent psychologist services not covered for adults age twenty-one (21) and older.

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
- Sex change surgery and related services
- Sexual or marriage counseling

- Court ordered testing
- 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 "Annual Opportunity" 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 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 must provide 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 various Medicaid-covered mental health (MH) services available through the 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 free-standing psychiatric hospital.

Substance Abuse Services: There are a number of various 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: MCPs are responsible for the payment of Medicaid-covered prescription drugs prescribed by a CMHC or ODADAS-certified provider when obtained through an MCP's panel pharmacy. MCPs are also responsible for the payment of Medicaid-covered services provided by an MCP's panel laboratory when referred by a CMHC or ODADAS-certified provider. Additionally, MCPs are responsible for the payment of all other behavioral health services obtained through providers other than those who are CMHC or ODADAS-certified providers when arranged/authorized by the MCP. MCPs are not responsible for paying for behavioral health services provided through CMHCs and ODADAS-certified Medicaid providers. MCPs are also not required to cover the payment of partial hospitalization (mental health), inpatient psychiatric care in a free-standing inpatient psychiatric hospital, outpatient detoxification, or methadone maintenance.

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 §5111.72, 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 hematapoietic stem cell transplant services, as defined in OAC 3701:84-01, is contingent upon review and recommendation by the "Ohio Hematapoietic 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 (Modification) Programs

General Provisions - Pursuant to OAC rule 5101:3-26-03.1(A)(7), MCPs must implement the ODJFS-required emergency department diversion (EDD) utilization management program to maximize the effectiveness of the care provided to members and may develop other utilization management programs, subject to prior approval by ODJFS. For the purposes of this requirement, the specific utilization management programs which require ODJFS prior-approval are those programs designed by the MCP with the purpose of redirecting or restricting access to a particular service or service location. These programs are referred to as utilization modification programs. MCP care coordination and disease management activities which are designed to enhance the services provided to members with specific health care needs would not be considered utilization management programs nor would the designation of specific services requiring prior approval by the MCP or the member=s PCP. 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 approval.

Pharmacy Programs - Pursuant to ORC Sec. 5111.172 and OAC rule 5101:3-26-03(A) and (B), MCPs subject to ODJFS prior-approval, may implement strategies, including prior authorization and limitations on the type of provider and locations where certain medications may be administered, for the management of pharmacy utilization.

MCPs must receive prior approval from ODJFS on the types of medication that they wish to cover through prior authorizations. 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) 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 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.

MCPs may also, with ODJFS prior approval, implement pharmacy utilization modification programs designed to address members demonstrating high or inappropriate utilization of specific prescription drugs.

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.

4. Case Management

In accordance with 5101:3-26-03.1(A)(8), MCPs must offer and provide 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's case management system 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; 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.

iii. Case Management –

Risk Stratification/Levels of Care

The MCP must develop a strategy to assign members to risk stratification levels, based on the member's comprehensive needs assessment. Once the member's

risk level has been determined, the MCP must, at a minimum: -develop a care treatment plan (as described below);

- implement member-level interventions;
- continuously monitor the progress of the member;
- identify gaps between care recommended and actual care provided, and propose and implement interventions to address the gaps; and
- implement a system to monitor the delivery of specific services, including a review of service utilization, to re-evaluate the member's risk level and adjust the level of case management services accordingly.

Care Treatment Plan

The MCP must assure and coordinate the placement of the member into case-management – including identification of the member's need for services, completion of the comprehensive health needs assessment, and development of a care treatment plan-within ninety (90) days of membership. 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 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 physician, 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.

Coordination of Care and Communication

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)]. 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 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.

iv. 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 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.

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 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.

vi. 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 physicians 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.

vii. 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.

viii. 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 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 the status of cases (e.g., closed, open, and/or active) in CAMS on an annual basis with the information contained in the member's case management record. The CAMS files are due the 10th business day of each month.

c. All MCPs must have an ODJFS-approved case management system which includes the items in Section 4(a) and (b) of Appendix G. 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 system description must be submitted to ODJFS in writing for review and approval prior to implementation. Refer to *Appendix K* for the requirements regarding the annual review of the case management program.

d. 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 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;
- 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).

The MCP must notify ODJFS when this requirement has been fulfilled.

e. 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 tha**t** 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 28.i.c. of Appendix C.

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 that **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). 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 Physicians (PCPs)

Primary Care Physicians (PCPs) may be individuals or group practices/clinics [Primary Care Clinics (PCCs)]. Acceptable specialty types for PCPs are family/general practice, and internal medicine. 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, and to be included in the MCP's total PCP capacity calculation. 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 also compare a PCP's capacity against the number of members assigned to that PCP, and/or the number of patient encounters attributed to that PCP to determine if the reported capacity number reasonably reflects a PCP's expected caseload for a specific MCP. 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 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 as PCPs, however, they must be submitted to PVS 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 and therefore may not appear as PCPs in the MCP's provider directory. Also, no PCP capacity will be counted for these providers. 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 55% of the eligibles in 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).]

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. All MCP-contracting OB/GYNs must have current hospital delivery privileges at a hospital under contract with the MCP in the region.

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.

Contracting CNMs must have hospital delivery privileges at a hospital under contract to the MCP in the region. 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. 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. Contracting general surgeons, orthopedists, otolaryngologists, *cardiologists, gastroenterologists, nephrologists, neurologists, oncologists, podiatrists, physiatrists, psychiatrists, and urologists* must have admitting privileges at a hospital under contract with the MCP in the region.

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.

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.

MCPs are to follow the procedures specified in the current *MCP PVS Instructional Manual*, posted on the ODJFS website, in order to comply with these federal access requirements.

North East Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required Hospitals: In-Region
General Hospital		1			1	1	1	1	1	
Hospital System[1]	1		1							1

1 Hospital system includes; physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

North East Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Columbiana	Mahoning	Trumbull	Additional Required Hospitals: In-Region
General Hospital	3	1	1		1
Hospital System					

East Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required Hospitals: In- Region
General Hospital	7				1	1	1		1	1	2
Hospital System[1]	1							1			

[1] Hospital system includes; physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

South East Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Athens	Belmont	Coshocton	Gallia	Guernsey	Harrison	Jackson	Jefferson	Lawrence	Meigs	Monroe	Morgon	Muskingum	Noble	Vinton	Washington	Additional Required Hospitals: In-Region
General Hospital Hospital System	8	1	1	1	1	1			1					1			1	

Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Crawford	Delaware	Fairfield	Fayette	Franklin	Hocking	Knox	Licking	Logan	Madison	Marion	Morrow	Perry	Pickaway	Pike	Ross	Scioto	Union	Additional Required Hospitals: In-Region
General Hospital	10			1	1				1			1			1		1	1		3
Hospital System[1]	2					2														

[1] Hospital system includes; physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

South West Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required Hospitals: In-Region
General Hospital	6		1	1		1	1	1		1
Hospital System[1]	2						2			

1 Hospital system includes; physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

West Central Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required Hospitals: In-Region
General Hospital	5		1		1	1				2
Hospital System[2]	1						1			

1 Hospital system includes; physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

North West Region - Hospitals

Minimum Provider Panel Requirements

	Total Required Hospitals	Allen	Auglaize	Defiance	Fulton	Hancock	Hardin	Henry	Lucas	Mercer	Ottawa	Paulding	Putnam	Sandusky	Seneca	Van Wert	Williams	Wood	Wyandot	Additional Required Hospitals: In- Region
General Hospital	7	1		1		1								1						3
Hospital System[1]	1								1											

1 Hospital system includes; physician networks and therefore these physicians could be considered when fulfilling contracts for PCP and non-PCP provider panel requirements.

Last Revised May 25, 2006

North East Region - PCP Capacity

Minimum PCP Capacity Requirements - ABD

PCPs	Total Required	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required: In-Region *
Capacity	**14,196**	799	10,587	283	117	228	541	1,372	269	
PCPs[1]	**31**	4	16	2	1	1	2	4	1	
Number of Eligibles	**25,810**	1453	19249	514	212	415	983	2495	489	

1 Acceptable PCP specialty types include Family/General Practice or Internal Medicine

North East Central Region - PCP Capacity

Minimum PCP Capacity Requirements - ABD

PCPs	Total Required	Columbiana	Mahoning	Trumbull	Additional Required: In- Region *
Capacity	**4,230**	798	2,028	1,405	
PCPs[1]	**11**	3	4	4	
Number of Eligibles	**7,691.00**	1,450	3,687	2,554	

1 Acceptable PCP specialty types include Family/General Practice or Internal Medicine

Last Revised May 25, 2006

East Central Region - PCP Capacity

Minimum PCP Capacity Requirements - ABD

PCPs	Total Required	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required: In-Region *
Capacity	**7,415**	152	134	83	479	710	1,870	3,051	458	480	
PCPs[1]	**21**	1	1	1	2	3	4	5	2	2	
Number of Eligbles	**13,482**	276	243	150	871	1,290	3,400	5,547	833	872	

1 Acceptable PCP specialty types include Family/General Practice or Internal Medicine

South East Region - PCP Capacity

Minimum PC8P Capacity Requirements - ABD

County	Capacity	PCPs[1]	Number of Eligbles
Total Required	**7,434**	**30**	**13,516**
Athens	724	2	1,317
Belmont	654	2	1,189
Coshocton	234	1	426
Gallia	457	2	830
Guernsey	395	2	718
Harrison	172	1	313
Jackson	483	2	879
Jefferson	795	3	1,445
Lawrence	1,154	4	2,098
Meigs	393	2	714
Monroe	134	1	244
Morgon	175	1	319
Muskingum	889	3	1,617
Noble	86	1	157
Vinton	197	1	359
Washington	490	2	891
Additional Required: In-Region *			

[1] Acceptable PCP specialty types include Family/General Practice or Internal Medicine

Central Region - PCP Capacity

Minimum PCP Capacity Requirements - ABD

County	Capacity	PCPs[1]	Number of Eligibles
Total Required	**13,660**	**59**	**24,837**
Crawford	258	2	469
Delaware	226	2	410
Fairfield	528	3	960
Fayette	207	2	377
Franklin	6,592	17	11,985
Hocking	237	2	431
Knox	282	2	512
Licking	682	4	1,240
Logan	168	2	305
Madison	149	1	270
Marion	496	3	902
Morrow	133	1	241
Perry	334	3	608
Pickaway	306	2	557
Pike	524	3	952
Ross	741	4	1,348
Scioto	1,687	5	3,068
Union	111	1	202
Additional Required: In-Region			

[1] Acceptable PCP specialty types include Family/General Practice or Internal Medicine

Last Revised May 25, 2006

West Central Region - PCP Capacity

Minimum PCP Capacity Requirements - ABD

PCPs	Total Required	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required: In-Region *
Capacity	**5,965**	138	986	171	498	316	3,537	147	174	
PCPs[1]	**17**	1	4	1	2	2	6	1	1	
Number of Eligibles	**10,846**	250	1,793	311	905	574	6,430	267	316	

[1] Acceptable PCP specialty types include Family/General Practice or Internal Medicine

Last Revised May 25, 2006

South West Region - PCP Capacity

Minimum PCP Capacity Requirements - ABD

PCPs	Total Required	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required: In-Region *
Capacity	**8,615**	502	248	1,581	717	212	4,696	315	344	
PCPs[1]	**22**	3	1	4	3	1	6	2	2	
Number of Eligibles	**15,663**	912	451	2,875	1,303	386	8,539	572	625	

1 Acceptable PCP specialty types include Family/General Practice or Internal Medicine

North West Region - PCP Capacity

Minimum PCP Capacity Requirements - ABD

County	Capacity	PCPs[1]	Number of Eligibles
Total Required	**6,748**	**33**	**12,269**
Allen	591	3	1,075
Auglaize	105	1	190
Defiance	150	1	272
Fulton	93	1	169
Hancock	212	2	385
Hardin	182	2	330
Henry	54	1	99
Lucas	3,963	9	7,206
Mercer	102	1	185
Ottawa	103	1	188
Paulding	90	1	163
Putnam	72	1	130
Sandusky	240	2	436
Seneca	243	2	442
Van Wert	111	1	202
Williams	128	1	233
Wood	253	2	460
Wyandot	57	1	104
Additional Required: In- Region *			

[1] Acceptable PCP specialty types include Family/General Practice or Internal Medicine

This chart was finalized 10/14/05 and supercedes the one distributed 9/20/05. The provider panel charts are a summary of the provider panel requirements. For the complete requirements, see RFA - Regional Provider Panel Specifications.

North East Region - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Ashtabula	Cuyahoga	Erie	Geauga	Huron	Lake	Lorain	Medina	Additional Required Providers[2]
Cardiovascular	**6**		3					1		2
Dentists	**28**	1	20				2	3	1	1
Gastroenterology	**3**		2							1
General Surgeons	**11**		6	1		1	1	1	1	
Nephrology	**2**		1							1
Neurology	**3**		2							1
OB/GYNs	**12**		8	1				1		2
Oncology	**1**									1
Orthopedists	**7**		4					1		2
Otolaryngologist	**3**		1					1		1
Physical Med Rehab	**3**		2							1
Podiatry	**8**		4					2		2
Psychiatry	**11**		5					3		3
Urology	**4**		2							2
Vision	**14**	1	7	1			1	1		3

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

North East Central - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Columbiana	Mahoning	Trumbull	Additional Required Providers [2]
Cardiovascular	**2**		1		1
Dentists	**7**	1	3	3	
Gastroenterology	**1**				1
General Surgeons	**3**	1	1	1	
Nephrology	**1**				1
Neurology	**1**				1
OB/GYNs	**4**	1	1	1	1
Oncology	**1**				1
Orthopedists	**2**		1		1
Otolaryngologist	**1**		1		
Physical Med Rehab	**1**				1
Podiatry	**1**				1
Psychiatry	**6**		3	2	1
Urology	**1**				1
Vision	**5**		2	2	1

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

East Central - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Ashland	Carroll	Holmes	Portage	Richland	Stark	Summit	Tuscarawas	Wayne	Additional Required Providers [2]
Cardiovascular	**3**						1	1			1
Dentists	**14**	1				2	4	6	1		
Gastroenterology	**2**										2
General Surgeons	**7**					1	1	2		1	2
Nephrology	**1**										1
Neurology	**2**										2
OB/GYNs	**6**						2	4			
Oncology	**1**										1
Orthopedists	**4**						1	1			2
Otolaryngologist	**2**						1	1			
Physical Med Rehab	**2**										2
Podiatry	**4**						1	2			1
Psychiatry	**6**						2	3			1
Urology	**2**										2
Vision	**8**					1	2	3			2

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

South East - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Athens	Belmont	Coshocton	Gallia	Guernsey	Harrison	Jackson	Jefferson	Lawrence	Meigs	Monroe	Morgon	Muskingum	Noble	Vinton	Washington	Additional Required Providers[2]
Cardiovascular	**3**				1									1				1
Dentists	**8**	1	1			1				1				1			1	2
Gastroenterology	**2**																	2
General Surgeons	**5**		1		1	1			1					1				
Nephrology	**1**																	1
Neurology	**2**																	2
OB/GYNs	**6**	1				1			1					1			1	1
Oncology	**1**																	1
Orthopedists	**4**				1									1			1	1
Otolaryngologist	**2**				1									1				
Physical Med Rehab	**2**																	2
Podiatry	**4**		1											1				2
Psychiatry	**6**	2	1											1				2
Urology	**2**																	2
Vision	**8**	1	1		1	1		1		1				1			1	

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

Central - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Crawford	Delaware	Fairfield	Fayette	Franklin	Hocking	Knox	Licking	Logan	Madison	Marion	Morrow	Perry	Pickaway	Pike	Ross	Scioto	Union	Additional Required Providers[2]
Cardiovascular	**5**					2														3
Dentists	**21**		1	1		15		1	1			1					1			
Gastroenterology	**3**					1														2
General Surgeons	**10**		1	1		5											1	1		1
Nephrology	**2**					1														1
Neurology	**3**					1														2
OB/GYNs	**10**		1	1		6														2
Oncology	**1**																			1
Orthopedists	**7**			1		3			1			1					1			
Otolaryngologist	**3**		1			2														
Physical Med Rehab	**3**					1														2
Podiatry	**7**		1			3														3
Psychiatry	**11**		1	1		5														4
Urology	**4**																			
Vision	**14**	1	1	1		5		1	1	1		1					1	1		

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

South West - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Adams	Brown	Butler	Clermont	Clinton	Hamilton	Highland	Warren	Additional Required Providers[2]
Cardiovascular	**4**						1		1	2
Dentists	**15**			3	1		8	1	1	1
Gastroenterology	**2**									2
General Surgeons	**9**			1	1	1	3	2	1	
Nephrology	**1**									1
Neurology	**2**									2
OB/GYNs	**7**		1	1			4		1	
Oncology	**1**									1
Orthopedists	**5**			1			2			2
Otolaryngologist	**2**						1			1
Physical Med Rehab	**2**									2
Podiatry	**5**			1			2			2
Psychiatry	**7**						3			4
Urology	**3**									3
Vision	**8**			1		1	3	1	1	1

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

West Central - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Champaign	Clark	Darke	Greene	Miami	Montgomery	Preble	Shelby	Additional Required Providers [2]
Cardiovascular	**3**						1			2
Dentists	**5**		1				3			1
Gastroenterology	**1**									1
General Surgeons	**5**		1		1		1			2
Nephrology	**1**									1
Neurology	**2**									2
OB/GYNs	**5**		1		1		3			
Oncology	**1**									1
Orthopedists	**3**				1		1			1
Otolaryngologist	**2**						1			1
Physical Med Rehab	**2**									2
Podiatry	**4**						2			2
Psychiatry	**5**				1		2			2
Urology	**2**									2
Vision	**7**		1		1		3			2

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

North West - Practitioners

ABD Provider Panel Requirements

Provider Types	Total Required Providers[1]	Allen	Auglaize	Defiance	Fulton	Hancock	Hardin	Henry	Lucas	Mercer	Ottawa	Paulding	Putnam	Sandusky	Seneca	Van Wert	Williams	Wood	Wyandot	Additional Required Providers[2]
Cardiovascular	**3**								1											2
Dentists	**11**	1			1				6				1	1			1			
Gastroenterology	**2**								1											1
General Surgeons	**5**	1							2									1		1
Nephrology	**1**																			1
Neurology	**2**								1											1
OB/GYNs	**6**	1							2					1	1			1		
Oncology	**1**																			1
Orthopedists	**4**	1					1		1									1		
Otolaryngologist	**2**								1											1
Physical Med Rehab	**2**								1											1
Podiatry	**4**								2									1		1
Psychiatry	**6**	1							3									1		1
Urology	**2**								1											1
Vision	**7**	1		1					2	1				1		1				

1 All required providers must be located within the region.
2 Additional required providers may be located anywhere within the region.

APPENDIX I

PROGRAM INTEGRITY
ABD ELIGIBLE POPULATION

MCPs must comply with all applicable program integrity requirements, including those specified in 42 CFR 455 and Subpart H.

1. Fraud and Abuse Program:

   In addition to the specific requirements of OAC rule 5101:3-26-06, MCPs must have a program that includes administrative and management arrangements or procedures, including a mandatory compliance plan, to guard against fraud and abuse. The MCP's compliance plan must designate staff responsibility for administering the plan and include clear goals, milestones or objectives, measurements, key dates for achieving identified outcomes, and explain how the MCP will determine the compliance plan's effectiveness.

   a. Monitoring for fraud and abuse: In addition to the requirements in OAC rule 5101:3-26-06, the MCP's program which safeguards against fraud and abuse must specifically address the MCP's prevention, detection, investigation, and reporting strategies in at least the following areas:

      i. Embezzlement and theft – MCPs must monitor activities on an ongoing basis to prevent and detect activities involving embezzlement and theft (e.g., by staff, providers, contractors, etc.) and respond promptly to such violations.

      ii. Underutilization of services – MCPs must monitor for the potential underutilization of services by their members in order to assure that all Medicaid-covered services are being provided, as required. If any underutilized services are identified, the MCP must immediately investigate and, if indicated, correct the problem(s) which resulted in such underutilization of services.

      The MCP's monitoring efforts must, at a minimum, include the following activities: a) an annual review of their prior authorization procedures to determine that they do not unreasonably limit a member's access to Medicaid-covered services; b) an annual review of the procedures providers are to follow in appealing the MCP's denial of a prior authorization request to determine that the process does not unreasonably limit a member's access to Medicaid-covered services; and c) ongoing monitoring of MCP service denials and utilization in order to identify services which may be underutilized.

iii. Claims submission and billing – On an ongoing basis, MCPs must identify and correct claims submission and billing activities which are potentially fraudulent including, at a minimum, double-billing and improper coding, such as upcoding and bundling, to the satisfaction of ODJFS.

b. Reporting MCP fraud and abuse activities: Pursuant to OAC rule 5101:3-26-06, MCPs are required to submit annually to ODJFS a report which summarizes the MCP's fraud and abuse activities for the previous year in each of the areas specified above. The MCP's report must also identify any proposed changes to the MCP's compliance plan for the coming year.

c. Reporting fraud and abuse: MCPs are required to promptly report all instances of provider fraud and abuse to ODJFS and member fraud to the CDJFS. The MCP, at a minimum, must report the following information on cases where the MCP's investigation has revealed that an incident of fraud and/or abuse has occurred:

i. provider's name and Medicaid provider number or provider reporting number (PRN);

ii. source of complaint;

iii. type of provider;

iv. nature of complaint;

v. approximate range of dollars involved, if applicable; vi. results of MCP's investigation and actions taken;

vii. name(s) of other agencies/entities (e.g., medical board, law enforcement) notified by MCP; and

viii. legal and administrative disposition of case, including actions taken by law enforcement officials to whom the case has been referred.

2. Data Certification:

Pursuant to 42 CFR 438.604 and 42 CFR 438.606, MCPs are required to provide certification as to the accuracy, completeness, and truthfulness of data and documents submitted to ODJFS which may affect MCP payment.

a. MCP Submissions: MCPs must submit the appropriate ODJFS-developed certification concurrently with the submission of the following data or documents:

i. Encounter Data [as specified in the Data Quality Appendix (Appendix L)]

ii. Prompt Pay Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

iii. Cost Reports [as specified in the Fiscal Performance Appendix (Appendix J)]

b. Source of Certification: The above MCP data submissions must be certified by one of the following:

i. The MCP's Chief Executive Officer;

ii. The MCP's Chief Financial Officer, or

iii. An individual who has delegated authority to sign for, or who reports directly to, the MCP's Chief Executive Officer or Chief Financial Officer.

ODJFS may also require MCPs to certify as to the accuracy, completeness, and truthfulness of additional submissions.

3. Prohibited Affiliations:

Pursuant to 42 CFR 438.610, MCPs must not knowingly have a relationship with individuals debarred by Federal Agencies, as specified in Article XII of the Agreement.

APPENDIX J

FINANCIAL PERFORMANCE
ABD 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. 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);

f. Reinsurance agreements, as outlined in OAC rule 5101:3-26-09(C);

g. 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;

h. 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;

i. 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);

j. 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 2007, a minimum net worth per member of $155.00, 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 minus Franchise Fees 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 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 $150,000 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 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 2008 Provider Agreement. Initiation of the PIPs will begin in the second year of participation in the ABD Medicaid managed care program.

In addition, as noted in Appendix M, if an MCP fails to meet the Minimum Performance Standard for selected Clinical Performance Measures, the MCP will be required to complete a PIP.

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, beginning in SFY 2005, 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 2008 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.

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 REVIEW AND NON-DUPLICATION OF MANDATORY ACTIVITIES

The EQRO will conduct administrative compliance assessments for each MCP every three (3) years. The review will include, but not be limited to, the following domains as specified by ODJFS: member rights and services, QAPI program, access standards, provider network, grievance system, case management, coordination and continuity of care, and utilization management. 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 07.

b. ANNUAL REVIEW OF QAPI AND CASE MANAGEMENT PROGRAM

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.

The annual QAPI and case management (refer to Appendix G) program submissions are subject to an administrative review by the EQRO. If the EQRO identifies deficiencies during its review, the MCP must develop and implement Corrective Action Plan(s) that are prior approved by ODJFS. Serious deficiencies may result in immediate termination or non-renewal of the provider agreement.

c. EXTERNAL QUALITY REVIEW PERFORMANCE

In accordance with OAC rule 5101:3-26-07, each MCP must participate in clinical or non-clinical focused quality of care studies as part of the annual external quality review survey. If the EQRO cites a deficiency in clinical or non-clinical performance, the MCP will be required to complete a Corrective Action Plan (e.g., ODJFS technical assistance session), Quality Improvement Directives or Performance Improvement Projects 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, Blinded 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): Encounter Data Omissions, 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 (i.e., to include all counties with ABD memberships served by the MCP).

Report Period: The report periods for the SFY 2007 and SFY 2008 contract periods are listed in the table below.

Table 1. Report Periods for the SFY 2007 and 2008 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	SFY 2007
Qtr 1, Qtr 2 2007	October 2007	November 2007	
Qtr 1 thru Qtr 3 2007	January 2008	February 2008	
Qtr 1 thru Qtr 4 2007	April 2007	May 2007	SFY 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	

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 (see below, Table 2 – Encounter Data Volume Standards).

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. Encounter Data Omissions

Omission studies will evaluate the completeness of the encounter data.

Measure: This study will compare the medical records of members during the time of membership to the encounters submitted. Omission rates will be calculated per MCP (i.e., to include all counties serviced by the MCP).

The encounters documented in the medical record that do not appear in the encounter data 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.

Medical records retrieval from the provider and submittal to ODJFS or its designee is an integral component of the omission measure. 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: The data quality standard is a maximum omission rate of 15% for studies with time periods ending in CY 2008.

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.iii. 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 (i.e., to include all counties serviced by the MCP).

Report Period: For the SFY 2007 contract period, perf ormance will be evaluated using the following report periods: January – March 2007; April – June 2007. For the SFY 2008 contract period, performance will be evaluated using the following report periods: January - March 2007; April – June 2007; July-September 2007; October – December 2007; January – March 2008; April – June 2008.

Data Quality Standard: The data quality standard is a minimum rate of 95%.

Determination of Compliance: Performance is monitored once every quarter. If the standard is not met in all report periods, then the MCP will be determined to be noncompliant.

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.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 (i.e., to include all counties serviced by the MCP).

Report Period: For the SFY 2007 contract period, performance will be evaluated using the following report periods: January – March 2007; April – June 2007. 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.

Data Quality Standard 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 (i.e., to include all counties serviced by the 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 Data Quality Standard 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 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 (i.e., to include all counties serviced by the 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 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 months with membership: 50%

Seventh through twelfth month with membership: 25%

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 Data Quality Standard 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 only once per measure 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 (i.e. accepted encounters per 1,000 member months). The measure will be calculated per MCP (i.e., to include all counties serviced by the 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 only once per measure 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.

1.a.vi. Informational Encounter Data Completeness Measures

The encounter data quality measures listed below (section 1.a.vi. (1) –(2)) are informational only for the ABD population. Although there are no minimum performance standards for these measures, results will be reported and used as one component in monitoring the quality of data submitted to ODJFS by the MCPs.

(1) Incomplete Data For Last Menstrual Period

(2) Incomplete Birth Weight Data

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 (i.e., to include all counties serviced by the 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.

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 (i.e., to include all counties serviced by the 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 2007 contract period, performance will be evaluated using the following report periods: January – March 2007; April – June 2007. For the SFY 2008 contract period, performance will be evaluated using the following report periods: January – March 2007; April – June 2007; July-September 2007; October – December 2007; January – March 2008; April – June 2008.

Data Quality Standard: A maximum generic provider usage rate of 10%.

Determination of Compliance: Performance is monitored once every quarter. If the standard is not met in all report periods, then the MCP will be determined to be noncompliant.

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

MCP submissions of encounter data files in the ODJFS-specified medium per format to ODJFS are limited to two per format per month. Should an MCP wish to send additional files in the ODJFS-specified medium per format, permission to do so must be obtained by contacting BMHC. 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 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

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: January – March 2007, and 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.

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 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 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 the clinical 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.

If an MCP does not complete a study because either their encounter data is of insufficient quality or too few medical records are submitted, accurate evaluation of clinical quality in the study area cannot be determined for the individual MCP and the assurance of adequate clinical quality for the program as a whole is jeopardized.

3.a. Independent External Quality Review

Measure: The independent external quality review covers both administrative and clinical focus areas of study.

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 1: Sufficient encounter data quality in each study area to draw a sample as determined by the external quality review organization

Penalty for noncompliance with Data Quality Standard 1: 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.

Data Quality Standard 2: A minimum record submittal rate of 85% for each clinical measure.

Penalty for noncompliance for Data Quality Standard 2: 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 physician 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; however, no ABD member may have more than one PCP identified.

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

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 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, October – December 2007, January – March 2008 and April – June 2008 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. A minimum rate of 85% of new members with PCP designation by their effective date of enrollment for quarter 3 and quarter 4 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 who have had at least three months of continuous enrollment during each month of the entire report period.

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 physician (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 G*rievance 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.v., and 1.a.v.i., 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 both an administrative review and focused quality of care studies 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 the administrative review or quality of care studies, the MCP will be required to complete a Corrective Action Plan, Quality Improvement Directive, or Performance Improvement Project as outlined in Appendix K of the Agreement. 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.ii. 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.

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.]

Minimum Performance Standard: For the fourth quarters of SFY 2007, a case management rate of 30%. For the first and second quarters of SFY 2008, a case management rate of 35%. For the third and fourth quarters of SFY 2008, a case management rate of 40%. ODJFS expects the minimum standard for this measure to increase to 50% by the fourth quarter of SFY 2009.

Penalty for Noncompliance: The first time an MCP is noncompliant with the 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 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 new member selection freeze/reduction of assignments will be lifted.

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 severe mental illness 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 high risk or high cost substance abuse disorders 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 severe cognitive and/or developmental limitation 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 diabetes who have had at least three consecutive months of enrollment in one MCP that are case managed.

Measure 8: 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 9: 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 1-9: 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.

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.]

Minimum Performance Standard for Measures 1-9: For the fourth quarter of SFY 2007, a case management rate of 60%. For the first and second quarters of SFY 2008, a case management rate of 65%. For the third and fourth quarters of SFY 2008, a case management rate of 70%. ODJFS expects the minimum standard for this measure to increase to 80% by the fourth quarter of SFY 2009.

Penalty for Noncompliance for Measures 1-9: The first time an MCP is noncompliant with the 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 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 new member selection freeze/reduction of assignments will be lifted.

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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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) – ACE Inhibitor/Angiotensin Receptor Blocker

Measure: The percentage of members who had a diagnosis of CHF in the year prior to the reporting year, who were enrolled for six or more months in the reporting year, who received one or more prescriptions for an ACE Inhibitor or Angiotensin Receptor Blocker 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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. 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%, then the MCP is required to complete a Performance Improvement Project, as described in

Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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) – 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 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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) – 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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) – 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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. Beta Blocker Treatment after Heart Attack

Measure: The percentage of members 35 years 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of

noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance.

If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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%, then the MCP is required to complete a Performance Improvement Project, as described in

Appendix K, *Quality Assessment and Performance Improvement Program*, to address the area of noncompliance. If the standard is not met and the results are at or above TBD%, then 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 Physician (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 physicians 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 physicians 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 in itial 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, 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 CY2008 reporting period.

Minimum Performance Standard: A maximum PCP Turnover rate of 18%.

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 an 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 physician (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 member's 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 age 21 and older 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 CY2008 reporting 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 periodically 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. 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 ABD Medicaid Managed Care Program Consumer Satisfaction Performance Measures*, which are incorporated in this Appendix.

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.

Report Period: For the SFY 2008 contract period, the measure is under review and the report period has not been determined.

Minimum Performance Standard: An average score of no less than 7.0.

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 ABD Medicaid Managed Care Program Administrative Capacity Performance Measures*, which are incorporated in this Appendix.

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 ED services and implement action plans designed to minimize inappropriate ED utilization.

Measure: The percentage of members who had TBD ED visits during a 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 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.

APPENDIX N

COMPLIANCE ASSESSMENT SYSTEM (CAS)
ABD ELIGIBLE POPULATION

The Compliance Assessment System (CAS) is designed to improve the quality of each MCP's performance through actions taken by ODJFS to address identified failures to meet certain program requirements. The CAS assesses progressive remedies with specified values (occurrences or points) assigned for certain documented failures to satisfy the deliverables required by the Agreement. Remedies are progressive based upon the severity of the violation, or a repeated pattern of violations. The CAS does not include categories which require subjective assessments or which are not within the MCPs' control. CAS allows the accumulated point total to reflect both patterns of less serious violations as well as less frequent, more serious violations.

The CAS focuses on clearly identifiable deliverables, and occurrences/points are only assessed in documented and verified instances of noncompliance. 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 Ohio Administrative Code (OAC) rule 5101:3-26-10, including the proposed termination, amendment, or nonrenewal of the MCP's provider agreement.

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.

Corrective Action Plans (CAPs) – MCPs may be required to develop CAPs for any instance of noncompliance, and CAPs are not limited to actions taken under the CAS. All CAPs requiring ongoing activity on the part of an MCP to ensure their compliance with a program requirement remain in effect for the next provider agreement period. 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 an ODJFS-approvable CAP, ODJFS may require the MCP to comply with an ODJFS-developed or "directed" CAP.

Occurrences and Points – Occurrences and points are defined and applied as follows:

Occurrences – Failures to meet program requirements, including but not limited to, noncompliance with administrative requirements.

Examples include:
- Use of unapproved marketing materials.
- Failure to attend a required meeting.
- Second failure to meet a call center standard.

5 Points – Failures to meet program requirements, including but not limited to, actions which could impair the member's ability to access information regarding services in a timely manner or which could impair a member's rights.

Examples include:
- 24-hour call-in system is not staffed by medical personnel.
- Failure to notify a member of their right to a state hearing when the MCP proposes to deny, reduce, suspend or terminate a Medicaid-covered service.
- Failure to appropriately notify ODJFS of provider panel terminations.

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 member to access covered services.

Examples include:
- Failure to comply with the minimum provider panel requirements specified in Appendix H of the Agreement.
- Failure to provide medically-necessary Medicaid covered services to members.
- Failure to meet the electronic claims adjudication requirements.

Failure to submit or comply with CAPs will result in the assessment of occurrences or points based on the nature of the violation under correction.

Notwithstanding the assessment of occurrences and/or points as a result of individual events, the following cumulative actions will be imposed for repeated violations.

- After accumulating a total of three occurrences within a contract term, all subsequent occurrences during the period will be assessed as 5-point violations, regardless of the number of 5-point violations which have been accrued by the MCP.
- After accumulating a total of three 5-point violations within a contract term, all subsequent 5-point violations during the period will be assessed as 8-point violations, except as specified above.
- After accumulating a total of two 10-point violations within a contract term, all subsequent 10-point violations during the period will be assessed as 15-point violations.

Occurrences and points will accumulate over the contract term of the Agreement. Upon the beginning of a new Agreement, the MCP will begin a new contract term with a score of zero unless the MCP has accrued a total of 55 points or more during the prior provider agreement period. Those MCPs who have accrued a total of 55 points or more during the contract term of a prior provider agreement will carry these points over for the first three (3) months of their next provider agreement. If the MCP does not accrue any additional points during this three (3) month period the MCP will then have their point total reduced to zero and continue on in the new contract term. If the MCP does accrue additional points during this three-month period, the MCP will continue to carry the points accrued from the prior provider agreement plus any additional points accrued during the new provider agreement contract term.

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 provider agreement period will be subject to remedial action under CAS at the time that ODJFS first becomes aware of this noncompliance.

In cases where an MCP subcontracting provider is found to have violated a program requirement (e.g., failing to provide adequate contract termination notice, marketing to potential members, unapprovable billing of members, etc.), ODJFS will not assess occurrences or 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, occurrences or points may be assessed, as determined by ODJFS.

All required submissions are to be received by their specified deadline. Unless otherwise specified, late submissions will initially be addressed through CAPs, with repeated instances of untimely submissions resulting in escalating penalties, as may be determined by ODJFS.

If an MCP determines that they will be unable to meet a program deadline, the MCP must verbally inform the designated ODJFS contact person (or their supervisor) of such and submit a written request (by facsimile transmission) for an extension of the deadline as soon as possible, but no later than 3 PM Eastern Time (ET) on the date of the deadline in question. Extension requests should only be submitted in situations where unforeseeable circumstances have arisen which make it impossible for the MCP to meet an ODJFS-stipulated deadline and all such requests will be evaluated upon that basis and with that in mind. Only written approval as may be granted by ODJFS of a deadline extension will preclude the assessment of a CAP, occurrence or points for untimely submissions.

No points or occurrences 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.).

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 issued under the CAS are nonrefundable.

1-9 Points	Corrective Action Plan (CAP)
10-19 Points	CAP + $5,000 fine
20-29 Points	CAP + $10,000 fine
30-39 Points	CAP + $20,000 fine
40-69 Points	CAP + $30,000 fine
70+ Points	Proposed Contract Termination

New Member Selection Freezes:

Notwithstanding any other penalty, occurrence or point assessment that ODJFS may impose on an MCP under this Appendix, ODJFS may prohibit an MCP from receiving new membership through consumer initiated selection or the assignment process (selection freeze) in one or more counties if : (1) the MCP has accumulated a total of 20 or more points during a contract term; (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 is denied by CMS in accordance with the requirements in 42 CFR 438.730.

Reduction of Assignments

ODJFS may reduce the number of assignments an MCP receives if ODJFS, in its sole discretion, determines that the MCP lacks sufficient administrative capacity to meet the needs of the increased volume in membership. Examples of circumstances which ODJFS may determine demonstrate a lack of sufficient administrative capacity include, but are not limited to, an MCP's failure to: 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.

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 10-point penalty and a monetary sanction of $20,000 per day for the period of noncompliance. ODJFS may assess additional penalty points based on the length of noncompliance, as it may determine in its sole discretion.

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.

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 the contract term will result in the assessment of 5 points, quarterly prompt pay reporting, and submission of monthly status reports to ODJFS until the next quarterly report is due. The second and any subsequent violation during the contract term will result in the submission of monthly status reports, assessment of 10 points 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.

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 a selection freeze of not less than three (3) months duration.

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.
- A 10 point penalty assessment for the period of noncompliance.

- 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.

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.

Noncompliance with Encounter Data Submissions:

Submission of unpaid encounters (except for immunization services as specified in Appendix L) will result in the assessment of a nonrefundable $1,000 fine for each violation.

Noncompliance with Abortion and Sterilization Payment

Noncompliance with abortion and sterilization requirements as specified by ODJFS will result in the assessment of a nonrefundable $1,000 fine for each documented violation. Additionally, MCPs must take all appropriate action to correct each such ODJFS-documented violation.

Negligent Breach of Protected Health Information (PHI) Standards

Non-compliance with the HIPAA Privacy Regulations and negligent breach of protected health information (PHI) standards will be assessed in accordance with Appendix C. Therefore, the progressive remedies specified under Appendix N, Compliance Assessment System will not be utilized for assessing non-compliance with the HIPAA Privacy Regulations and negligent breach of PHI.

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.

General Provisions:

All notifications of the imposition by ODJFS of a fine or freeze will be made via certified or overnight mail to the identified MCP Medicaid Coordinator.

Pursuant to procedures as may be 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.

Refundable monetary sanctions/assurances applied by ODJFS will be based on the premium payment for the month in which the MCP was cited for the deficiency. Any monies collected through the imposition of such a 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. 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.

Notwithstanding any other action ODJFS may take under this Appendix, ODJFS may impose a combined remedy which will address multiple 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.

In addition, 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.

In addition to the remedies imposed under the CAS, remedies related to areas of data quality and financial performance may also be imposed pursuant to Appendices J, L, and M respectively, of the Agreement.

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, the ODJFS may, pursuant to the provisions of OAC rule 5101:3-26-10(A): (1) notify the MCP's members that they may terminate from the MCP without cause; and/or (2) suspend any further new member selections.

REQUESTS FOR RECONSIDERATIONS

Requests for reconsiderations of remedial action taken under the CAS shall be submitted to ODJFS as follows:

- MCPs notified of ODJFS' imposition of remedial action taken under the CAS (i.e., occurrences, points, fines, assignment reductions and selection freezes), will have five (5) working days from the date of receipt to request reconsideration, although ODJFS will impose selection freezes based on an access to care concern concurrent with initiating notification to the MCP. (All notifications of the imposition of a fine or a freeze will be made via certified or overnight mail to the identified MCP Contact.) 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 timeframe in writing.
- 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 fifth business day after receipt of notification of the imposition of the remedial action by ODJFS.

  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.
- Final decisions or requests for additional information will be made by ODJFS within five (5) business days of receipt of the request for reconsideration.

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.

- 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.

POINT COMPLIANCE SYSTEM – POINT VALUES

OCCURRENCES: Failures to meet program requirements, including but not limited to, noncompliance with administrative requirements, as determined by ODJFS. Examples include, but are not limited to, the following:

- Unapproved use of marketing/member materials.
- Failure to attend ODJFS-required meetings or training sessions.
- Failure to maintain ODJFS-required documentation.
- Use of unapproved subcontracting providers where prior approval is required by ODJFS.
- Use of unapprovable subcontractors (e.g., not in good standing with Medicaid and/or Medicare programs, provider listed in directory but no current contract, etc.) where prior-approval is not required by ODJFS.
- Failure to provide timely notification to members, as required by ODJFS (e.g., notice of PCP or hospital termination from provider panel).
- Participation in a prohibited or unapproved marketing activity.
- Second failure to meet the monthly call-center requirements for either the member services or 24-hour call-in system lines.
- Failure to submit and/or comply with a Corrective Action Plan (CAP) requested by ODJFS as the result of an occurrence, or when no occurrence was designated for the precipitating violation of OAC rules or provider agreement
- Failure to comply with the physician incentive plan requirements, except for noncompliance where member rights are violated (i.e., failure to complete required patient satisfaction surveys or to provide members with requested physician incentive information) or where false, misleading or inaccurate information is provided to ODJFS.

5 POINTS: Failures to meet program requirements, including but not limited to, actions which could impair the member's ability to access information regarding services in a timely manner or which could impair a consumer's or member's rights, as determined by ODJFS. Examples include, but are not limited to, the following:

- Violations which result in selection or termination counter to the recipient's preference (e.g., a recipient makes a selection decision based on inaccurate provider panel information from the MCP).
- Any violation of a member's rights.
- Failure to provide member materials to new members in a timely manner.
- Failure to comply with appeal, grievance**,** or state hearing requirements, including timely submission to ODJFS.
- Failure to staff 24-hour call-in system with appropriate trained medical personnel.
- Third failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Failure to submit and/or comply with a CAP as a result of a 5-point violation.
- Failure to meet the prompt payment requirements (first violation).
- Provision of false, inaccurate or materially misleading information to health care providers, the MCP's members, or any eligible individuals.
- Failure to submit a required monthly CAMS file (as specified in Appendix L of the Agreement) by the end of the month the submission was required.
- Failure to submit a required monthly Members' Designated PCP file (as specified in Appendix L of the Agreement) by the end of the month the submission was required.

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:

- Failure to meet any of the provider panel requirements as specified in Appendix H of the Agreement.
- 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 process prior authorization requests within prescribed time frame.
- Failure to remit any ODJFS-required payments within the specified time frame.
- Failure to meet the electronic claims adjudication requirements.
- Failure to submit and/or comply with a CAP as a result of a 10-point violation.
- Failure to meet the prompt payment requirements (second and subsequent violations).
- Fourth and any subsequent failure to meet the monthly call-center requirements for either the member services or the 24-hour call-in system lines.
- Failure to provide ODJFS with a required submission after ODJFS has notified the MCP that the prescribed deadline for that submission has passed.
- Failure to submit a required monthly appeal or grievance file (as specified in Appendix L of the Agreement) by the end of the month the submission was required.
- Misrepresentation or falsification of information that the MCP furnishes to the ODJFS or to the Centers for Medicare and Medicaid Services.

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. SFY2009 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.

- 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

3. Satisfaction with MCP Customer Service (Appendix M, Section 3.)

Report Period: The most recent consumer satisfaction survey completed prior to the end of the SFY 2009 contract period.

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
1.	CHF: ACE Inhibitor/Angiotensin Receptor Blocker	TBD
2.	CAD: Beta-Blocker Treatment after Heart Attack (AMI -related admission)	TBD
3.	CAD: Cholesterol Management for Patients with Cardiovascular Conditions/LDL-C screening performed	TBD
4.	Hypertension: Inpatient Hospital Discharge Rate	TBD
5.	Diabetes: Comprehensive Diabetes Care (CDC)/Eye exam	TBD
6.	COPD: Inpatient Hospital Discharge Rate	TBD
7.	Asthma: Use of Appropriate Medications for People with Asthma	TBD
8.	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 2008

   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

MCP's 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 as determined by ODJFS. For MCPs receiving additional P4P, the amount in the P4P fund (see section 2.) will be divided equally, up to the maximum amount, among all MCPs'ABD and/or CFC programs receiving additional P4P. The maximum amount to be awarded to a single plan in P4P additional to the at-risk amount is $250,000 per contract year. 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 as compliance with many performance standards requires two (2) calendar years to determine. 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 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.

APPENDIX P

MCP TERMINATIONS/NONRENEWALS/AMENDMENTS
ABD ELIGIBLE POPULATION

Upon termination either by the MCP or ODJFS, nonrenewal or denial of an MCP's provider agreement, all previously collected refundable monetary sanctions will be retained by ODJFS.

MCP-INITIATED TERMINATIONS/NONRENEWALS

If an MCP provides notice of the termination/nonrenewal of their provider agreement to ODJFS, pursuant to Article VIII of the agreement, the MCP will be required to submit a refundable monetary assurance. This monetary assurance will be held by ODJFS until such time that the MCP has submitted all outstanding monies owed and reports, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP=s provider agreement. The monetary assurance must be in an amount of either $50,000 or 5 % of the capitation amount paid by ODJFS in the month the termination/nonrenewal notice is issued, whichever is greater.

The MCP must also return to ODJFS the at-risk amount paid to the MCP under the current provider agreement. The amount to be returned will be based on actual MCP membership for preceding months and estimated MCP membership through the end date of the contract. MCP membership for each month between the month the termination/nonrenewal is issued and the end date of the provider agreement will be estimated as the MCP membership for the month the termination/nonrenewal is issued. Any over payment will be determined by comparing actual to estimated MCP membership and will be returned to the MCP following the end date of the provider agreement.

The MCP must remit the monetary assurance and the at-risk amount in the specified amounts via separate electronic fund transfers (EFT) payable to *Treasurer of State*, *State of Ohio (ODJFS)*. The MCP should contact their Contract Administrator to verify the correct amounts required for the monetary assurance and the at-risk amount and obtain an invoice number prior to submitting the monetary assurance and the at-risk amount. Information from the invoices must be included with each EFT to ensure monies are deposited in the appropriate ODJFS Fund account. In addition, the MCP must send copies of the EFT bank confirmations and copies of the invoices to their Contract Administrator.

If the monetary assurance and the at-risk amount are not received as specified above, ODJFS will withhold the MCP's next month's capitation payment until such time that ODJFS receives documentation that the monetary assurance and the at-risk amount are received by the Treasurer of State. If within one year of the date of issuance of the invoice, an MCP does not submit all outstanding monies owed and required submissions, including, but not limited to, grievance, appeal, encounter and cost report data related to time periods through the final date of service under the MCP's provider agreement, the monetary assurance will not be refunded to the MCP.

ODJFS-INITIATED TERMINATIONS

If ODJFS initiates the proposed termination, nonrenewal or amendment of an MCP=s provider agreement pursuant to OAC rule 5101:3-26-10 and the MCP appeals that proposed action, the MCP's provider agreement will be extended through the duration of the appeals process.

During this time, the MCP will continue to accrue points and be assessed penalties for each subsequent compliance assessment occurrence/violation under Appendix N of the provider agreement. If the MCP exceeds 69 points, each subsequent point accrual will result in a $15,000 nonrefundable fine.

Pursuant to OAC rule 5101:3-26-10(H), if ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement, ODJFS may notify the MCP's members of this proposed action and inform the members of their right to immediately terminate their membership with that MCP without cause. If ODJFS has proposed the termination, nonrenewal, denial or amendment of a provider agreement and access to medically-necessary covered services is jeopardized, ODJFS may propose to terminate the membership of all of the MCP's members. The appeal process for reconsideration of either of these proposed actions is as follows:

- All notifications of such a proposed MCP membership termination will be made by ODJFS via certified or overnight mail to the identified MCP Contact.
- MCPs notified by ODJFS of such a proposed MCP membership termination will have three working days from the date of receipt to request reconsideration.
- All reconsideration requests must be submitted by either facsimile transmission or overnight mail to the Deputy Director, Office of Ohio Health Plans, and received by 3PM Eastern Time (ET) on the third working day following receipt of the ODJFS notification of termination. The address and fax number to be used in making these requests will be specified in the ODJFS notification of termination document.
- The MCP will be responsible for verifying timely receipt of all reconsideration requests. All requests must explain in detail why the proposed MCP membership termination is not justified. The MCP's justification for reconsideration will be limited to a review of the written material submitted by the MCP.
- A final decision or request for additional information will be made by the Deputy Director within three working days of receipt of the request for reconsideration. Should the Deputy Director require additional time in rendering the final reconsideration decision, the MCP will be notified of such in writing.
- The proposed MCP membership termination will not occur while an appeal is under review and pending the Deputy Director's decision. If the Deputy Director denies the appeal, the MCP membership termination will proceed at the first possible effective date. The date may be retroactive if the ODJFS determines that it would be in the best interest of the members.

Contractual Document (CD)

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment A – HHSC Uniform Managed Care Contract Terms & Conditions Version 1.6

Texas Health & Human Services Commission

Uniform Managed Care Contract Terms & Conditions

Version 1.6

TABLE OF CONTENTS

Article 1. Introduction

Section 1.01 ***Purpose.***

The purpose of this Contract is to set forth the terms and conditions for the HMO's participation as a managed care organization in one or more of the HMO Programs administered by HHSC. Under the terms of this Contract, HMO will provide comprehensive health care services to qualified Program recipients through a managed care delivery system.

Section 1.02 ***Risk-based contract.***

This is a Risk-based contract.

Section 1.03 ***Inducements.***

In making the award of this Contract, HHSC relied on HMO's assurances of the following:

(1) HMO is an established health maintenance organization that arranges for the delivery of health care services, is currently licensed as such in the State of Texas and is fully authorized to conduct business in the Service Areas;

(2) HMO and the HMO Administrative Service Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in the RFP, HMO's Proposal, and this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;

(3) HMO has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC's current program and operating environment for the activities that are the subject of the Contract and the needs and requirements of the State during the Contract term;

(4) HMO has had the opportunity to review and understand the State's stated objectives in entering into this Contract and, based on such review and understanding, HMO currently has the capability to perform in accordance with the terms and conditions of this Contract;

(5) HMO also has reviewed and understands the risks associated with the HMO Programs as described in the RFP, including the risk of non-appropriation of funds.

Accordingly, on the basis of the terms and conditions of this Contract, HHSC desires to engage HMO to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth in this Contract.

Section 1.04 ***Construction of the Contract.***

(a) Scope of Introductory Article.

The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Contract or to alter the plain meaning of the terms and conditions of the Contract.

(b) References to the "State."

References in the Contract to the "State" shall mean the State of Texas unless otherwise specifically indicated and shall be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the HMO Programs, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

(c) Severability.

If any provision of this Contract is construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.

(d) Survival of terms.

Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

(1) The Parties have expressly agreed shall survive any such termination or expiration; or

(2) Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration.

(e) Headings.

The article, section and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.

(f) Global drafting conventions.

(1) The terms "include," "includes," and "including" are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation."

(2) Any references to "sections," "appendices," "exhibits" or "attachments" are deemed to be references to sections, appendices, exhibits or attachments to this Contract.

(3) Any references to laws, rules, regulations, and manuals in this Contract are deemed references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

Section 1.05 ***No implied authority.***

The authority delegated to HMO by HHSC is limited to the terms of this Contract. HHSC is the state agency designated by the Texas Legislature to administer the HMO Programs, and no other agency of the State grants HMO any authority related to this program unless directed through HHSC. HMO may not rely upon implied authority, and specifically is not delegated authority under this Contract to:

(1) make public policy;

(2) promulgate, amend or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of HHSC Programs; or

(3) unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

HMO is required to cooperate to the fullest extent possible to assist HHSC in communications and negotiations with state and federal governments and agencies concerning matters relating to the scope of the Contract and the HMO Program(s), as directed by HHSC.

Section 1.06 ***Legal Authority.***

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; and/or Chapter 62, Texas Health & Safety Code. HMO is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.

(b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute this Contract and to validly and legally bind the Parties to all of its terms, performances, and provisions.

Article 2. Definitions

As used in this Contract, the following terms and conditions shall have the meanings assigned below:

[Definition added by Version 1.1]

1915(c) Nursing Facility Waiver means the HHSC waiver program that provides home and community based services to aged and disabled adults as cost-effective alternatives to institutional care in nursing homes.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid or CHIP Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medicaid or CHIP Program.

Account Name means the name of the individual who lives with the child(ren) and who applies for the Children's Health Insurance Program coverage on behalf of the child(ren).

Action (Medicaid only) means:

(1) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial in whole or in part of payment for service;

(4) the failure to provide services in a timely manner;

(5) the failure of an HMO to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b); or

(6) for a resident of a rural area with only one HMO, the denial of a Medicaid Members' request to obtain services outside of the Network.

An Adverse Determination is one type of Action.

Acute Care means preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital means a hospital that provides acute care services.

Adjudicate means to deny or pay a clean claim.

Administrative Services see HMO Administrative Services.

Administrative Services Contractor see HHSC Administrative Services Contractor.

Adverse Determination means a determination by an HMO or Utilization Review agent that the Health Care Services furnished, or proposed to be furnished to a patient, are not Medically Necessary or not appropriate.

Affiliate means any individual or entity owning or holding more than a five percent (5%) interest in the HMO or in which the HMO owns or holds more than a five percent (5%) interest; any parent entity; or subsidiary entity of the HMO, regardless of the organizational structure of the entity.

Agreement or Contract means this formal, written, and legally enforceable contract and amendments thereto between the Parties.

Allowable Expenses means all expenses related to the Contract between HHSC and the HMO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with the HHSC Uniform Managed Care Manual's "Cost Principles for Administrative Expenses."

AAP means the American Academy of Pediatrics.

Approved Non-Profit Health Corporation (ANHC) means an organization formed in compliance with Chapter 844 of the Texas Insurance Code and licensed by TDI. See also **HMO**.

Appeal (Medicaid only) means the formal process by which a Member or his or her representative request a review of the HMO's Action, as defined above.

[Definition amended by Version 1.3]

Appeal (CHIP and CHIP Perinatal Program only) means the formal process by which a Utilization Review agent addresses Adverse Determinations.

Auxiliary Aids and Services includes:

(1) qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;

(2) taped texts, large print, Braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and

(3) other effective methods to ensure that materials (delivered both aurally and visually) are available to those with cognitive or other Disabilities affecting communication.

Behavioral Health Services means Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Benchmark means a target or standard based on historical data or an objective/goal.

Business Continuity Plan or BCP means a plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Business Day means any day other than a Saturday, Sunday, or a state or federal holiday on which HHSC's offices are closed, unless the context clearly indicates otherwise.

CAHPS means the Consumer Assessment of Health Plans Survey. This survey is conducted annually by the EQRO.

Call Coverage means arrangements made by a facility or an attending physician with an appropriate level of health care provider who agrees to be available on an as-needed basis to provide medically appropriate services for routine, high risk, or Emergency Medical Conditions or Emergency Behavioral Health Conditions that present without being scheduled at the facility or when the attending physician is unavailable.

Capitation Rate means a fixed predetermined fee paid by HHSC to the HMO each month in accordance with the Contract, for each enrolled Member in a defined Rate Cell, in exchange for the HMO arranging for or providing a defined set of Covered Services to such a Member, regardless of the amount of Covered Services used by the enrolled Member.

Capitation Payment means the aggregate amount paid by HHSC to the HMO on a monthly basis for the provision of Covered Services to enrolled Members in accordance with the Capitation Rates in the Contract.

Case Head means the head of the household that is applying for Medicaid.

C.F.R. means the Code of Federal Regulations.

Chemical Dependency Treatment means treatment provided for a chemical dependency condition by a Chemical Dependency Treatment facility, chemical dependency counselor or hospital.

Children's Health Insurance Program or **CHIP** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.

Child (or Children) with Special Health Care Needs (CSHCN) means a child (or children) who:

(1) ranges in age from birth up to age nineteen (19) years;

(2) has a serious ongoing illness, a complex chronic condition, or a disability that\ has lasted or is anticipated to last at least twelve (12) continuous months or more;

(3) has an illness, condition or disability that results (or without treatment would be expected to result) in limitation of function, activities, or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development;

(4) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel; and

(5) has a need for health and/or health-related services at a level significantly above the usual for the child's age.

CHIP HMO Program, or CHIP Program, means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Members.

CHIP HMOs means HMOs participating in the CHIP HMO Program.

[Definition added by Version 1.3]

CHIP Perinatal HMOs means HMOs participating in the CHIP Perinatal Program.

[Definition added by Version 1.3]

CHIP Perinatal Program means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP

Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract. An HMO must specifically contract with HHSC as a CHIP Perinatal HMO in order to participate in this part of the CHIP Program.

[Definition added by Version 1.3]

CHIP Perinate means a CHIP Perinatal Program Member identified prior to birth.

[Definition added by Version 1.3]

CHIP Perinate Newborn means a CHIP Perinate who has been born alive.

Chronic or Complex Condition means a physical, behavioral, or developmental condition which may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated.

Clean Claim means a claim submitted by a physician or provider for medical care or health care services rendered to an enrollee, with documentation reasonably necessary for the HMO to process the claim. The HMO may not require a physician or provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

CMS means the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HCFA), which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid and CHIP.

COLA means the Cost of Living Adjustment.

[Definition added by Version 1.1]

Community-based Long Term Care Services means services provided to STAR+PLUS Members in their home or other community based settings necessary to provide assistance with activities of daily living to allow the Member to remain in the most integrated setting possible. Community-based Long-term Care includes services available to all STAR+PLUS Members as well as those services available only to STAR+PLUS Members who qualify under the 1915(c) Nursing Facility Waiver services.

Community Resource Coordination Groups (CRCGs) means a statewide system of local interagency groups, including both public and private providers, which coordinate services for "multi-need" children and youth. CRCGs develop individual service plans for children and adolescents whose needs can be met only through interagency cooperation. CRCGs address Complex Needs in a model that promotes local decision-making and ensures that children receive the integrated combination of social, medical and other services needed to address their individual problems.

[Definition modified by Version 1.3]

Complainant means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint.

Complaint (CHIP and CHIP Perinatal Programs only) means any dissatisfaction, expressed by a Complainant, orally or in writing to the HMO, with any aspect of the HMO's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

Complaint (Medicaid only) means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the HMO, about any matter related to the HMO other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

Complex Need means a condition or situation resulting in a need for coordination or access to services beyond what a PCP would normally provide, triggering the HMO's determination that Care Coordination is required.

Comprehensive Care Program: See definition for Texas Health Steps.

Confidential Information means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) consisting of:

(1) Confidential Client information, including HIPAA-defined protected health information;

(2) All non-public budget, expense, payment and other financial information;

(3) All Privileged Work Product;

(4) All information designated by HHSC or any other State agency as confidential, and all information designated as confidential under the Texas Public Information Act, Texas Government Code, Chapter 552;

(5) The pricing, payments, and terms and conditions of the Contract, unless disclosed publicly by HHSC or the State; and

(6) Information utilized, developed, received, or maintained by HHSC, the HMO, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

Consumer-Directed Services means the Member of his legal guardian is the employer of and retains control over the hiring, management, and termination of an individual providing personal assistance or respite.

Continuity of Care means care provided to a Member by the same PCP or specialty provider to ensure that the delivery of care to the Member remains stable, and services are consistent and unduplicated.

Contract or **Agreement** means this formal, written, and legally enforceable contract and amendments thereto between the Parties.

Contract Period or **Contract Term** means the Initial Contract Period plus any and all Contract extensions.

Contractor or **HMO** means the HMO that is a party to this Contract and is an insurer licensed by TDI as an HMO or as an ANHC formed in compliance with Chapter 844 of the Texas Insurance Code.

Core Service Area (CSA) means the core set Service Area counties defined by HHSC for the STAR and/or CHIP HMO Programs in which Eligibles will be required to enroll in an HMO. (See Attachment B-6 to the HHSC Managed Care Contract document for detailed information on the Service Area counties.)

Copayment (CHIP only) means the amount that a Member is required to pay when utilizing certain benefits within the health care plan. Once the copayment is made, further payment is not required by the Member.

Corrective Action Plan means the detailed written plan that may be required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against HMO.

[Definition modified by Version 1.1]

Court-Ordered Commitment means a commitment of a STAR, STAR+PLUS or CHIP Member to a psychiatric facility for treatment ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII Subtitle C.

[Definition modified by Version 1.3]

Covered Services means Health Care Services the HMO must arrange to provide to Members, including all services required by the Contract and state and federal law, and all Value-added Services negotiated by the Parties (see **Attachments B-2, B-2.1, B-2.2 and B-3** of the **HHSC Managed Care Contract** relating to "Covered Services" and "Value-added Services"). Covered Services include Behavioral Health Services.

Credentialing means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility and to deliver Covered Services.

Cultural Competency means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

Date of Disenrollment means the last day of the last month for which HMO receives payment for a Member.

Day means a calendar day unless specified otherwise.

[Definition modified by Version 1.1 and 1.3]

Default Enrollment means the process established by HHSC to assign a mandatory STAR, STAR+PLUS, or CHIP Perinate enrollee who has not selected an MCO to an MCO.

Deliverable means a written or recorded work product or data prepared, developed, or procured by HMO as part of the Services under the Contract for the use or benefit of HHSC or the State of Texas.

[Definition modified by Version 1.3]

Delivery Supplemental Payment means a onetime per pregnancy supplemental payment for STAR, CHIP and CHIP Perinatal HMOs.

DADS means the Texas Department of Aging and Disability Services or its successor agency (formerly Department of Human Services).

DSHS means the Texas Department of State Health Services or its successor agency (formerly Texas Department of Health and Texas Department of Mental Health and Mental Retardation).

Disease Management means a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

Disproportionate Share Hospital (DSH) means a hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

Disabled Person or Person with Disability means a person under sixty-five (65) years of age, including a child, who qualifies for Medicaid services because of a disability.

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Disability-related Access means that facilities are readily accessible to and usable by individuals with disabilities, and that auxiliary aids and services are provided to ensure effective communication, in compliance with Title III of the Americans with Disabilities Act.

Disaster Recovery Plan means the document developed by the HMO that outlines details for the restoration of the MIS in the event of an emergency or disaster.

DSM-IV means the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition*, which is the American Psychiatric Association's official classification of behavioral health disorders.

[Definition added by Version 1.1]

Dual Eligibles means Medicaid recipients who are also eligible for Medicare.

ECI means Early Childhood Intervention, a federally mandated program for infants and children under the age of three with or at risk for developmental delays and/or disabilities. The federal ECI regulations are found at 34 §C.F.R. 303.1 *et seq*. The State ECI rules are found at 25 TAC §621.21 *et seq*.

EDI means electronic data interchange.

Effective Date means the effective date of this Contract, as specified in the HHSC Managed Care Contract document.

Effective Date of Coverage means the first day of the month for which the HMO has received payment for a Member.

[Definition modified by Versions 1.1 and 1.3]

Eligibles means individuals residing in one of the Service Areas and eligible to enroll in a STAR, STAR+PLUS, CHIP, or CHIP Perinatal HMO, as applicable.

Emergency Behavioral Health Condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or

(2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Encounter means a Covered Service or group of Covered Services delivered by a Provider to a Member during a visit between the Member and Provider. This also includes Value-added Services.

Encounter Data means data elements from Fee-for-Service claims or capitated services proxy claims that are submitted to HHSC by the HMO in accordance with HHSC's required format for Medicaid and CHIP HMOs.

Enrollment Report/Enrollment File means the daily or monthly list of Eligibles that are enrolled with an HMO as Members on the day or for the month the report is issued.

EPSDT means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. 1396d(r). The name has been changed to Texas Health Steps (THSteps) in the State of Texas.

Exclusive Provider Organization (EPO) means the vendor contracted with HHSC to operate the CHIP EPO in Texas.

Expansion Area means a county or Service Area that has not previously provided healthcare to HHSC's HMO Program Members utilizing a managed care model.

Expansion Children means children who are generally at least one, but under age 6, and live in a family whose income is at or below 133 percent of the federal poverty level (FPL). Children in this coverage group have either elected to bypass TANF or are not eligible for TANF in Texas.

[Definition modified by Versions 1.2 and 1.3]

Experience Rebate means the portion of the HMO's net income before taxes that is returned to the State in accordance with Section 10.11 for the STAR, CHIP and CHIP Perinatal Programs and 10.11.1 for the STAR+PLUS Program ("Experience Rebate").

Expedited Appeal means an appeal to the HMO in which the decision is required quickly based on the Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

Expiration Date means the expiration date of this Contract, as specified in HHSC's Managed Care Contract document.

External Quality Review Organization (EQRO) means the entity that contracts with HHSC to provide external review of access to and quality of healthcare provided to Members of HHSC's HMO Programs.

Fair Hearing means the process adopted and implemented by HHSC in 25 T.A.C. Chapter 1, in compliance with federal regulations and state rules relating to Medicaid Fair Hearings.

Fee-for-Service means the traditional Medicaid Health Care Services payment system under which providers receive a payment for each unit of service according to rules adopted pursuant to Chapter 32, Texas Human Resources Code.

Force Majeure Event means any failure or delay in performance of a duty by a Party under this Contract that is caused by fire, flood, hurricane, tornadoes, earthquake, an act of God, an act of war, riot, civil disorder, or any similar event beyond the reasonable control of such Party and without the fault or negligence of such Party.

FQHC means a Federally Qualified Health Center, certified by CMS to meet the requirements of §1861(aa)(3) of the Social Security Act as a federally qualified health center, that is enrolled as a provider in the Texas Medicaid program.

FPL means the Federal Poverty Level.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

FSR means Financial Statistical Report.

[Definition added by Version 1.1]

Functionally Necessary Covered Services means Community-based Long Term Care services provided to assist STAR+PLUS Members with activities of daily living based on a functional assessment of the Member's activities of daily living and a determination of the amount of supplemental supports necessary for the STAR+PLUS Member to remain independent or in the most integrated setting possible.

Habilitative and Rehabilitative Services means Health Care Services described in **Attachment B-2** that may be required by children who fail to reach (habilitative) or have lost (rehabilitative) age appropriate developmental milestones.

Health Care Services means the Acute Care, Behavioral Health Care and health-related services that an enrolled population might reasonably require in order to be maintained in good health.

Health and Human Services Commission or **HHSC** means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code, or its designee, including, but not limited to, the HHS Agencies.

Health-related Materials are materials developed by the HMO or obtained from a third party relating to the prevention, diagnosis or treatment of a medical condition.

HEDIS, the Health Plan Employer Data and Information Set, is a registered trademark of NCQA. HEDIS is a set of standardized performance measures designed to reliably compare the performance of managed health care plans. HEDIS is sponsored, supported and maintained by NCQA.

HHS Agency means the Texas health and human service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

[Definition modified by Versions 1.1 and 1.3]

HHSC Administrative Services Contractor (ASC) means an entity performing HMO administrative services functions, including member enrollment functions, for STAR, STAR+PLUS, CHIP, or CHIP Perinatal HMO Programs under contract with HHSC.

[Definition modified by Versions 1.1 and 1.3]

HHSC HMO Programs or HMO Programs mean the STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMO Programs.

HHSC Uniform Managed Care Manual means the manual published by or on behalf of HHSC that contains policies and procedures required of all HMOs participating in the HHSC Programs.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

HMO or **Contractor** means the HMO that is a party to this Contract, and is either:

(1) an insurer licensed by TDI as a Health Maintenance Organization in accordance with Chapter 843 of the Texas Insurance Code, or

(2) a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code.

HMO Administrative Services means the performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of the delivery of and payment for Covered Services, including but not limited to Network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation and reporting.

HMO's Service Area means all the counties included in any HHSC-defined Core or Optional Service Area, as applicable to each HMO Program and within which the HMO has been selected to provide HMO services.

Home and Community Support Services Agency or HCSS means an entity licensed to provide home health, hospice, or personal assistance services provided to individuals in their own home or independent living environment as prescribed by a physician or individualized service plan. Each HCSS must provide clients with a plan of care that includes specific services the agency agrees to perform. The agencies are licensed and monitored by DADS or its successor.

Hospital means a licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

ICF-MR means an intermediate care facility for the mentally retarded.

Individual Family Service Plan (IFSP) means the plan for services required by the Early Childhood Intervention (ECI) Program and developed by an interdisciplinary team.

Initial Contract Period means the Effective Date of the Contract through August 31, 2008.

Inpatient Stay means at least a 24-hour stay in a facility licensed to provide hospital care.

JCAHO means Joint Commission on Accreditation of Health Care Organizations.

Joint Interface Plan (JIP) means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file I.D. The JIP must include each of the HMO's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the HMO's interface partners to ensure the development and maintenance of the interface; and the timely transfer of required data elements between contractors and partners.

Key HMO Personnel means the critical management and technical positions identified by the HMO in accordance with **Article 4**.

Linguistic Access means translation and interpreter services, for written and spoken language to ensure effective communication. Linguistic access includes sign language interpretation, and the provision of other auxiliary aids and services to persons with disabilities.

Local Health Department means a local health department established pursuant to Health and Safety Code, Title 2, Local Public Health Reorganization Act §121.031.

Local Mental Health Authority (LMHA) means an entity within a specified region responsible for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental health care services to persons with mental illness in one or more local service areas.

[Definition modified by Version 1.3]

Major Population Group means any population, which represents at least 10% of the Medicaid, CHIP, and/or CHIP Perinatal Program population in any of the counties in the Service Area served by the HMO.

Material Subcontractor or **Major Subcontractor** means any entity that contracts with the HMO for all or part of the HMO Administrative Services, where the value of the subcontracted HMO Administrative Service(s) exceeds $100,000, or is reasonably expected to exceed $100,000, per State Fiscal Year. Providers in the HMO's Provider Network are not Material Subcontractors.

Mandated or Required Services means services that a state is required to offer to categorically needy clients under a state Medicaid plan.

Marketing means any communication from the HMO to a Medicaid or CHIP Eligible who is not enrolled with the HMO that can reasonably be interpreted as intended to influence the Eligible to:

(1) enroll with the HMO; or

(2) not enroll in, or to disenroll from, another MCO.

Marketing Materials means materials that are produced in any medium by or on behalf of the HMO and can reasonably be interpreted as intending to market to potential Members. Health-related Materials are not Marketing Materials.

MCO means managed care organization.

Medicaid means the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. §1396 *et seq*.) and administered by HHSC.

[Definition modified by Version 1.1]

Medicaid HMOs means contracted HMOs participating in STAR and/or STAR+PLUS.

[Definition added by Version 1.1]

Medical Assistance Only (MAO) means a person that does not receive SSI benefits but qualifies financially and functionally for limited Medicaid assistance.

Medical Home means a PCP or specialty care Provider who has accepted the responsibility for providing accessible, continuous, comprehensive and coordinated care to Members participating in a HHSC HMO Program.

Medically Necessary means:

(1) Non-behavioral health related Health Care Services that are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;

(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;

(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(d) consistent with the diagnoses of the conditions;

(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or Provider; and

(2) Behavioral Health Services that are:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(d) are the most appropriate level or supply of service that can safely be provided;

(e) could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or Provider.

[Definition modified by Versions 1.1 and 1.3]

Member means a person who:

(1) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the STAR or STAR+PLUS Program, and is enrolled in the STAR or STAR+PLUS Program and the HMO's STAR or STAR+PLUS HMO;

(2) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included as a voluntary participant in the STAR or STAR+PLUS Program, and is enrolled in the STAR or STAR+PLUS Program and the HMO's STAR or STAR+PLUS HMO;

(3) has met CHIP eligibility criteria and is enrolled in the HMO's CHIP HMO; or

(4) has met CHIP Perinatal Program eligibility criteria and is enrolled in the HMO's CHIP Perinatal Program.

Member Materials means all written materials produced or authorized by the HMO and distributed to Members or potential members containing information concerning the HMO Program(s). Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

Member Month means one Member enrolled with the HMO during any given month. The total Member Months for each month of a year comprise the annual Member Months.

Member(s) with Special Health Care Needs (MSHCN) includes a Child or Children with a Special Health Care Need (CSHCN) and any adult Member who:

(1) has a serious ongoing illness, a Chronic or Complex Condition, or a Disability that has lasted or is anticipated to last for a significant period of time, and

(2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

[Definition added by Version 1.1]

Minimum Data Set for Home Care (MDS-HC) means the assessment instrument included in the **Uniform Managed Care Manual** that is used to collect data such as health, social support and service use information on persons receiving long term care services outside of an institutional setting.

MIS means Management Information System.

National Committee for Quality Assurance (NCQA) means the independent organization that accredits HMOs, managed behavioral health organizations, and accredits and certifies disease management programs. HEDIS and the Quality Compass are registered trademarks of NCQA.

Net Income before Taxes means an aggregate excess of Revenues over Allowable Expenses.

Network or Provider Network means all Providers that have a contract with the HMO, or any Subcontractor, for the delivery of Covered Services to the HMO's Members under the Contract.

Network Provider or Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Non-capitated Services means those Medicaid services identified in Attachment B-1, Section 8.2.2.8.

Non-provider Subcontracts means contracts between the HMO and a third party that performs a function, excluding delivery of health care services, that the HMO is required to perform under its Contract with HHSC.

[Definition added by Version 1.1]

Nursing Facility Cost Ceiling means the annualized cost of serving a client in a nursing facility. A per diem cost is established for each Medicaid nursing facility resident based on the level of care needed. This level of care is referred to as the Texas Index for Level of Effort or the TILE level. The per diem cost is annualized to achieve the nursing facility ceiling.

[Definition added by Version 1.1]

Nursing Facility Level of Care means the determination that the level of care required to adequately serve a STAR+PLUS Member is at or above the level of care provided by a nursing facility.

OB/GYN means obstetrician-gynecologist.

Open Panel means Providers who are accepting new patients for the HMO Program(s) served.

Operational Start Date means the first day on which an HMO is responsible for providing Covered Services to Members of an HMO Program in a Service Area in exchange for a Capitation Payment under the Contract. The Operational Start Date may vary per HMO Program and Service Area. The Operational Start Date(s) applicable to this Contract are set forth in the **HHSC Managed Care Contract** document.

[Definition modified by Version 1.3]

Optional Service Area (OSA) means an HHSC defined county or counties, contiguous to a CSA, in which CHIP or CHIP Perinatal HMOs provide health care coverage to CHIP Eligibles. The CHIP or CHIP Perinatal HMO must serve the associated Core Service Area in order to provide coverage in the OSA. The **HHSC Managed Care Contract** document includes OSAs, if applicable.

Operations Phase means the period of time when HMO is responsible for providing the Covered Services and all related Contract functions for a Service Area. The Operations Phase begins on the Operational Start Date, and may vary by HMO Program and Service Area.

[Definition added by Version 1.1]

Outpatient Hospital Services means diagnostic, therapeutic, and rehabilitative services that are provided to Members in an organized medical facility, for less than a 24-hour period, by or under the direction of a physician. To distinguish between the types of services being billed, hospitals must indicate a three-digit type of bill (TOB) code in block 4 of the UB-92 claim form. Most commonly for hospitals, this code will be 131 for an outpatient hospital claims.

Out-of-Network (OON) means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Parties means HHSC and HMO, collectively.

Party means either HHSC or HMO, individually.

Pended Claim means a claim for payment, which requires additional information before the claim can be adjudicated as a clean claim.

Population Risk Group means a distinct group of members identified by age, age range, gender, type of program, or eligibility category.

Post-stabilization Care Services means Covered Services, related to an Emergency Medical Condition that are provided after a Medicaid Member is stabilized in order to maintain the stabilized condition, or, under the circumstances described in 42 §§C.F.R. 438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid Member's condition.

Primary Care Physician or Primary Care Provider (PCP) means a physician or provider who has agreed with the HMO to provide a Medical Home to Members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Provider types that can be PCPs are from any of the following practice areas: General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Pediatric and Family Advanced Practice Nurses (APNs) and Physician Assistants (when practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract), , Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinics; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions.

Proposal means the proposal submitted by the HMO in response to the RFP.

Provider or Network Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Provider Contract means a contract entered into by a direct provider of health care services and the HMO or an intermediary entity.

Provider Network or Network means all Providers that have contracted with the HMO for the applicable HMO Program.

Proxy Claim Form means a form submitted by Providers to document services delivered to Members under a capitated arrangement. It is not a claim for payment.

Public Health Entity means a HHSC Public Health Region, a Local Health Department, or a hospital district.

Public Information means information that:

(1) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and

(2) The governmental body owns or has a right of access to.

[Definition added by Version 1.1]

Qualified and Disabled Working Individual (QDWI) means an individual whose only Medicaid benefit is payment of the Medicare Part A premium.

[Definition added by Version 1.1]

Qualified Medicare Beneficiary (QMB) means a Medicare beneficiary whose only Medicaid benefits are payment of Medicare premiums, deductibles, and coinsurance for individuals who are entitled to Medicare Part A, whose income does not exceed 100% of the federal poverty level, and whose resources do not exceed twice the resource limit of the SSI program.

Quality Improvement means a system to continuously examine, monitor and revise processes and systems that support and improve administrative and clinical functions.

Rate Cell means a Population Risk Group for which a Capitation Rate has been determined.

Rate Period 1 means the period of time beginning on the Operational Start Date and ending on August 31, 2007.

Rate Period 2 means the period of time beginning on September 1, 2007 and ending on August 31, 2008.

Real-Time Captioning (also known as CART, Communication Access Real-Time Translation) means a process by which a trained individual uses a shorthand machine, a computer, and real-time translation software to type and simultaneously translate spoken language into text on a computer screen. Real Time Captioning is provided for individuals who are deaf, have hearing impairments, or have unintelligible speech. It is usually used to interpret spoken English into text English but may be used to translate other spoken languages into text.

Readiness Review means the assurances made by a selected HMO and the examination conducted by HHSC, or its agents, of HMO's ability, preparedness, and availability to fulfill its obligations under the Contract.

Request for Proposals or **RFP** means the procurement solicitation instrument issued by HHSC under which this Contract was awarded and all RFP addenda, corrections or modifications, if any.

Revenue means all managed care revenue received by the HMO pursuant to this Contract during the Contract Period, including retroactive adjustments made by HHSC. This would include any funds earned on Medicaid or CHIP managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated Networks.

Risk means the potential for loss as a result of expenses and costs of the HMO exceeding payments made by HHSC under the Contract.

Routine Care means health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a rural health clinic under 1861(aa)(1) of the Social Security Act and approved for participation in the Texas Medicaid Program.

[Definition added by Version 1.1]

Service Coordination means a specialized care management service that is performed by a Service Coordinator and that includes but is not limited to:

(1) identification of needs, including physical health, mental health services and for STAR+PLUS Members, long term support services,

(2) development of a Service Plan to address those identified needs;

(3) assistance to ensure timely and a coordinated access to an array of providers and Covered Services;

(4) attention to addressing unique needs of Members; and

(5) coordination of Plan services with social and other services delivered outside the Plan, as necessary and appropriate.

[Definition added by Version 1.1]

Service Coordinator means the person with primary responsibility for providing service coordination and care management to STAR+PLUS Members.

Scope of Work means the description of Services and Deliverables specified in this Contract, the RFP, the HMO's Proposal, and any agreed modifications to these documents.

SDX means State Data Exchange.

SED means severe emotional disturbance as determined by a Local Mental Health Authority.

Service Area means the counties included in any HHSC-defined Core and Optional Service Area as applicable to each HMO Program.

[Definition modified by Version 1.3]

Service Management is an administrative service in the STAR, CHIP and CHIP Perinatal Programs performed by the HMO to facilitate development of a Service Plan and coordination of services among a Member's PCP, specialty providers and non-medical providers to ensure Members with Special Health Care Needs and/or Members needing high-cost treatment have access to, and appropriately utilize, Medically Necessary Covered Services, Non-capitated Services, and other services and supports.

Service Plan (SP) means an individualized plan developed with and for Members with Special Health Care Needs, including persons with disabilities or chronic or complex conditions. The SP includes, but is not limited to, the following:

(1) the Member's history;

(2) summary of current medical and social needs and concerns;

(3) short and long term needs and goals;

(4) a list of services required, their frequency, and

(5) a description of who will provide such services.

The Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for members in the Early Childhood Intervention (ECI) Program.

The Service Plan may include information for services outside the scope of covered benefits such as how to access affordable, integrated housing.

Services means the tasks, functions, and responsibilities assigned and delegated to the HMO under this Contract.

Significant Traditional Provider or STP (for Medicaid) means primary care providers and long-term care providers, identified by HHSC as having provided a significant level of care to Fee-for-Service clients. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

Significant Traditional Provider or STP (for CHIP) means primary care providers participating in the CHIP HMO Program prior to May 2004, and Disproportionate Share Hospitals (DSH).

Skilled Nursing Facility Services (CHIP only) Services provided in a facility that provides nursing or rehabilitation services and Medical supplies and use of appliances and equipment furnished by the facility.

Software means all operating system and applications software used by the HMO to provide the Services under this Contract.

SPMI means severe and persistent mental illness as determined by the Local Mental Health Authority.

Specialty Hospital means any inpatient hospital that is not a general Acute Care hospital.

Specialty Therapy means physical therapy, speech therapy or occupational therapy.

[Definition added by Version 1.1]

Specified Low-Income Medicare Beneficiary (SLMB) means a Medicare beneficiary whose only Medicaid benefit is payment of the Medicare Part B premium.

SSA means the Social Security Administration.

SSI Administrative Fee means the monthly per member per month fee paid to an HMO to provide administrative services to manage the healthcare of the HMO's voluntary SSI beneficiaries. These services are described in more detail under Section 10.10 of this document.

Stabilize means to provide such medical care as to assure within reasonable medical probability that no deterioration of the condition is likely to result from, or occur from, or occur during discharge, transfer, or admission of the Member.

[Definition modified by Version 1.1]

STAR+PLUS or STAR+PLUS Program means the State of Texas Medicaid managed care program in which HHSC contracts with HMOs to provide, arrange, and coordinate preventive, primary, acute and long term care Covered Services to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO program. Children under age 21, who qualify for Medicaid through the SSI program, may voluntarily participate in the STAR+PLUS program.

[Definition added by Version 1.1]

STAR+PLUS HMOs means contracted HMOs participating in the STAR+PLUS Program.

State Fiscal Year (SFY) means a 12-month period beginning on September 1 and ending on August 31 the following year.

Subcontract means any agreement between the HMO and other party to fulfill the requirements of the Contract.

Subcontractor means any individual or entity, including an Affiliate, that has entered into a Subcontract with HMO.

Subsidiary means an Affiliate controlled by such person or entity directly or indirectly through one or more intermediaries.

[Definition added by Version 1.1]

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

T.A.C. means Texas Administrative Code.

TDD means telecommunication device for the deaf. It is interchangeable with the term Teletype machine or TTY.

TDI means the Texas Department of Insurance.

Temporary Assistance to Needy Families (TANF) means the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid. This program was formerly known as the Aid to Families with Dependent Children (AFDC) program.

Texas Health Network (THN) is the name of the Medicaid primary care case management program in Texas.

Texas Health Steps (THSteps) is the name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. §1396d(r), and defined and codified at 42 C.F.R. §§440.40 and 441.56-62. HHSC's rules are contained in 25 T.A.C., Chapter 33 (relating to Early and Periodic Screening, Diagnosis and Treatment).

Texas Medicaid Bulletin means the bi-monthly update to the Texas Medicaid Provider Procedures Manual.

Texas Medicaid Provider Procedures Manual means the policy and procedures manual published by or on behalf of HHSC that contains policies and procedures required of all health care providers who participate in the Texas Medicaid program. The manual is published annually and is updated bi-monthly by the Texas Medicaid Bulletin.

Texas Medicaid Service Delivery Guide means an attachment to the Texas Medicaid Provider Procedures Manual.

Third Party Liability (TPL) means the legal responsibility of another individual or entity to pay for all or part of the services provided to Members under the Contract (see 1 TAC §354.2301 *et seq*., relating to Third Party Resources).

Third Party Recovery (TPR) means the recovery of payments on behalf of a Member by HHSC or the HMO from an individual or entity with the legal responsibility to pay for the Covered Services.

TP 40 means Type Program 40, which is a Medicaid program eligibility type assigned to pregnant women under 185% of the federal poverty level (FPL).

TP 45 means Type Program 45, which is a Medicaid program eligibility code assigned to newborns (under 12 months of age) who are born to mothers who are Medicaid eligible at the time of the child's birth.

Transition Phase includes all activities the HMO is required to perform between the Contract Effective Date and the Operational Start Date for a Service Area.

Turnover Phase includes all activities the HMO is required to perform in order to close out the Contract and/or transition Contract activities and operations for a Service Area to HHSC or a subsequent contractor.

Turnover Plan means the written plan developed by HMO, approved by HHSC, to be employed during the Turnover Phase. The Turnover Plan describes HMO's policies and procedures that will assure:

(1) The least disruption in the delivery of Health Care Services to those Members who are enrolled with the HMO during the transition to a subsequent health plan;

(2) Cooperation with HHSC and the subsequent health plan in notifying Members of the transition and of their option to select a new plan, as requested and in the form required or approved by HHSC; and

(3) Cooperation with HHSC and the subsequent health plan in transferring information to the subsequent health plan, as requested and in the form required or approved by HHSC.

URAC /American Accreditation Health Care Commission means the independent organization that accredits Utilization Review functions and offers a variety of other accreditation and certification programs for health care organizations.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

Urgent Condition means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Utilization Review means the system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Health Care Services provided, being provided, or proposed to be provided to a Member. The term does not include elective requests for clarification of coverage.

Value-added Services means additional services for coverage beyond those specified in the RFP. Value-added Services must be actual health care services or benefits rather than gifts, incentives, health assessments or educational classes. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Waste means practices that are not cost-efficient.

Article 3. General Terms & Conditions

Section 3.01 ***Contract elements.***

(a) Contract documentation.

The Contract between the Parties will consist of the HHSC Managed Care Contract document and all attachments and amendments.

(b) Order of documents.

In the event of any conflict or contradiction between or among the contract documents, the documents shall control in the following order of precedence:

(1) The final executed **HHSC Managed Care Contract** document, and all amendments thereto;

(2) HHSC Managed Care Contract **Attachment A** – "HHSC's Uniform Managed Care Contract Terms and Conditions," and all amendments thereto;

(3) HHSC Managed Care Contract **Attachment B** – "Scope of Work/Performance Measures," and all attachments and amendments thereto;

(4) The **HHSC Uniform Managed Care Manual**, and all attachments and amendments thereto;

(5) HHSC Managed Care Contract **Attachment C-3** – "Agreed Modifications to HMO's Proposal;"

(6) HHSC Managed Care Contract **Attachment C-2**, "HMO Supplemental Responses," and

(7) HHSC Managed Care Contract **Attachment C-1 –** "HMO's Proposal."

Section 3.02 ***Term of the Contract.***

The term of the Contract will begin on the Effective Date and will conclude on the Expiration Date. The Parties may renew the Contract for an additional period or periods, but the Contract Term may not exceed a total of eight (8) years. All reserved contract extensions beyond the Expiration Date will be subject to good faith negotiations between the Parties and mutual agreement to the extension(s).

Section 3.03 ***Funding.***

This Contract is expressly conditioned on the availability of state and federal appropriated funds. HMO will have no right of action against HHSC in the event that HHSC is unable to perform its obligations under this Contract as a result of the suspension, termination, withdrawal, or failure of funding to HHSC or lack of sufficient funding of HHSC for any activities or functions contained within the scope of this Contract. If funds become unavailable, the provisions of **Article 12** ("Remedies and Disputes") will apply. HHSC will use all reasonable efforts to ensure that such funds are available, and will negotiate in good faith with HMO to resolve any HMO claims for payment that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC shall make best efforts to provide reasonable written advance notice to HMO upon learning that funding for this Contract may be unavailable.

Section 3.04 ***Delegation of authority.***

Whenever, by any provision of this Contract, any right, power, or duty is imposed or conferred on HHSC, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. The Commissioner will reduce any such delegation of authority to writing and provide a copy to HMO on request.

Section 3.05 ***No waiver of sovereign immunity.***

The Parties expressly agree that no provision of this Contract is in any way intended to constitute a waiver by HHSC or the State of Texas of any immunities from suit or from liability that HHSC or the State of Texas may have by operation of law.

Section 3.06 ***Force majeure.***

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if such failure or delay is due to any cause beyond the reasonable control of such Party, including, but not limited to, unusually severe weather, strikes, natural disasters, fire, civil disturbance, epidemic, war, court order, or acts of God. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five (5) Business Days of the existence of a force majeure event or otherwise waive this right as a defense.

Section 3.07 ***Publicity.***

(a) HMO may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the HHSC HMO Program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least seven (7) calendar days prior to distributing the material, the HMO submits the information to HHSC for review and comment. If HHSC has not responded within seven (7) calendar days, the HMO may use the submitted information. HHSC reserves the right to object to and require changes to the publication if, at HHSC's sole discretion, it determines that the publication does not accurately reflect the terms of the Contract or the HMO's performance under the Contract. .

(b) HMO will provide HHSC with one (1) electronic copy of any information described in Subsection 3.07(a) prior to public release. HMO will provide additional copies, including hard copies, at the request of HHSC.

c) The requirements of Subsection 3.07(a) do not apply to:

(1) proposals or reports submitted to HHSC, an administrative agency of the State of Texas, or a governmental agency or unit of another state or the federal government;

(2) information concerning the Contract's terms, subject matter, and estimated value:

(a) in any report to a governmental body to which the HMO is required by law to report such information, or

(b) that the HMO is otherwise required by law to disclose; and

(3) Member Materials (the HMO must comply with **the Uniform Managed Care Manual's** provisions regarding the review and approval of Member Materials).

Section 3.08 ***Assignment.***

(a) Assignment by HMO.

HMO shall not assign all or any portion of its rights under or interests in the Contract or delegate any of its duties without prior written consent of HHSC. Any written request for assignment or delegation must be accompanied by written acceptance of the assignment or delegation by the assignee or delegation by the delegate. Except where otherwise agreed in writing by HHSC, assignment or delegation will not release HMO from its obligations pursuant to the Contract. An HHSC-approved Material Subcontract will not be considered to be an assignment or delegation for purposes of this section.

(b) Assignment by HHSC.

HMO understands and agrees HHSC may in one or more transactions assign, pledge, transfer, or hypothecate the Contract. This assignment will only be made to another State agency or a non-State agency that is contracted to perform agency support.

(c) Assumption.

Each party to whom a transfer is made (an "Assignee") must assume all or any part of HMO'S or HHSC's interests in the Contract, the product, and any documents executed with respect to the Contract, including, without limitation, its obligation for all or any portion of the purchase payments, in whole or in part.

Section 3.09 ***Cooperation with other vendors and prospective vendors.***

HHSC may award supplemental contracts for work related to the Contract, or any portion thereof. HMO will reasonably cooperate with such other vendors, and will not commit or permit any act that may interfere with the performance of work by any other vendor.

Section 3.10 ***Renegotiation and reprocurement rights.***

(a) Renegotiation of Contract terms.

Notwithstanding anything in the Contract to the contrary, HHSC may at any time during the term of the Contract exercise the option to notify HMO that HHSC has elected to renegotiate certain terms of the Contract. Upon HMO's receipt of any notice pursuant to this Section, HMO and HHSC will undertake good faith negotiations of the subject terms of the Contract, and may execute an amendment to the Contract in accordance with **Article 8**.

(b) Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Contract to the contrary, whether or not HHSC has accepted or rejected HMO's Services and/or Deliverables provided during any period of the Contract, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Contract or Scope of Work similar or comparable to the Scope of Work performed by HMO under the Contract.

(c) Termination rights upon reprocurement.

If HHSC elects to procure the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, HHSC will have the termination rights set forth in **Article 12** ("Remedies and Disputes").

Section 3.11 ***RFP errors and omissions.***

HMO will not take advantage of any errors and/or omissions in the RFP or the resulting Contract. HMO must promptly notify HHSC of any such errors and/or omissions that are discovered.

Section 3.12 ***Attorneys' fees.***

In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, HMO agrees to pay all reasonable expenses of such action, including attorneys' fees and costs, if HHSC is the prevailing Party.

Section 3.13 ***Preferences under service contracts.***

HMO is required in performing the Contract to purchase products and materials produced in the State of Texas when they are available at a price and time comparable to products and materials produced outside the State.

Section 3.14 ***Time of the essence.***

In consideration of the need to ensure uninterrupted and continuous HHSC HMO Program performance, time is of the essence in the performance of the Scope of Work under the Contract.

Section 3.15 ***Notice***

(a) Any notice or other legal communication required or permitted to be made or given by either Party pursuant to the Contract will be in writing and in English, and will be deemed to have been given:

(1) Three (3) Business Days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;

(2) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or

(3) When delivered if delivered personally or sent by express courier service.

(b) The notices described in this Section may not be sent by electronic mail.

(c) All notices must be sent to the Project Manager identified in the **HHSC Managed Care Contract** document. In addition, legal notices must be sent to the Legal Contact identified in the **HHSC Managed Care Contract** document.

(d) Routine communications that are administrative in nature will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration & Management

Section 4.01 ***Qualifications, retention and replacement of HMO employees.***

HMO agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under this Contract. The personnel HMO assigns to perform the duties and responsibilities under this Contract will be properly trained and qualified for the functions they are to perform. Notwithstanding transfer or turnover of personnel, HMO remains obligated to perform all duties and responsibilities under this Contract without degradation and in accordance with the terms of this Contract.

Section 4.02 ***HMO's Key Personnel.***

(a) Designation of Key Personnel.

HMO must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas for each HMO Program included within the scope of the Contract:

(1) Member Services;

(2) Management Information Systems;

(3) Claims Processing,

(4) Provider Network Development and Management;

(5) Benefit Administration and Utilization and Care Management;

(6) Quality Improvement;

(7) Behavioral Health Services;

(8) Financial Functions;

(9) Reporting;

(10) Executive Director(s) for applicable HHSC HMO Program(s) as defined in **Section 4.03** ("Executive Director");

(11) Medical Director(s) for applicable HHSC HMO Program(s) as defined in **Section 4.04** ("Medical Director"); and

[Section 4.04(a)(12) added by Version 1.1]

(12) STAR+PLUS Service Coordinators for STAR+PLUS HMOs as defined in **Section 4.04.1** ("STAR+PLUS Service Coordinator.")

(b) Support and Replacement of Key Personnel.

The HMO must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. The HMO must ensure project continuity by timely replacement of Key Personnel, if necessary, with a sufficient number of persons having the requisite skills, experience and other qualifications. Regardless of specific personnel changes, the HMO must maintain the overall level of expertise, experience, and skill reflected in the Key HMO Personnel job descriptions and qualifications included in the HMO's proposal.

(c) Notification of replacement of Key Personnel.

HMO must notify HHSC within fifteen (15) Business Days of any change in Key Personnel. Hiring or replacement of Key Personnel must conform to all Contract requirements. If HHSC determines that a satisfactory working relationship cannot be established between certain Key Personnel and HHSC, it will notify the HMO in writing. Upon receipt of HHSC's notice, HHSC and HMO will attempt to resolve HHSC's concerns on a mutually agreeable basis.

Section 4.03 ***Executive Director.***

(a) The HMO must employ a qualified individual to serve as the Executive Director for its HHSC HMO Program(s). Such Executive Director must be employed full-time by the HMO, be primarily dedicated to HHSC HMO Program(s), and must hold a Senior Executive or Management position in the HMO's organization, except that the HMO may propose an alternate structure for the Executive Director position, subject to HHSC's prior review and written approval.

(b) The Executive Director must be authorized and empowered to represent the HMO regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as

liaison between the HMO and the HHSC and must have responsibilities that include, but are not limited to, the following:

(1) ensuring the HMO's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

(2) receiving and responding to all inquiries and requests made by HHSC related to the Contract, in the time frames and formats specified by HHSC. Where practicable, HHSC must consult with the HMO to establish time frames and formats reasonably acceptable to the Parties;

(3) attending and participating in regular HHSC HMO Executive Director meetings or conference calls;

(4) attending and participating in regular HHSC Regional Advisory Committees (RACs) for managed care (the Executive Director may designate key personnel to attend a RAC if the Executive Director is unable to attend);

(5) making best efforts to promptly resolve any issues identified either by the HMO or HHSC that may arise and are related to the Contract;

(6) meeting with HHSC representative(s) on a periodic or as needed basis to review the HMO's performance and resolve issues, and

(7) meeting with HHSC at the time and place requested by HHSC, if HHSC determines that the HMO is not in compliance with the requirements of the Contract.

Section 4.04 ***Medical Director.***

[Section 4.04(a) modified by Version 1.2]

(a) The HMO must have a qualified individual to serve as the Medical Director for its HHSC HMO Program(s). The Medical Director must be currently licensed in Texas under the Texas Medical Board as an M.D. or D.O. with no restrictions or other licensure limitations. The Medical Director must comply with the requirements of 28 T.A.C. §11.1606 and all applicable federal and state statutes and regulations.

(b) The Medical Director, or his or her physician designee meeting the same Contract qualifications that apply to the Medical Director, must be available by telephone 24 hours a day, seven days a week, for Utilization Review decisions. The Medical Director, and his/her designee, must either possess expertise with Behavioral Health Services, or ready access to such expertise to ensure timely and appropriate medical decisions for Members, including after regular business hours.

(c) The Medical Director, or his or her physician designee meeting the same Contract qualifications that apply to the Medical Director, must be authorized and empowered to represent the HMO regarding clinical issues, Utilization Review and quality of care inquiries. The Medical Director, or his or her physician designee, must exercise independent medical judgment in all decisions relating to medical necessity. The HMO must ensure that its decisions relating to medical necessity are not adversely influenced by fiscal management decisions. HHSC may conduct reviews of decisions relating to medical necessity upon reasonable notice.

Section 4.04.1 ***STAR+PLUS Service Coordinator***

[Section 4.04.1 added by Version 1.1]

(a) STAR+PLUS HMOs must employ as Service Coordinators persons experienced in meeting the needs of people with disabilities, old and young, and vulnerable populations who have Chronic or Complex Conditions. A Service Coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a Registered Nurse, Licensed Vocational Nurse, Advanced Nurse Practitioner, or a Physician Assistant.

(b) The STAR+PLUS HMO must monitor the Service Coordinator's workload and performance to ensure that he or she is able to perform all necessary Service Coordination functions for the STAR+PLUS Members in a timely manner.

(c) The Service Coordinator must be responsible for working with the Member or his or her representative, the PCP and other Providers to develop a seamless package of care in which primary, Acute Care, and long-term care service needs are met through a single, understandable, rational plan. Each Member's Service Plan must also be well coordinated with the Member's family and community support systems, including Independent Living Centers, Area Agencies on Aging and Mental Retardation Authorities. The Service Plan should be agreed to and signed by the Member or the Member's representative to indicate agreement with the plan. The plan should promote consumer direction and self-determination and may include information for services outside the scope of Covered Services such as how to access affordable, integrated housing. For dual eligible Members, the STAR+PLUS HMO is responsible for meeting the Member's Community Long- term Care Service needs.

(d) The STAR+PLUS HMO must empower its Service Coordinators to authorize the provision and delivery of Covered Services, including Community Long-term Care Covered Services.

Section 4.05 ***Responsibility for HMO personnel and Subcontractors.***

(a) HMO's employees and Subcontractors will not in any sense be considered employees of HHSC or the State of Texas, but will be considered for all purposes as the HMO's employees or its Subcontractor's employees, as applicable.

(b) Except as expressly provided in this Contract, neither HMO nor any of HMO's employees or Subcontractors may act in any sense as agents or representatives of HHSC or the State of Texas.

(c) HMO agrees that anyone employed by HMO to fulfill the terms of the Contract is an employee of HMO and remains under HMO's sole direction and control. HMO assumes sole and full responsibility for its acts and the acts of its employees and Subcontractors.

(d) HMO agrees that any claim on behalf of any person arising out of employment or alleged employment by the HMO (including, but not limited to, claims of discrimination against HMO, its officers, or its agents) is the sole responsibility of HMO and not the responsibility of HHSC. HMO will indemnify and hold harmless the State from any and all claims asserted against the State arising out of such employment or alleged employment by the HMO. HMO understands that any person who alleges a claim arising out of employment or alleged employment by HMO will not be entitled to any compensation, rights, or benefits from HHSC (including, but not limited to, tenure rights, medical and hospital care, sick and annual/vacation leave, severance pay, or retirement benefits).

(e) HMO agrees to be responsible for the following in respect to its employees:

(1) Damages incurred by HMO's employees within the scope of their duties under the Contract; and

(2) Determination of the hours to be worked and the duties to be performed by HMO's employees.

(f) HMO agrees and will inform its employees and Subcontractor(s) that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to them by HMO pursuant to this Contract or any judgment rendered against the HMO. HHSC's liability to the HMO's employees, agents and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (TEX. CIV. PRACT. & REM. CODE §101.001et seq.).

(g) HMO understands that HHSC does not assume liability for the actions of, or judgments rendered against, the HMO, its employees, agents or Subcontractors. HMO agrees that it has no right to indemnification or contribution from HHSC for any such judgments rendered against HMO or its Subcontractors.

Section 4.06 ***Cooperation with HHSC and state administrative agencies.***

(a) Cooperation with Other MCOs.

HMO agrees to reasonably cooperate with and work with the other MCOs in the HHSC HMO Programs, Subcontractors, and third-party representatives as requested by HHSC. To the extent permitted by HHSC's financial and personnel resources, HHSC agrees to reasonably cooperate with HMO and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the HMO.

(b) Cooperation with state and federal administrative agencies.

HMO must ensure that HMO personnel will cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of HHSC programs including, but not limited to the following purposes:

(1) The investigation and prosecution of fraud, abuse, and waste in the HHSC programs;

(2) Audit, inspection, or other investigative purposes; and

(3) Testimony in judicial or quasi-judicial proceedings relating to the Services and/or Deliverables under this Contract or other delivery of information to HHSC or other agencies' investigators or legal staff.

Section 4.07 ***Conduct of HMO personnel.***

(a) While performing the Scope of Work, HMO's personnel and Subcontractors must:

(1) Comply with applicable State rules and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and

(2) Otherwise conduct themselves in a businesslike and professional manner.

(b) If HHSC determines in good faith that a particular employee or Subcontractor is not conducting himself or herself in accordance with this Contract, HHSC may provide HMO with notice and documentation concerning such conduct. Upon receipt of such notice, HMO must promptly investigate the matter and take appropriate action that may include:

(1) Removing the employee from the project;

(2) Providing HHSC with written notice of such removal; and

(3) Replacing the employee with a similarly qualified individual acceptable to HHSC.

(c) Nothing in the Contract will prevent HMO, at the request of HHSC, from replacing any personnel who are not adequately performing their assigned responsibilities or who, in the reasonable opinion of HHSC's Project Manager, after consultation with HMO, are unable to work effectively with the members of the HHSC's staff. In such event, HMO will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review. The Parties will work together in the event of any such replacement so as not to disrupt the overall project schedule.

(d) HMO agrees that anyone employed by HMO to fulfill the terms of the Contract remains under HMO's sole direction and control.

(e) HMO shall have policies regarding disciplinary action for all employees who have failed to comply with federal and/or state laws and the HMO's standards of conduct, policies and procedures, and Contract requirements. HMO shall have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

Section 4.08 ***Subcontractors.***

(a) HMO remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by HMO's employees, and for purposes of this Contract such work will be deemed work performed by HMO. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a Subcontractor.

(b) HMO must:

(1) actively monitor the quality of care and services, as well as the quality of reporting data, provided under a Subcontract;

(2) notify HHSC in writing at least 60 days prior to reprocurement of services provided by any Material Subcontractor;

(3) notify HHSC in writing within three (3) Business Days after making a decision to terminate a Subcontract with a Material Subcontractor or upon receiving notification from the Material Subcontractor of its intent to terminate such Subcontract;

(4) notify HHSC in writing within one (1) Business Day of making a decision to enter into a Subcontract with a new Material Subcontractor, or a new Subcontract for newly procured services of an existing Material Subcontractor; and

(5) provide HHSC with a copy of TDI filings of delegation agreements.

(c) During the Contract Period, Readiness Reviews by HHSC or its designated agent may occur if:

(1) a new Material Subcontractor is employed by HMO;

(2) an existing Material Subcontractor provides services in a new Service Area;

(3) an existing Material Subcontractor provides services for a new HMO Program;

(4) an existing Material Subcontractor changes locations or changes its MIS and or operational functions;

(5) an existing Material Subcontractor changes one or more of its MIS subsystems, claims processing or operational functions; or

(6) a Readiness Review is requested by HHSC.

The HMO must submit information required by HHSC for each proposed Material Subcontractor as indicated in **Attachment B-1, Section 7**.

(d) HMO must not disclose Confidential Information of HHSC or the State of Texas to a Subcontractor unless and until such Subcontractor has agreed in writing to protect the confidentiality of such Confidential Information in the manner required of HMO under this Contract.

(e)HMO must identify any Subcontractor that is a subsidiary or entity formed after the Effective Date of the Contract, whether or not an Affiliate of HMO, substantiate the proposed Subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. The HMO will assume responsibility for all contractual responsibilities whether or not the HMO performs them. Further, HHSC considers the HMO to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Contract.

(f) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and all Subcontractor records relating to the Contract and the Subcontract. This requirement does not apply to agreements with utility or mail service providers.

(g) A Subcontract whereby HMO receives rebates, recoupments, discounts, payments, or other consideration from a Subcontractor (including without limitation Affiliates) pursuant to or related to the execution of this Contract must be in writing and must provide HHSC the right to examine the Subcontract and all records relating to such consideration.

(h) All Subcontracts described in subsections (f) and (g) must show the dollar amount, the percentage of money, or the value of any consideration that HMO pays to or receives from the Subcontractor.

(i) HMO must submit a copy of each Material Subcontract executed prior to the Effective Date of the Contract to HHSC no later than thirty (30) days after the Effective Date of the Contract. For Material Subcontracts executed after the Effective Date of the Contract, HMO must submit a copy to HHSC no later than five (5) Business Days after execution.

(j) Network Provider Contracts must include the mandatory provisions included in the **HHSC Uniform Managed Care Manual**.

(k) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

Section 4.09 ***HHSC's ability to contract with Subcontractors.***

The HMO may not limit or restrict, through a covenant not to compete, employment contract or other contractual arrangement, HHSC's ability to contract with Subcontractors or former employees of the HMO.

Section 4.10 ***HMO Agreements with Third Parties***

(a) If the HMO intends to report compensation paid to a third party (including without limitation an Affiliate) as an Allowable Expense under this Contract, and the compensation paid to the third party exceeds $100,000, or is reasonably anticipated to exceed $100,000, in a State Fiscal Year, then the HMO's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and all records relating to the agreement.

(b) All agreements whereby HMO receives rebates, recoupments, discounts, payments, or other consideration from a third party (including without limitation Affiliates) pursuant to or related to the execution of this Contract, must be in writing and must provide HHSC the right to examine the agreement and all records relating to such consideration. .

(c) All agreements described in subsections (a) and (b) must show the dollar amount, the percentage of money, or the value of any consideration that HMO pays to or receives from the third party.

(d) HMO must submit a copy of each third party agreement described in subsections (a) and (b) to HHSC. If the third party agreement is entered into prior to the Effective Date of the Contract, HMO must submit a copy no later than thirty (30) days after the Effective Date of the Contract. If the third party agreement is executed after the Effective Date of the Contract, HMO must submit a copy no later than five (5) Business Days after execution.

(e) For third party agreements valued under $100,000 per State Fiscal Year that are reported as Allowable Expenses, the HMO must maintain financial records and data sufficient to verify the accuracy of such expenses in accordance with the requirements of **Article 9**.

(f) HHSC reserves the right to reject any third party agreement or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

(g) This section shall not apply to Provider Contracts, or agreements with utility or mail service providers.

Article 5. Member Eligibility & Enrollment

Section 5.01 ***Eligibility Determination***

The State or its designee will make eligibility determinations for each of the HHSC HMO Programs.

Section 5.02 ***Member Enrollment & Disenrollment.***

(a) The HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the HMO Program. To enroll in an HMO, the Member's permanent residence must be located within the HMO's Service Area. The HMO is not allowed to induce or accept disenrollment from a Member. The HMO must refer the Member to the HHSC Administrative Services Contractor.

(b) HHSC makes no guarantees or representations to the HMO regarding the number of eligible Members who will ultimately be enrolled into the HMO or the length of time any such enrolling Members remain enrolled with the HMO beyond the minimum mandatory enrollment periods established for each HHSC HMO Program.

(c) The HHSC Administrative Services Contractor will electronically transmit to the HMO new Member information and change information applicable to active Members.

(d) As described in the following Sections, depending on the HMO Program, special conditions may also apply to enrollment and span of coverage for the HMO.

[Section 5.02(e) modified by Version 1.2]

(e) HMO has a limited right to request a Member be disenrolled from HMO without the Member's consent. HHSC must approve any HMO request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

(1) Member misuses or loans Member's HMO membership card to another person to obtain services.

(2) Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs HMO's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.

(3) Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow HMO to treat the underlying medical condition).

(4) HMO must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

(5) For STAR+PLUS HMOs, under limited conditions, the HMO may request disenrollment of members who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease.

(f) HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.

(g) If the Member disagrees with the decision to disenroll the Member from HMO, HHSC must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

(h) HMO cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

[Section 5.02(i) modified by Version 1.2]

(i) Upon implementation of the Comprehensive Healthcare Program for Foster Care, STAR and CHIP Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled effective the date of conservatorship.

Section 5.03 ***STAR enrollment for pregnant women and infants.***

(a) The HHSC Administrative Services Contractor will retroactively enroll some pregnant Members in a Medicaid HMO based on their date of eligibility.

(b) The HHSC Administrative Services Contractor will enroll newborns born to Medicaid eligible mothers who are enrolled in a STAR HMO in the same HMO for 90 days following the date of birth, unless the mother requests a plan change as a special exception. The Administrative Service Contractor will consider such requests on a case-by-case basis. The HHSC Administrative Services Contractor will retroactively, to date of birth, enroll newborns in the applicable STAR HMO.

Section 5.04 ***CHIP eligibility and enrollment.***

[Section 5.04(a) modified by Version 1.5]

(a) Continuous coverage.

Except as provided in 1 T.A.C. §370.307, a child who is CHIP-eligible will have six (6) months of continuous coverage. Children enrolling in CHIP for the first time, or returning to CHIP after disenrollment, will be subject to a waiting period before coverage actually begins, except as provided in 1 T.A.C. §370.46. The waiting period for a child is determined by the date on which he/she is found eligible for CHIP, and extends for a duration of three months. If the child is found eligible for CHIP on or before the 15th day of a month, then the waiting period begins on the first day of that same month. If the child is found eligible on or after the 16th day of a month, then the waiting period begins on the first day of the next month.

[Section 5.04(b) modified by Version 1.2]

(b) Pregnant Members and Infants.

(1) The HHSC Administrative Contractor will refer pregnant CHIP Members, with the exception of Legal Permanent Residents and other legally qualified aliens barred from Medicaid due to federal eligibility restrictions, to Medicaid for eligibility determinations. Those CHIP Members who are determined to be Medicaid Eligible will be disenrolled from HMO's CHIP plan. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

(2) In the event the HMO remains unaware of a Member's pregnancy until delivery, the delivery will be covered by CHIP. Babies are automatically enrolled in the mother's CHIP health plan at birth with CHIP eligibility and re-enrollment following the timeframe as that of the mother. The HHSC Administrative Services Contractor will then set the Member's eligibility expiration date at the later of (1) the end of the second month following the month of the baby's birth or (2) the Member's original eligibility expiration date.

Section 5.04.1 ***CHIP Perinatal eligibility, enrollment, and disenrollment***

[Section 5.04.1 added by Version 1.3]

(a) The HHSC Administrative Contractor will electronically transmit to the HMO new CHIP Perinate Member information based on the appropriate CHIP Perinate or CHIP Perinate Newborn Rate Cell. There is no waiting period for CHIP Perinatal Program Members.

(b) CHIP Perinate Newborns are eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

(c) If only one CHIP Perinatal HMO operates in a Service Area, HHSC will automatically enroll a prospective member in that CHIP Perinatal HMO. If multiple CHIP Perinatal HMOs offer coverage in the Service Area, HHSC will send an enrollment packet to the prospective Member's household. If the household of a prospective member does not make a selection within 15 calendar days, the HHSC Administrative Services Contractor will notify the household that the prospective member has been assigned to a CHIP Perinatal HMO ("Default Enrollment"). When this occurs the household has 30 calendar days to select another CHIP Perinatal HMO for the Member.

(d) HHSC's Administrative Services Contractor will assign prospective members to CHIP Perinatal HMOs in a Service Area in a rotational basis. Should HHSC implement one or more administrative rules governing the Default Enrollment processes, such administrative rules will take precedence over the Default Enrollment process set forth herein.

(e) When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Program Member's health plan. All members of the household must remain in the same health plan through the end of the CHIP Perinatal Program Member's enrollment period.

[Section 5.04.1 modified by Version 1.5]

(f) In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information. Once the child's CHIP Perinatal Program coverage expires, the child will be added to his or her siblings' existing CHIP program case.

Section 5.05 ***Span of Coverage***

(a) Medicaid HMOs.

(1) HHSC will conduct continuous open enrollment for Medicaid Eligibles and the HMO must accept all persons who choose to enroll as Members in the HMO or who are assigned as Members in the HMO by HHSC, without regard to the Member's health status or any other factor. Persons in a hospital on the enrollment date will not be enrolled until they are discharged from the hospital.

(2) Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically re-enrolled into the same health plan, if available. Temporary loss of eligibility is defined as a period of six months or less.

(3) A Member cannot change from one Medicaid MCO to another Medicaid MCO during an inpatient hospital stay. The MCO responsible for the hospital charges at the start of an Inpatient Stay remains responsible for hospital charges until the time of discharge, or until such time that there is a loss of Medicaid eligibility. Medicaid MCOs are responsible for professional charges during every month for which the MCO receives a full capitation for a Member.

(b) CHIP HMOs.

If a CHIP Member's Effective Date of Coverage occurs while the CHIP Member is confined in a hospital, HMO is responsible for the CHIP Member's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Member is disenrolled while the CHIP Member is confined in a hospital, HMO's responsibility for the CHIP Member's costs of Covered Services terminates on the Date of Disenrollment.

(c) CHIP Perinatal HMOs.

[Section 5.05(c) added by Version 1.3]

If a CHIP Perinate's Effective Date of Coverage occurs while the CHIP Perinate is confined in a Hospital, HMO is responsible for the CHIP Perinate's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Perinate is disenrolled while the CHIP Perinate is confined in a Hospital, the HMO's responsibility for the CHIP Perinate's costs of Covered Services terminates on the Date of Disenrollment.

Section 5.06 ***Verification of Member Eligibility.***

Medicaid MCOs are prohibited from entering into an agreement to share information regarding their Members with an external vendor that provides verification of Medicaid recipients' eligibility to Medicaid providers. All such external vendors must contract with the State and obtain eligibility information from the State.

Section 5.07 ***Special Temporary STAR Default Process***

(a) STAR HMOs that did not contract with HHSC prior to the Effective Date of the Contract to provide Medicaid Health Care Services will be assigned a limited number of Medicaid-eligibles, who have not actively made a STAR HMO choice, for a finite period. The number will vary by Service Area as set forth below. To the extent possible, the special default assignment will be based on each eligible's prior history with a PCP and geographic proximity to a PCP.

(b) For the Bexar, Dallas, El Paso, Harris, Tarrant, and Travis Service Areas, the special default process will begin with the Operational Start Date and conclude when the HMO has achieved an enrollment of 15,000 mandatory STAR members, or at the end of six months, whichever comes first.

(c) For the Lubbock Service Area, the special default process will begin with the Operational Start Date and conclude when the HMO has achieved an enrollment of 5,000 mandatory STAR members, or at the end of six months, whichever comes first.

(d) Special default periods may be extended for one or more Service Areas if consistent with HHSC administrative rules.

(e) This Section does not apply to the Nueces Service Area.

Section 5.08 ***Special Temporary STAR+PLUS Default Process***

[Section 5.08 added by Version 1.5]

(a) STAR+PLUS HMOs that did not contract with HHSC to provide STAR+PLUS services in Harris County prior to the Effective Date of the Contract will be assigned a limited number of STAR+PLUS

Medicaid-eligibles in Harris County, who have not actively made a STAR+PLUS HMO choice, for a finite period. To the extent possible, the special default assignment will be based on each eligible's prior history with a PCP and geographic proximity to a PCP.

(b) For the Harris Service Area, the special default process will begin on the Operational Start Date. All defaults for Harris County will be awarded to the new HMO during the special default process. The special default process will conclude at the end of the first 6-month period following the Operational Start Date, or when the HMO has achieved a total enrollment of 8,000 STAR+PLUS Members for the entire Harris Service Area (includes Harris and Harris Contiguous counties), whichever comes first.

(c) The special default process will apply to Harris County only. The Harris Contiguous counties will follow the standard default process.

(d) This Section does not apply to the Bexar, Nueces or Travis Service Areas for STAR+PLUS.

Article 6. Service Levels & Performance Measurement

Section 6.01 ***Performance measurement.***

Satisfactory performance of this Contract will be measured by:

(a) Adherence to this Contract, including all representations and warranties;

(b) Delivery of the Services and Deliverables described in Attachment B;

(c) Results of audits performed by HHSC or its representatives in accordance with **Article 9** ("Audit and Financial Compliance");

(d) Timeliness, completeness, and accuracy of required reports; and

(e) Achievement of performance measures developed by HMO and HHSC and as modified from time to time by written agreement during the term of this Contract.

Article 7. Governing Law & Regulations

Section 7.01 ***Governing law and venue.***

This Contract is governed by the laws of the State of Texas and interpreted in accordance with Texas law. Provided HMO first complies with the procedures set forth in **Section 12.13** ("Dispute Resolution,") proper venue for claims arising from this Contract will be in the State District Court of Travis County, Texas.

Section 7.02 ***HMO responsibility for compliance with laws and regulations.***

(a) HMO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, all applicable provisions of state and federal laws, rules, regulations, federal waivers, policies and guidelines, and any court-ordered consent decrees, settlement agreements, or other court orders that govern the performance of the Scope of Work including, but not limited to:

(1) Titles XIX and XXI of the Social Security Act;

(2) Chapters 62 and 63, Texas Health and Safety Code;

(3) Chapters 531 and 533, Texas Government Code;

(4) 42 C.F.R. Parts 417 and 457, as applicable;

(5) 45 C.F.R. Parts 74 and 92;

[Section 7.02(a)(6) modified by Version 1.2]

(6) 48 C.F.R. Part 31, or OMB Circular A-122, based on whether the entity is for-profit or nonprofit;

(7) 1 T.A.C. Part 15, Chapters 361, 370, 391, and 392; and

(8) all State and Federal tax laws, State and Federal employment laws, State and Federal regulatory requirements, and licensing provisions.

(b) The Parties acknowledge that the federal and/or state laws, rules, regulations, policies, or guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that affect the performance of the Scope of Work may change from time to time or be added, judicially interpreted, or amended by competent authority. HMO acknowledges that the HMO Programs will be subject to continuous change during the term of the Contract and, except as provided in Section 8.02, HMO has provided for or will provide for adequate resources, at no additional charge to HHSC, to reasonably accommodate such changes. The Parties further acknowledge that HMO was selected, in part, because of its expertise, experience, and knowledge concerning applicable Federal and/or state laws, regulations, policies, or guidelines that affect the performance of the Scope of Work. In keeping with HHSC's reliance on this knowledge and expertise, HMO is responsible for identifying the impact of changes in applicable Federal or state legislative enactments and regulations that affect the performance of the Scope of Work or the State's use of the Services and Deliverables. HMO must timely notify HHSC of such changes and must work with HHSC to identify the impact of such changes on how the State uses the Services and Deliverables.

(c) HHSC will notify HMO of any changes in applicable law, regulation, policy, or guidelines that HHSC becomes aware of in the ordinary course of its business.

(d) HMO is responsible for any fines, penalties, or disallowances imposed on the State or HMO arising from any noncompliance with the laws and regulations relating to the delivery of the Services or Deliverables by the HMO, its Subcontractors or agents.

(e) HMO is responsible for ensuring each of its employees, agents or Subcontractors who provide Services under the Contract are properly licensed, certified, and/or have proper permits to perform any activity related to the Services.

(f) HMO warrants that the Services and Deliverables will comply with all applicable Federal, State, and County laws, regulations, codes, ordinances, guidelines, and policies. HMO will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with HMO's failure to comply with or violation of any such law, regulation, code, ordinance, or policy.

Section 7.03 ***TDI licensure/ANHC certification and solvency.***

(a) Licensure

HMO must be either licensed by the TDI as an HMO or a certified ANHC in all counties for the Service Areas included within the scope of the Contract.

(b) Solvency

HMO must maintain compliance with the Texas Insurance Code and rules promulgated and administered by the TDI requiring a fiscally sound operation. HMO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of benefits, until the time of discharge, to Members who are confined on the date of insolvency in a Hospital or other inpatient facility;

(2) payment to unaffiliated health care providers and affiliated health care providers whose agreements do not contain member "hold harmless" clauses acceptable to TDI, and

(3) continuation of benefits for the duration of the Contract period for which HHSC has paid a Capitation Payment.

Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI.

Section 7.04 ***Immigration Reform and Control Act of 1986.***

HMO shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq*.) regarding employment verification and retention of verification forms for any individual(s) hired on or after November 6, 1986, who will perform any labor or services under this Contract.

Section 7.05 ***Compliance with state and federal anti-discrimination laws.***

HMO shall comply with Title VI of the Civil Rights Act of 1964, Executive Order 11246 (Public Law 88-352), Section 504 of the Rehabilitation Act of 1973 (Public Law 93-112), the Americans with Disabilities Act of 1990 (Public Law 101-336), and all amendments to each, and all requirements imposed by the regulations issued pursuant to these Acts. In addition, HMO shall comply with Title 40, Chapter 73 of the Texas Administrative Code, "Civil Rights," to the extent applicable to this Contract. These provide in part that no persons in the United States must, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in, or denied, any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to any discrimination.

Section 7.06 ***Environmental protection laws.***

HMO shall comply with the applicable provisions of federal environmental protection laws as described in this Section:

(a) Pro-Children Act of 1994.

HMO shall comply with the Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*), as applicable, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

(b) National Environmental Policy Act of 1969.

HMO shall comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality").

(c) Clean Air Act and Water Pollution Control Act regulations.

HMO shall comply with any applicable provisions relating to required notification of facilities violating the requirements of Executive Order 11738 ("Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, or Loans").

(d) State Clean Air Implementation Plan.

HMO shall comply with any applicable provisions requiring conformity of federal actions to State (Clean Air) Implementation Plans under §176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §740 *et seq.*).

(e) Safe Drinking Water Act of 1974.

HMO shall comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 7.07 ***HIPAA.***

HMO shall comply with applicable provisions of HIPAA. This includes, but is not limited to, the requirement that the HMO's MIS system comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. HMO must comply with HIPAA EDI requirements.

Article 8. Amendments & Modifications

Section 8.01 ***Mutual agreement.***

This Contract may be amended at any time by mutual agreement of the Parties. The amendment must be in writing and signed by individuals with authority to bind the Parties.

Section 8.02 ***Changes in law or contract.***

If Federal or State laws, rules, regulations, policies or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, the effect of which is to alter the ability of either Party to fulfill its obligations under this Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract and any schedule(s) or attachment(s) made a part of this Contract. Such modifications or alterations must be in writing and signed by individuals with authority to bind the parties, equitably adjust the terms and conditions of this Contract, and must be limited to those provisions of this Contract affected by the change.

Section 8.03 ***Modifications as a remedy.***

This Contract may be modified under the terms of **Article 12** ("Remedies and Disputes").

Section 8.04 ***Modifications upon renewal or extension of Contract.***

(a) If HHSC seeks modifications to the Contract as a condition of any Contract extension, HHSC's notice to HMO will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms and conditions.

(b) HMO must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within thirty (30) days of receipt. Upon receipt of HMO's response to the proposed modifications, HHSC may enter into negotiations with HMO to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC will provide written notice to HMO of its intent not to extend the Contract beyond the Contract Term then in effect.

Section 8.05 ***Modification of HHSC Uniform Managed Care Manual.***

(a) HHSC will provide HMO with at least thirty (30) days advance written notice before implementing a substantive and material change in the HHSC Uniform Managed Care Manual (a change that materially and substantively alters the HMO's ability to fulfill its obligations under the Contract). The Uniform Managed Care Manual, and all modifications thereto made during the Contract Term, are incorporated by reference into this Contract. HHSC will provide HMO with a reasonable amount of time to comment on such changes, generally at least ten (10) Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

(b) The Parties agree to work in good faith to resolve disagreements concerning material and substantive changes to the HHSC Uniform Managed Care Manual. If the Parties are unable to resolve issues relating to material and substantive changes, then either Party may terminate the agreement in accordance with **Article 12** ("Remedies and Disputes").

(c) Changes will be effective on the date specified in HHSC's written notice, which will not be earlier than the HMO's response deadline, and such changes will be incorporated into the HHSC Uniform Managed Care Manual. If the HMO has raised an objection to a material and substantive change to the HHSC Uniform Managed Care Manual and submitted a notice of termination in accordance with **Section 12.04(d),** HHSC will not enforce the policy change during the period of time between the receipt of the notice and the date of Contract termination.

Section 8.06 ***CMS approval of Medicaid amendments***

[Section 8.06 modified by Version 1.1]

The implementation of amendments, modifications, and changes to STAR and STAR+PLUS HMO contracts is subject to the approval of the Centers for Medicare and Medicaid Services ("CMS.")

Section 8.07 ***Required compliance with amendment and modification procedures.***

No different or additional services, work, or products will be authorized or performed except as authorized by this Article. No waiver of any term, covenant, or condition of this Contract will be valid unless executed in compliance with this Article. HMO will not be entitled to payment for any services, work or products that are not authorized by a properly executed Contract amendment or modification.

Article 9. Audit & Financial Compliance

Section 9.01 ***Financial record retention and audit.***

HMO agrees to maintain, and require its Subcontractors to maintain, supporting financial information and documents that are adequate to ensure that payment is made and the Experience Rebate is calculated in accordance with applicable Federal and State requirements, and are sufficient to ensure the accuracy and validity of HMO invoices. Such documents, including all original claims forms, will be maintained and retained by HMO or its Subcontractors for a period of five (5) years after the Contract Expiration Date or until the resolution of all litigation, claim, financial management review or audit pertaining to this Contract, whichever is longer.

Section 9.02 ***Access to records, books, and documents.***

(a) Upon reasonable notice, HMO must provide, and cause its Subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the Scope of Work.

(b) HMO and its Subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes:

(1) Examination;

(2) Audit;

(3) Investigation;

(4) Contract administration; or

(5) The making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials and/or entities:

(1) The United States Department of Health and Human Services or its designee;

(2) The Comptroller General of the United States or its designee;

(3) HMO Program personnel from HHSC or its designee;

(4) The Office of Inspector General;

(5) Any independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;

(6) The Office of the State Auditor of Texas or its designee;

(7) A State or Federal law enforcement agency;

(8) A special or general investigating committee of the Texas Legislature or its designee; and

(9) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

(d) HMO agrees to provide the access described wherever HMO maintains such books, records, and supporting documentation. HMO further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. HMO will require its Subcontractors to provide comparable access and accommodations.

Section 9.03 ***Audits of Services, Deliverables and inspections.***

(a) Upon reasonable notice from HHSC, HMO will provide, and will cause its Subcontractors to provide, such auditors and inspectors as HHSC may from time to time designate, with access to:

(1) HMO service locations, facilities, or installations; and

(2) HMO Software and Equipment.

(b) The access described in this Section will be for the purpose of examining, auditing, or investigating:

(1) HMO's capacity to bear the risk of potential financial losses;

(2) the Services and Deliverables provided;

(3) a determination of the amounts payable under this Contract;

(4) detection of fraud, waste and/or abuse; or

(5) other purposes HHSC deems necessary to perform its regulatory function and/or enforce the provisions of this Contract.

(c) HMO must provide, as part of the Scope of Work, any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

(d) If, as a result of an audit or review of payments made to the HMO, HHSC discovers a payment error or overcharge, HHSC will notify the HMO of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the HMO, or to collect such funds directly from the HMO. HMO must return funds owed to HHSC within thirty (30) days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will calculate interest at the Department of Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. In the event that an audit reveals that errors in reporting by the HMO have resulted in errors in payments to the HMO or errors in the calculation of the Experience Rebate, the HMO will indemnify HHSC for any losses resulting from such errors, including the cost of audit.

Section 9.04 ***SAO Audit***

The HMO understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. The HMO further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. The HMO will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through HMO and the requirement to cooperate is included in any Subcontract it awards, and in any third party agreements described in **Section 4.10 (a-b)**.

Section 9.05 ***Response/compliance with audit or inspection findings.***

(a) HMO must take action to ensure its or a Subcontractor's compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under this Article. This action will include HMO'S delivery to HHSC, for HHSC'S approval, a Corrective Action Plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

(b) HMO must bear the expense of compliance with any finding of noncompliance under this Section that is:

(1) Required by Texas or Federal law, regulation, rule or other audit requirement relating to HMO's business;

(2) Performed by HMO as part of the Services or Deliverables; or

(3) Necessary due to HMO's noncompliance with any law, regulation, rule or audit requirement imposed on HMO.

(c) As part of the Scope of Work, HMO must provide to HHSC upon request a copy of those portions of HMO's and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to HHSC under the Contract.

Article 10. Terms & Conditions of Payment

Section 10.01 ***Calculation of monthly Capitation Payment.***

(a) This is a Risk-based contract. For each applicable HMO Program, HHSC will pay the HMO fixed monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Members by each applicable Member Rate Cell. In consideration of the Monthly Capitation Payment(s), the HMO agrees to provide the Services and Deliverables described in this Contract.

(b) HMO will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Encounter Data provided by HMO must conform to all HHSC requirements. Encounter Data containing non-compliant information, including, but not limited to, inaccurate client or member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the HMO's experience for rate-setting purposes.

(c) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: (1) within thirty (30) days of receipt of the letter from HHSC requesting the information or data; and (2) no later than March 31st of each year.

[Section 10.01(d)(4) added by Version 1.2]

(d) The fixed monthly Capitation Rate consists of the following components:

(1) an amount for Health Care Services performed during the month;

(2) an amount for administering the program,

(3) an amount for the HMO's Risk margin, and

(4) with respect to the Medicaid program, pass through funds for high-volume providers.

Capitation Rates for each HMO Program may vary by Service Area and MCO. HHSC will employ or retain qualified actuaries to perform data analysis and calculate the Capitation Rates for each Rate Period.

(e) HMO understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

Section 10.02 ***Time and Manner of Payment.***

(a) During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Capitation Payments by the 10th Business Day of each month.

(b) The HMO must accept Capitation Payments by direct deposit into the HMO's account.

(c) HHSC may adjust the monthly Capitation Payment to the HMO in the case of an overpayment to the HMO, for Experience Rebate amounts due and unpaid, and if money damages are assessed in accordance with **Article 12** ("Remedies and Disputes").

(d) HHSC's payment of monthly Capitation Payments is subject to availability of federal and state appropriations. If appropriations are not available to pay the full monthly Capitation Payment, HHSC may:

(1) equitably adjust Capitation Payments for all participating Contractors, and reduce scope of service requirements as appropriate in accordance with **Article 8**, or

(2) terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.03 ***Certification of Capitation Rates.***

HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Capitation Rates contained in this Contract. HHSC will also employ or retain a qualified actuary to certify all revisions or modifications to the Capitation Rates.

Section 10.04 ***Modification of Capitation Rates.***

The Parties expressly understand and agree that the agreed Capitation Rates are subject to modification in accordance with **Article 8** ("Amendments and Modifications,") if changes in state or federal laws, rules, regulations or policies affect the rates or the actuarial soundness of the rates. HHSC will provide the HMO notice of a modification to the Capitation Rates 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the HMO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.05 ***STAR Capitation Structure.***

(a) STAR Rate Cells.

STAR Capitation Rates are defined on a per Member per month basis by Rate Cells and Service Areas. STAR Rate Cells are:

(1) TANF adults;

(2) TANF children over 12 months of age;

(3) Expansion children over 12 months of age;

(4) Newborns less than or equal to 12 months of age;

(5) TANF children less than or equal to 12 months of age;

(6) Expansion children less than or equal to 12 months of age;

(7) Federal mandate children; and

(8) Pregnant women.

(b) STAR Capitation Rate development:

(1) Capitation Rates for Rate Periods 1 and 2 for Service Areas with historical STAR Program participation.

For Service Areas where HHSC operated the STAR Program prior to the Effective Date of this Contract, HHSC will develop base Capitation Rates by analyzing historical STAR Encounter Data and financial data for the Service Area. This analysis will apply to all MCOs in the Service Area, including MCOs that have no historical STAR Program participation in the Service Area. The analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. If the HMO participated in the STAR Program in the Service Area prior to the Effective Date of this Contract, HHSC may modify the Service Area base Capitation Rates using diagnosis-based risk adjusters to yield the final Capitation Rates.

(2) Capitation Rates for Rate Periods 1 and 2 for Service Areas with no historical STAR Program participation.

For Service Areas where HHSC has not operated the STAR Program prior to the Effective Date of this Contract, HHSC will establish base Capitation Rates for Rate Periods 1 and 2 by analyzing Fee-for-Service claims data for the Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(3) Capitation Rates for subsequent Rate Periods for Service Areas with no historical STAR Program participation.

For Service Areas where HHSC has not operated the STAR Program prior to the Effective Date of this Contract, HHSC will establish base Capitation Rates for the Rate Periods following Rate Period 2 by analyzing historical STAR Encounter Data and financial data for the Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(c) Acuity adjustment.

HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the HMO for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all HMOs in a Service Area, and is determined by combining all the experience for all HMOs in a Service Area to get an average rate for the Service Area.

Value-added Services will not be included in the rate-setting process.

Section 10.05.1*STAR+PLUS Capitation Structure.*

[Section 10.05.1 added by Version 1.1]

(a) STAR+PLUS Rate Cells.

STAR+PLUS Capitation Rates are defined on a per Member per month basis by Rate Cells. STAR+PLUS Rate Cells are based on client category as follows:

(1) Medicaid Only Standard Rate

(2) Medicaid Only 1915 (c) Nursing Facility Waiver Rate

(3) Dual Eligible Standard Rate

(4) Dual Eligible 1915(c) Nursing Facility Waiver Rate

(5) Nursing Facility – Medicaid only

(6) Nursing Facility - Dual Eligible

These Rate Cells are subject to change after Rate Period 2.

(b) STAR+PLUS Capitation Rates

For All Service Areas, HHSC will establish base Capitation Rates by Service Area based on fee-for-service experience in the counties included in the Service Area. For the base Capitation Rate in the Harris Service Area, the encounter data from existing STAR+PLUS plans in Harris County will be blended with the fee-for-service experience from the balance of counties in the Harris Service Area. HHSC may adjust the base Capitation Rate by the HMO's Case Mix Index to yield the final Capitation Rates.

HHSC reserves the right to trend forward these rates until sufficient Encounter Data is available to base Capitation Rates on Encounter Data.

Section 10.06 ***CHIP Capitation Rates Structure.***

(a) CHIP Rate Cells.

CHIP Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to a Service Area. CHIP Rate Cells are based on the Member's age group as follows:

(1) under age one (1);

(2) ages one (1) through five (5);

(3) ages six (6) through fourteen (14); and

(4) ages fifteen (15) through eighteen (18).

(b) CHIP Capitation Rate development:

HHSC will establish base Capitation Rates by analyzing Encounter Data and financial data for each Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the Service Area base Capitation Rate using diagnosis based risk adjusters to yield the final Capitation Rates.

(c) Acuity adjustment.

HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the HMO for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all HMOs in a Service Area, and is determined by combining all the experience for all HMOs in a Service Area to get an average rate for the Service Area.

(d) Value-added Services will not be included in the rate-setting process.

Section 10.06.1 ***CHIP Perinatal Program Capitation Structure.***

[Section 10.06.1 added by Version 1.3]

(a) CHIP Perinatal Program Rate Cells.

CHIP Perinatal Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to a Service Area. CHIP Perinatal Rate Cells are based on the Member's birth status and household income as follows:

[Section 10.06.1 Modified by Version 1.5]

(1) CHIP Perinate 0% - 185% of FPL;

(2) CHIP Perinate 186% - 200% of FPL;

(3) CHIP Perinate Newborn 0% - 185% of FPL; and

(4) CHIP Perinate Newborn 186% - 200% of FPL.

(b) CHIP Perinatal Program Capitation Rate Development

Until such time as adequate encounter data is available to set rates, CHIP Perinatal Program capitation rates will be established based on experience from comparable populations in the Medicaid Fee-for-Service and STAR programs. This analysis will include: a review of historical enrollment and claims experience information; changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the Service Area based Capitation Rate using diagnosis-based risk adjusters to yield the final Capitation Rates.

(c) Value-added Services will not be included in the rate-setting process.

Section 10.07 ***HMO input during rate setting process.***

(1) In Service Areas with historical STAR or CHIP Program participation, HMO must provide certified Encounter Data and financial data as prescribed in **HHSC's Uniform Managed Care Manual**. Such information may include, without limitation: claims lag information by Rate Cell,

capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or for additional financial information from the HMO. HHSC will notify the HMO of the deadline for submitting a response, which will include a reasonable amount of time for response.

(2) HHSC will allow the HMO to review and comment on data used by HHSC to determine base Capitation Rates. In Service Areas with no historical STAR Program participation, this will include Fee-for-Service data for Rate Periods 1 and 2. HHSC will notify the HMO of deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider comments received after the deadline in its rate analysis.

(3) During the rate setting process, HHSC will conduct at least two (2) meetings with the HMO. HHSC may conduct the meetings in person, via teleconference, or by another method deemed appropriate by HHSC. Prior to the first meeting, HHSC will provide the HMO with proposed Capitation Rates. During the first meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate setting process, and receive input from the HMO. HHSC will notify the HMO of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate setting process. After reviewing such comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and changes resulting from HMO comments, if any.

Section 10.08 ***Adjustments to Capitation Payments.***

(a) Recoupment.

HHSC may recoup a payment made to the HMO for a Member if:

(1) the Member is enrolled into the HMO in error, and the HMO provided no Covered Services to the Member during the month for which the payment was made;

(2) the Member moves outside the United States, and the HMO has not provided Covered Services to the Member during the month for which the payment was made;

(3) the Member dies before the first day of the month for which the payment was made; or

(4) a Medicaid Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted.

(b) Appeal of recoupment.

The HMO may appeal the recoupment or adjustment of capitations in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.13**, ("Dispute Resolution").

Section 10.09 ***Delivery Supplemental Payment for CHIP, CHIP Perinatal and STAR HMOs.***

(a) The Delivery Supplemental Payment (DSP) is a function of the average delivery cost in each Service Area. Delivery costs include facility and professional charges.

[Section 10.09(b) modified by Version 1.3]

(b) CHIP and STAR HMOs will receive a Delivery Supplemental Payment (DSP) from HHSC for each live or stillbirth by a Member. CHIP Perinatal HMOs will receive a DSP from HHSC for each live or stillbirth by a mother of a CHIP Perinatal Program Member in the 186% to 200% FPL (measured at the time of enrollment in the CHIP Perinatal Program). CHIP Perinatal HMOs will not receive a DSP from HHSC for a live or stillbirth by the mother of a CHIP Perinatal Program Member in the 100%-185% FPL. For STAR, CHIP and CHIP Perinatal Program HMOs, the one-time DSP payment is made in the amount identified in the **HHSC Managed Care Contract** document regardless of whether there is a single birth or there are multiple births at time of delivery. A delivery is the birth of a live born infant, regardless of the duration of the pregnancy, or a stillborn (fetal death) infant of twenty (20) weeks or more of gestation. A delivery does not include a spontaneous or induced abortion, regardless of the duration of the pregnancy.

(c) HMO must submit a monthly DSP Report as described in **Attachment B-1, Section 8** to the **HHSC Managed Care Contract** document, in the format prescribed in **HHSC's Uniform Managed Care Manual**.

(d) HHSC will pay the Delivery Supplemental Payment within twenty (20) Business Days after receipt of a complete and accurate report from the HMO.

(e) The HMO will not be entitled to Delivery Supplemental Payments for deliveries that are not reported to HHSC within 210 days after the date of delivery, or within thirty (30) days from the date of discharge from the hospital for the stay related to the delivery, whichever is later.

(f) HMO must maintain complete claims and adjudication disposition documentation, including paid and denied amounts for each delivery. The HMO must submit the documentation to HHSC within five (5) Business Days after receiving a request for such information from HHSC.

Section 10.10 ***Administrative Fee for SSI Members***

(a) Administrative Fee.

STAR HMOs will receive a monthly fee for administering benefits to each SSI Beneficiary who voluntarily enrolls in the HMO (a "Voluntary SSI Member"), in the amount identified in the **HHSC Managed Care Contract** document. The HHSC will pay for Health Care Services for such Voluntary SSI

Members under the Medicaid Fee-for-Services program. SSI Beneficiaries in all Service Areas except Nueces may voluntarily participate in the STAR Program; however, HHSC reserves the right to discontinue such voluntary participation.

(b) Administrative services and functions.

(1) HMO must perform the same administrative services and functions for Voluntary SSI Members as are performed for other Members under this contract. These administrative services and functions include, but are not limited to:

(i) prior authorization of services;

(ii) all Member services functions, including linguistic services and Member materials in alternative formats for the blind and disabled;

(iii) health education;

(iv) utilization management using HHSC Administrative Services Contractor encounter data to provide service management and appropriate interventions;

(v) quality assessment and performance improvement activities;

(vi) coordination to link Voluntary SSI Members with applicable community resources and Non-capitated services.

(2) HMO must require Network Providers to submit claims for health and health-related services to the HHSC Administrative Services Contractor for claims adjudication and payment.

(3) HMO must provide services to Voluntary SSI Members within the HMO's Network unless necessary services are unavailable within Network. HMO must also allow referrals to Out-of-Network providers if necessary services are not available within the HMO's Network. Records must be forwarded to Member's PCP following a referral visit.

[Section 10.10(c) modified by Version 1.2]

(c) Members who become eligible for SSI

A Member's SSI status is effective the date the State's eligibility system identifies the Member as Type Program 13 (TP13). On this effective date, the Member becomes a voluntary STAR enrollee. The State is responsible for updating the State's eligibility system within 45 days of official notice of the Member's Federal SSI eligibility by the Social Security Administration (SSA).

[Section 10.11 modified by Versions 1.1 and 1.3]

Section 10.11 ***STAR, CHIP, and CHIP Perinatal Experience Rebate***

(a) HMO's duty to pay.

At the end of each Rate Year beginning with Rate Year 1, the HMO must pay an Experience Rebate for the STAR, CHIP, and CHIP Perinatal Programs to HHSC if the HMO's Net Income before Taxes is greater than 3% of the total Revenue for the period. The Experience Rebate is calculated in accordance with the tiered rebate method set forth below based on the consolidated Net Income before Taxes for all of the HMO's STAR, CHIP, and CHIP Perinatal Service Areas included within the scope of the Contract, as measured by any positive amount on the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC.

(b) Graduated Experience Rebate Sharing Method.

Experience Rebate as a % of Revenues	HMO Share	HHSC Share
£ 3%	100%	0%
> 3% and £ 7%	75%	25%
> 7% and £ 10%	50%	50%
> 10% and £ 15%	25%	75%
> 15%	0%	100%

HHSC and the HMO will share the Net Income before Taxes for the STAR, CHIP, and CHIP Perinatal Programs as follows, unless HHSC provides the HMO an Experience Rebate Reward in accordance with Section 6 of **Attachment B-1** to the **HHSC Managed Care Contract** document and **HHSC's Uniform Managed Care Manual**:

(1) The HMO will retain all Net Income before Taxes that is equal to or less than 3% of the total Revenues received by the HMO.

(2) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 3% but less than or equal to 7% of the total Revenues received with 75% to the HMO and 25% to HHSC.

(3) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 7% but less than or equal to 10% of the total Revenues received with 50% to the HMO and 50% to HHSC.

(4) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 10% but less than or equal to 15% of the total Revenues received with 25% to the HMO and 75% to HHSC.

(5) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 15% of the total Revenues.

(c) Net income before taxes.

The HMO must compute the Net Income before Taxes in accordance with the **HHSC Uniform Managed Care Manual's "Cost Principles for Administrative Expenses"** and **"FSR Instructions for Completion"** and applicable federal regulations. The Net Income before Taxes will be confirmed by HHSC or its agent for the Rate Year relating to all revenues and expenses incurred pursuant to the Contract. HHSC reserves the right to modify the

"Cost Principles for Administrative Expenses" and **"FSR Instructions for Completion"** found in **HHSC's Uniform Managed Care Manual** in accordance with Section 8.05.

(d) Carry forward of prior Rate Year losses.

Losses incurred by a STAR, CHIP, or CHIP Perinatal HMO for one Rate Year may be carried forward to the next Rate Year, and applied as an offset against a STAR, CHIP, or CHIP Perinatal Experience Rebate. Prior losses may be carried forward for only one Rate Year for this purpose. If the HMO offsets a loss against another STAR, CHIP, or CHIP Perinatal Service Area, only that portion of the loss that was not used as an offset may be carried forward to the next Rate Year. Losses incurred by a STAR, CHIP, CHIP Perinatal HMO cannot be offset against the STAR+PLUS Program.

(e) Settlements for payment.

(1) There will be two settlements for HMO payment(s) of the State share of the Experience Rebate for the STAR, CHIP, and CHIP Perinatal Programs. The first settlement shall equal 100% of the State share of the Experience Rebate as derived from the FSR, and shall be paid on the same day the 90-day FSR Report is submitted to HHSC, accompanied by an actuarial opinion certifying the reserve.

(2) The second settlement shall be an adjustment to the first settlement and shall be paid by the HMO to HHSC on the same day that the 334-day FSR is submitted to HHSC if the adjustment is a payment from the HMO to HHSC.

(3) HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, to determine an adjustment to the amount of the second settlement, then final adjustment shall be made within three years from the date that the HMO submits the 334-day FSR.

(4) HHSC may offset any Experience Rebates owed to the State from future Capitation Payments, or collect such sums directly from the HMO. HHSC must receive the first and second settlements by the specified due dates for the first and second FSRs respectively or HMO will incur interest on the amounts due at the current prime interest rate as set forth below. HHSC may adjust the Experience Rebate if HHSC determines the HMO has paid amounts for goods or services that are not reasonable, necessary, and allowable in accordance with the **HHSC Uniform Managed Care Manual's "Cost Principles for Administrative Expenses"** and **"FSR Instructions for Completion"** and applicable federal regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(f) Interest on Experience Rebate.

Interest on any Experience Rebate owed to HHSC shall be charged beginning thirty (30) days after the date that the first and second settlements are due. In addition, if any adjusted amount is owed to HHSC at the final settlement date, then interest will be charged on the adjusted amount owed beginning thirty (30) days after the second settlement date to the date of the final settlement payment. HHSC will calculate interest at the Department of Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which the liability is assessed.

Section 10.11.1 ***STAR+PLUS Experience Rebate***

(a) HMO's duty to pay.

At the end of each Rate Year beginning with Rate Year 1, the HMO must pay an Experience Rebate to HHSC for the STAR+PLUS Program if the HMO produces a positive Net Income in STAR+PLUS. The STAR+PLUS Experience Rebate is calculated in accordance with the tiered rebate method set forth below based on the consolidated Net Income before Taxes for all of the HMO's STAR+PLUS Service Areas included within the scope of the Contract, as measured by any positive amount on the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC.

(b) Graduated STAR+PLUS Experience Rebate Sharing Method.

Experience Rebate as a % of Revenues	HMO Share	HHSC Share
£ 3%	50%	50%
> 3%	75%	25%

HHSC and the HMO will share the Net Income before Taxes for the STAR+PLUS Program as follows, unless HHSC provides the HMO an Experience Rebate Reward in accordance with Section 6 of **Attachment B-1** to the **HHSC Managed Care Contract** document and **HHSC's Uniform Managed Care Manual**:

(1) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is equal to or less than 3% of the total STAR+PLUS Revenues received with 50% to the HMO and 50% to HHSC.

(2) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 3% of the total STAR+PLUS Revenues received with 75% to the HMO and 25% to HHSC.

(c) Net income before taxes.

The HMO must compute the Net Income before Taxes in accordance with the **HHSC Uniform Managed Care Manual's "Cost Principles for Administrative Expenses"** and **"FSR Instructions for Completion"** and applicable federal regulations.

The Net Income before Taxes will be confirmed by HHSC or its agent for the Rate Year relating to all revenues and expenses incurred pursuant to the Contract. HHSC reserves the right to modify the **"Cost Principles for Administrative Expenses"** and **"FSR Instructions for Completion"** found in **HHSC's Uniform Managed Care Manual** in accordance with Section 8.05.

(d) Carry forward of prior Rate Year losses.

Losses incurred by a STAR+PLUS HMO for one Rate Year may be carried forward to the next Rate Year, and applied as an offset against a STAR+PLUS Experience Rebate. Prior losses may be carried forward for only one Rate Year for this purpose. If the HMO offsets a loss against another STAR+PLUS Service Area, only that portion of the loss that was not used as an offset may be carried forward to the next Rate Year. Losses incurred by a STAR+PLUS HMO cannot be offset against the STAR or CHIP Programs.

(e) Settlements for payment.

(1) There will be two settlements for HMO payment(s) of the State share of the Experience Rebate for the STAR+PLUS. The first settlement shall equal 100% of the State share of the Experience Rebate as derived from the FSR, and shall be paid on the same day the 90-day FSR Report is submitted to HHSC, accompanied by an actuarial opinion certifying the reserve.

(2) The second settlement shall be an adjustment to the first settlement and shall be paid by the HMO to HHSC on the same day that the 334-day FSR is submitted to HHSC if the adjustment is a payment from the HMO to HHSC.

(3) HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, to determine an adjustment to the amount of the second settlement, then final adjustment shall be made within three years from the date that the HMO submits the 334-day FSR.

(4) HHSC may offset any Experience Rebates owed to the State from future STAR+PLUS Capitation Payments, or collect such sums directly from the HMO. HHSC must receive the first and second settlements by the specified due dates for the first and second FSRs respectively or HMO will incur interest on the amounts due at the current prime interest rate as set forth below.

(f) Interest on Experience Rebate.

Interest on any Experience Rebate owed to HHSC shall be charged beginning thirty (30) days after the date that the first and second settlements are due. In addition, if any adjusted amount is owed to HHSC at the final settlement date, then interest will be charged on the adjusted amount owed beginning thirty (30) days after the second settlement date to the date of the final settlement payment. HHSC will calculate interest at the Department of Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which the liability is assessed.

Section 10.12 ***Payment by Members.***

(a) Medicaid HMOs

Medicaid HMOs and their Network Providers are prohibited from billing or collecting any amount from a Member for Health Care Services covered by this Contract. HMO must inform Members of costs for non-covered services, and must require its Network Providers to:

(1) inform Members of costs for non-covered services prior to rendering such services; and

(2) obtain a signed Private Pay form from such Members.

(b) CHIP HMOs.

(1) Families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service Contractor notifies the HMO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost-sharing limit for the term of coverage, the HMO will generate and mail to the CHIP Member a new Member ID card within five days, showing that the CHIP Member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

(2) Providers are responsible for collecting all CHIP Member co-payments at the time of service. Co-payments that families must pay vary according to their income level. No co-payments apply, at any income level, to well-child or well-baby visits or immunizations. Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the co-payments outlined in the CHIP Cost Sharing table in **the HHSC Uniform Managed Care Manual** are the only amounts that a provider may collect from a CHIP-eligible family.

(3) Federal law prohibits charging cost-sharing or deductibles to CHIP Members of Native Americans or Alaskan Natives. The HHSC Administrative Services Contractor will notify the HMO of CHIP Members who are not subject to cost-sharing requirements. The HMO is responsible for educating Providers regarding the cost-sharing waiver for this population.

(4) An HMO's monthly Capitation Payment will not be reduced for a family's failure to make its CHIP premium payment. There is no relationship between the per Member/per month amount owed to the HMO for coverage provided during a month and the family's payment of its CHIP premium obligation for that month.

[Section 10.12(c) added by Version 1.3]

(c) CHIP Perinatal HMOs

Cost-sharing does not apply to CHIP Perinatal Program Members. The exemption from cost-sharing applies through the end of the original 12-month enrollment period.

Section 10.13 ***Restriction on assignment of fees.***

During the term of the Contract, HMO may not, directly or indirectly, assign to any third party any beneficial or legal interest of the HMO in or to any payments to be made by HHSC pursuant to this Contract. This restriction does not apply to fees paid to Subcontractors.

Section 10.14 ***Liability for taxes.***

HHSC is not responsible in any way for the payment of any Federal, state or local taxes related to or incurred in connection with the HMO's performance of this Contract. HMO must pay and discharge any and all such taxes, including any penalties and interest. In addition, HHSC is exempt from Federal excise taxes, and will not pay any personal property taxes or income taxes levied on HMO or any taxes levied on employee wages.

Section 10.15 ***Liability for employment-related charges and benefits.***

HMO will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. HMO is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of this Contract, including but not limited to salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for Staff.

Section 10.16 ***No additional consideration.***

(a) HMO will not be entitled to nor receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

(b) No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the HMO to withhold Services and Deliverables due under the Agreement.

(c) HMO will not be entitled by virtue of the Contract to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

[Section 10.17 added by Version 1.2]

Section 10.17 ***Federal Disallowance***

If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the HMOs for these same expenses and/or costs, even if they had not been previously disallowed by the state and were incurred by the HMO, and any such expenses and/or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the HMOs due to a federal disallowance, the state will recoup the entire amount paid to the HMO for the federally disallowed expenses and/or costs, not just the federal portion.

Article 11. Disclosure & Confidentiality of Information

Section 11.01 ***Confidentiality.***

(a) HMO and all Subcontractors, consultants, or agents under the Contract must treat all information that is obtained through performance of the Services under the Contract, including, but not limited to, information relating to applicants or recipients of HHSC Programs as Confidential Information to the extent that confidential treatment is provided under law and regulations.

(b) HMO is responsible for understanding the degree to which information obtained through performance of this Contract is confidential under State and Federal law, regulations, or administrative rules.

(c) HMO and all Subcontractors, consultants, or agents under the Contract may not use any information obtained through performance of this Contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Contract.

(d) HMO must have a system in effect to protect all records and all other documents deemed confidential under this Contract maintained in connection with the activities funded under the Contract. Any disclosure or transfer of Confidential Information by HMO, including information required by HHSC, will be in accordance with applicable law. If the HMO receives a request for information deemed confidential under this Contract, the HMO will immediately notify HHSC of such request, and will make reasonable efforts to protect the information from public disclosure.

(e) In addition to the requirements expressly stated in this Section, HMO must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to Members, HMO'S operations, or HMO's performance of the Contract.

(f) In the event of the expiration of the Contract or termination of the Contract for any reason, all Confidential Information disclosed to and all copies thereof made by the HMOI shall be returned to HHSC or, at HHSC's option, erased or destroyed. HMO shall provide HHSC certificates evidencing such destruction.

(g) The obligations in this Section shall not restrict any disclosure by the HMO pursuant to any applicable law, or by order of any court or government agency, provided that the HMO shall give prompt notice to HHSC of such order.

(h) With the exception of confidential Member information, Confidential Information shall not be afforded the protection of the Contract if such data was:

(1) Already known to the receiving Party without restrictions at the time of its disclosure by the furnishing Party;

(2) Independently developed by the receiving Party without reference to the furnishing Party's Confidential Information;

(3) Rightfully obtained by the other Party without restriction from a third party after its disclosure by the furnishing Party;

(4) Publicly available other than through the fault or negligence of the other Party; or

(5) Lawfully released without restriction to anyone.

Section 11.02 ***Disclosure of HHSC's Confidential Information.***

(a) HMO will immediately report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its Subcontractor(s), consultant(s), or agent(s) is aware or has knowledge. HMO acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of State or federal laws. If HMO, its Subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover from HMO all damages and liabilities caused by or arising from HMO's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. HMO will defend with counsel approved by HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses (including without limitation reasonable attorneys' fees and costs) caused by or arising from HMO's or its Subcontractors', consultants' or agents' failure to protect HHSC's Confidential Information. HHSC will not unreasonably withhold approval of counsel selected by the HMO.

(b) HMO will require its Subcontractor(s), consultant(s), and agent(s) to comply with the terms of this provision.

Section 11.03 ***Member Records***

(a) HMO must comply with the requirements of state and federal laws, including the HIPAA requirements set forth in **Section 7.07**, regarding the transfer of Member Records.

(b) If at any time during the Contract Term this Contract is terminated, HHSC may require the transfer of Member Records, upon written notice to HMO, to another entity, as consistent with federal and state laws and applicable releases.

(c) The term "Member Record" for this Section means only those administrative, enrollment, case management and other such records maintained by HMO and is not intended to include patient records maintained by participating Network Providers.

Section 11.04 ***Requests for public information.***

(a) HHSC agrees that it will promptly notify HMO of a request for disclosure of information filed in accordance with the Texas Public Information Act, Chapter 552 of the Texas Government Code, that consists of the HMO'S confidential information, including without limitation, information or data to which HMO has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to HMO.

(b) With respect to any information that is the subject of a request for disclosure, HMO is required to demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise excepted from required public disclosure under law. HMO will provide HHSC with copies of all such communications.

(c) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from HMO that the HMO believes to be confidential information. HMO must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

Section 11.05 ***Privileged Work Product.***

(a) HMO acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that HMO is performing the Services with respect to privileged work product as an agent of HHSC, and that all matters related thereto are protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

(b) HHSC will notify HMO of any privileged work product to which HMO has or may have access. After the HMO is notified or otherwise becomes aware that such documents, data, database, or communications are privileged work product, only HMO personnel, for whom such access is necessary for the purposes of providing the Services, may have access to privileged work product.

(c) If HMO receives notice of any judicial or other proceeding seeking to obtain access to HHSC's privileged work product, HMO will:

(1) Immediately notify HHSC; and

(2) Use all reasonable efforts to resist providing such access.

(d) If HMO resists disclosure of HHSC's privileged work product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable State law, have the right and duty to:

(1) represent HMO in such resistance;

(2) to retain counsel to represent HMO; or

(3) to reimburse HMO for reasonable attorneys' fees and expenses incurred in resisting such access.

(e) If a court of competent jurisdiction orders HMO to produce documents, disclose data, or otherwise breach the confidentiality obligations imposed in the Contract, or otherwise with respect to maintaining the confidentiality, proprietary nature, and secrecy of privileged work product, HMO will not be liable for breach of such obligation.

Section 11.06 ***Unauthorized acts.***

Each Party agrees to:

(1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any HHSC Confidential Information or any information identified by the HMO as confidential or proprietary;

(2) Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information;

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

(4) Promptly prevent a reoccurrence of any such unauthorized possession, use, or knowledge such information.

Section 11.07 ***Legal action.***

Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof by any person or entity of HHSC's Confidential Information or information identified by the HMO as confidential or proprietary, which action or proceeding identifies the other Party such information without such Party's consent.

Article 12. Remedies & Disputes

Section 12.01 ***Understanding and expectations.***

The remedies described in this Section are directed to HMO's timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The HMO is expected to meet or exceed all HHSC objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility and/or requirement. Any and all responsibilities and/or requirements not fulfilled may be subject to remedies set forth in the Contract.

Section 12.02 ***Tailored remedies.***

(a) Understanding of the Parties.

HMO agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Notice and opportunity to cure for non-material breach.

(1) HHSC will notify HMO in writing of specific areas of HMO performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) HMO will, within five (5) Business Days (or another date approved by HHSC) of receipt of written notice of a non-material deficiency, provide the HHSC Project Manager a written response that:

(A) Explains the reasons for the deficiency, HMO's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

(B) If HMO disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

(3) HMO's proposed cure of a non-material deficiency is subject to the approval of HHSC. HMO's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Contract or any other appropriate remedy HHSC may have at law or equity.

(c) Corrective action plan.

(1) At its option, HHSC may require HMO to submit to HHSC a written plan (the "Corrective Action Plan") to correct or resolve a material breach of this Contract, as determined by HHSC.

(2) The Corrective Action Plan must provide:

(A) A detailed explanation of the reasons for the cited deficiency;

(B) HMO's assessment or diagnosis of the cause; and

(C) A specific proposal to cure or resolve the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify HMO in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts HMO's proposed Corrective Action Plan, HHSC may:

(A) Condition such approval on completion of tasks in the order or priority that HHSC may reasonably prescribe;

(B) Disapprove portions of HMO's proposed Corrective Action Plan; or

(C) Require additional or different corrective action(s).

Notwithstanding the submission and acceptance of a Corrective Action Plan, HMO remains responsible for achieving all written performance criteria.

(5) HHSC's acceptance of a Corrective Action Plan under this Section will not:

(A) Excuse HMO's prior substandard performance;

(B) Relieve HMO of its duty to comply with performance standards; or

(C) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(A) Assess liquidated damages in accordance with **Attachment B-5** to the **HHSC Managed Care Contract**, "Liquidated Damages Matrix;"

(B) Conduct accelerated monitoring of the HMO. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

(C) Require additional, more detailed, financial and/or programmatic reports to be submitted by HMO;

(D) Decline to renew or extend the Contract;

(E) Appoint temporary management;

(F) Initiate disenrollment of a Member or Members;

(G) Suspend enrollment of Members;

(H) Withhold or recoup payment to HMO;

(I) Require forfeiture of all or part of the HMO's bond; or

(J) Terminate the Contract in accordance with **Section 12.03**, ("Termination by HHSC").

(2) For purposes of the Contract, an item of material noncompliance means a specific action of HMO that:

(A) Violates a material provision of the Contract;

(B) Fails to meet an agreed measure of performance; or

(C) Represents a failure of HMO to be reasonably responsive to a reasonable request of HHSC relating to the Services for information, assistance, or support within the timeframe specified by HHSC.

(3) HHSC will provide notice to HMO of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require HMO to file a written response in accordance with this Section.

(4) The Parties agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) Damages.

(1) HHSC will be entitled to actual and consequential damages resulting from the HMO'S failure to comply with any of the terms of the Contract. In some cases, the actual damage to HHSC or State

of Texas as a result of HMO'S failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the HMO in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the HHSC in **Attachment B-5 to the HHSC Managed Care Contract,** "Deliverables/Liquidated Damages Matrix." Liquidated damages will be assessed if HHSC determines such failure is the fault of the HMO (including the HMO'S Subcontractors and/or consultants) and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the HMO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the HMO's nonperformance, including financial loss as a result of project delays. Accordingly, in the event HMO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If HMO fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

(A) Through direct assessment and demand for payment delivered to HMO; or

(B) By deduction of amounts assessed as liquidated damages as set-off against payments then due to HMO or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the HMO is received by HHSC.

(f) Equitable Remedies

(1) HMO acknowledges that, if HMO breaches (or attempts or threatens to breach) its material obligation under this Contract, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that HMO breached (or attempted or threatened to breach) any such obligations, HMO agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by HMO and restraining it from any further breaches (or attempted or threatened breaches).

(g) Suspension of Contract

(1) HHSC may suspend performance of all or any part of the Contract if:

(A) HHSC determines that HMO has committed a material breach of the Contract;

(B) HHSC has reason to believe that HMO has committed, assisted in the commission of Fraud, Abuse, Waste, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

(C) HHSC determines that the HMO knew, or should have known of, Fraud, Abuse, Waste, malfeasance, or nonfeasance by any party concerning the Contract, and the HMO failed to take appropriate action; or

(D) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify HMO in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(A) Be delivered in writing to HMO;

(B) Include a concise description of the facts or matter leading to HHSC's decision; and

(C) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from HMO or describe actions that HMO may take to avoid the contemplated suspension of the Contract.

Section 12.03 ***Termination by HHSC.***

This Contract will terminate upon the Expiration Date. In addition, prior to completion of the Contract Term, all or a part of this Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC.

HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC's notice of termination.

(b) Termination for cause.

HHSC reserves the right to terminate this Contract, in whole or in part, upon the following conditions:

(1) *Assignment for the benefit of creditors, appointment of receiver, or inability to pay debts*. HHSC may terminate this Contract at any time if HMO:

(A) Makes an assignment for the benefit of its creditors;

(B) Admits in writing its inability to pay its debts generally as they become due; or

(C) Consents to the appointment of a receiver, trustee, or liquidator of HMO or of all or any part of its property.

(2) *Failure to adhere to laws, rules, ordinances, or orders.*

HHSC may terminate this Contract if a court of competent jurisdiction finds HMO failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of HMO's duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(3) Breach *of confidentiality*.

HHSC may terminate this Contract at any time if HMO breaches confidentiality laws with respect to the Services and Deliverables provided under this Contract.

(4) *Failure to maintain adequate personnel or resources.*

HHSC may terminate this Contract if, after providing notice and an opportunity to correct, HHSC determines that HMO has failed to supply personnel or resources and such failure results in HMO's inability to fulfill its duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(5) *Termination for gifts and gratuities*.

(A) HHSC may terminate this Contract at any time following the determination by a competent judicial or quasi-judicial authority and HMO's exhaustion of all legal remedies that HMO, its employees, agents or representatives have either offered or given any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law.

(B) HMO must include a similar provision in each of its Subcontracts and shall enforce this provision against a Subcontractor who has offered or given any thing of value to any of the persons or entities described in this Section, whether or not the offer or gift was in HMO's behalf.

(C) Termination of a Subcontract by HMO pursuant to this provision will not be a cause for termination of the Contract unless:

(1) HMO fails to replace such terminated Subcontractor within a reasonable time; and

(2) Such failure constitutes cause, as described in this Subsection 12.03(b).

(D) For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with State and/or Federal law.

(6) *Termination for non-appropriation of funds*.

Notwithstanding any other provision of this Contract, if funds for the continued fulfillment of this Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate this Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least thirty (30) days advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) *Judgment and execution.*

(A) HHSC may terminate the Contract at any time if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against HMO, and HMO does not:

(1) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(2) Procure a stay of execution of the judgment within thirty (30) days from the date of entry thereof; or

(3) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.

(B) If a writ or warrant of attachment or any similar process is issued by any court against all

or any material portion of the property of HMO, and such writ or warrant of attachment or any similar process is not released or bonded within thirty (30) days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) *Termination for insolvency*.

(A) HHSC may terminate the Contract at any time if HMO:

(1) Files for bankruptcy;

(2) Becomes or is declared insolvent, or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar officer for it;

(3) Makes an assignment for the benefit of all or substantially all of its creditors; or

(4) Enters into an Contract for the composition, extension, or readjustment of substantially all of its obligations.

(B) HMO agrees to pay for all reasonable expenses of HHSC including the cost of counsel, incident to:

(1) The enforcement of payment of all obligations of the HMO by any action or participation in, or in connection with a case or proceeding under Chapters 7, 11, or 13 of the United States Bankruptcy Code, or any successor statute;

(2) A case or proceeding involving a receiver or other similar officer duly appointed to handle the HMO's business; or

(3) A case or proceeding in a State court initiated by HHSC when previous collection attempts have been unsuccessful.

(9) *Termination for HMO'S material breach of the Contract.*

HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that HMO has materially breached the Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

Section 12.04 ***Termination by HMO.***

(a) Failure to pay.

HMO may terminate this Contract if HHSC fails to pay the HMO undisputed charges when due as required under this Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under this Contract or that result from the HMO's failure to perform or the HMO's default under the terms of this Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date.

If HHSC fails to pay undisputed charges when due, then the HMO may submit a notice of intent to terminate for failure to pay in accordance with the requirements of **Subsection 12.04(d)**. If HHSC pays all undisputed amounts then due within thirty (30)-days after receiving the notice of intent to terminate, the HMO cannot proceed with termination of the Contract under this Article.

(b) Change to HHSC Uniform Managed Care Manual.

HMO may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the HHSC Uniform Managed Care Manual (a change that materially and substantively alters the HMO's ability to fulfill its obligations under the Contract). HMO must submit a notice of intent to terminate due to a material and substantive change in the HHSC Uniform Managed Care Manual no later than thirty (30) days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Capitation Rate.

If HHSC proposes a modification to the Capitation Rate that is unacceptable to the HMO, the HMO may terminate the Contract. HMO must submit a written notice of intent to terminate due to a change in the Capitation Rate no later than thirty (30) days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Notice of intent to terminate.

In order to terminate the Contract pursuant to this Section, HMO must give HHSC at least ninety (90) days written notice of intent to terminate. The termination date will be calculated as the last day of the month following ninety (90) days from the date the notice of intent to terminate is received by HHSC.

Section 12.05 ***Termination by mutual agreement.***

This Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 ***Effective date of termination.***

Except as otherwise provided in this Contract, termination will be effective as of the date specified in the notice of termination.

Section 12.07 ***Extension of termination effective date.***

The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 ***Payment and other provisions at Contract termination.***

(a) In the event of termination pursuant to this Article, HHSC will pay the Capitation Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) HMO must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under this Contract.

(c) HMO must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

Section 12.09 ***Modification of Contract in the event of remedies.***

HHSC may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with **Article 8**. HMO must negotiate such proposed modifications in good faith.

Section 12.10 ***Turnover assistance.***

Upon receipt of notice of termination of the Contract by HHSC, HMO will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Contract and move the work to another vendor or to perform the work itself.

Section 12.11 ***Rights upon termination or expiration of Contract.***

In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables and/or documentation in whatever form that they exist.

Section 12.12 ***HMO responsibility for associated costs.***

If HHSC terminates the Contract for Cause, the HMO will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the HMO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to HMO's failure to perform any Service in accordance with the terms of the Contract

Section 12.13 ***Dispute resolution.***

(a) General agreement of the Parties.

The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under this Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith.

Any dispute that in the judgment of any Party to this Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within ten (10) Business Days.

(c) Claims for breach of Contract.

(1) *General requirement.* HMO's claim for breach of this Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) *Negotiation of claims*. The Parties expressly agree that the HMO's claim for breach of this Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

(A) To initiate the process, HMO must submit written notice to HHSC that specifically states that HMO invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(B) The Parties expressly agree that the HMO's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) *Contested case proceedings*. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be HMO's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under Subsection (c)(2) of this Section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil

Practices & Remedies Code. Neither the execution of this Contract by HHSC nor any other conduct of any representative of HHSC relating to this Contract shall be considered a waiver of HHSC's sovereign immunity to suit.

(4) *HHSC rules.* The submission, processing and resolution of HMO's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code, found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(5) *HMO's duty to perform.* Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by HMO of any duty or obligation with respect to the performance of this Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with **Article 8** ("Amendments and Modifications").

Section 12.14 ***Liability of HMO.***

(a) HMO bears all risk of loss or damage to HHSC or the State due to:

(1) Defects in Services or Deliverables;

(2) Unfitness or obsolescence of Services or Deliverables; or

(3) The negligence or intentional misconduct of HMO or its employees, agents, Subcontractors, or representatives.

(b) HMO must, at the HMO's own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys' fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the HMO and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by HMO.

(c) HMO will not be liable to HHSC for any loss, damages or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with this Contract.

Article 13. Assurances & Certifications

Section 13.01 ***Proposal certifications.***

HMO acknowledges its continuing obligation to comply with the requirements of the following certifications contained in its Proposal, and will immediately notify HHSC of any changes in circumstances affecting these certifications:

(1) Federal lobbying;

(2) Debarment and suspension;

(3) Child support; and

(4) Nondisclosure statement.

Section 13.02 ***Conflicts of interest.***

(a) Representation.

HMO agrees to comply with applicable state and federal laws, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. HMO warrants that it has no interest and will not acquire any direct or indirect interest that would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest.

HMO will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. HMO will operate with complete independence and objectivity without actual, potential or apparent conflict of interest with respect to the activities conducted under this Contract with the State of Texas.

Section 13.03 ***Organizational conflicts of interest.***

(a) Definition.

An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which a HMO, or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the HMO's, or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the HMO or Subcontractor an unfair competitive advantage in future HHSC procurements (excluding the award of this Contract).

(b) Warranty.

Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, HMO warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Contract. HMO affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) HMO agrees that, if after the Effective Date, HMO discovers or is made aware of an organizational conflict of interest, HMO will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, HMO must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by HMO or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and HMO agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the action(s) that HMO has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy.

If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to **Subsection 12.03(b)(9).** If HHSC determines that HMO was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow down obligation.

HMO must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by HMO, and the terms "Contract," "HMO," and "project manager" modified appropriately to preserve the State's rights.

Section 13.04 ***HHSC personnel recruitment prohibition.***

HMO has not retained or promised to retain any person or company, or utilized or promised to utilize a consultant that participated in HHSC's development of specific criteria of the RFP or who participated in the selection of the HMO for this Contract.

Unless authorized in writing by HHSC, HMO will not recruit or employ any HHSC professional or technical personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two (2) years following the completion of this Contract.

Section 13.05 ***Anti-kickback provision.***

HMO certifies that it will comply with the Anti-Kickback Act of 1986, 41 U.S.C. §51-58 and Federal Acquisition Regulation 52.203-7, to the extent applicable.

Section 13.06 ***Debt or back taxes owed to State of Texas.***

In accordance with Section 403.055 of the Texas Government Code, HMO agrees that any payments due to HMO under the Contract will be first applied toward any debt and/or back taxes HMO owes State of Texas. HMO further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 ***Certification regarding status of license, certificate, or permit.***

Article IX, Section 163 of the General Appropriations Act for the 1998/1999 state fiscal biennium prohibits an agency that receives an appropriation under either Article II or V of the General Appropriations Act from awarding a contract with the owner, operator, or administrator of a facility that has had a license, certificate, or permit revoked by another Article II or V agency. HMO certifies it is not ineligible for an award under this provision.

Section 13.08 ***Outstanding debts and judgments.***

HMO certifies that it is not presently indebted to the State of Texas, and that HMO is not subject to an outstanding judgment in a suit by State of Texas against HMO for collection of the balance. For purposes of this Section, an indebtedness is any amount sum of money that is due and owing to the State of Texas and is not currently under dispute. A false statement regarding HMO's status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

Article 14. Representations & Warranties

Section 14.01 ***Authorization.***

(a) The execution, delivery and performance of this Contract has been duly authorized by HMO and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for HMO to enter into this Contract and perform its obligations under this Contract.

(b) HMO has obtained all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of HMO's performance of this Contract. HMO will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 ***Ability to perform.***

HMO warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 ***Minimum Net Worth.***

The HMO has, and will maintain throughout the life of this Contract, minimum net worth to the greater of (a) $1,500,000; (b) an amount equal to the sum of twenty-five dollars ($25) times the number of all enrollees including Members; or (c) an amount that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

Section 14.04 ***Insurer solvency.***

(a) The HMO must be and remain in full compliance with all applicable state and federal solvency requirements for basic-service health maintenance organizations, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. In the event the HMO fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the HMO becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the requirements of the Contract or its ability to pay its debts as they come due, the HMO must notify HHSC immediately in writing.

(c) The HMO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of Covered Services, until the time of discharge, to Members who are confined on the date of insolvency in a hospital or other inpatient facility;

(2) payments to unaffiliated health care providers and affiliated healthcare providers whose Contracts do not contain Member “hold harmless” clauses acceptable to the TDI;

(3) continuation of Covered Services for the duration of the Contract Period for which a capitation has been paid for a Member;

(4) provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the HMO is unable to provide Covered Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

Section 14.05 ***Workmanship and performance.***

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) HMO will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the services described in this Contract.

Section 14.06 ***Warranty of deliverables.***

HMO warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by HMO and HHSC. HMO will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.07 ***Compliance with Contract.***

HMO will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

Section 14.08 ***Technology Access***

(a) HMO expressly acknowledges that State funds may not be expended in connection with the purchase of an automated information system unless that system meets certain statutory requirements relating to accessibility by persons with visual impairments. Accordingly, HMO represents and warrants to HHSC that this technology is capable, either by virtue of features included within the technology or because it is readily adaptable by use with other technology, of:

(1) Providing equivalent access for effective use by both visual and non-visual means;

(2) Presenting information, including prompts used for interactive communications, in formats intended for non-visual use; and

(3) Being integrated into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired.

(b) For purposes of this Section, the phrase “equivalent access” means a substantially similar ability to communicate with or make use of the technology, either directly by features incorporated within the technology or by other reasonable means

such as assistive devices or services that would constitute reasonable accommodations under the Americans with Disabilities Act or similar State or Federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands and other means of navigating graphical displays, and customizable display appearance.

(c) In addition, all technological solutions offered by the HMO must comply with the requirements of Texas Government Code §531.0162. This includes, but is not limited to providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Article 15. Intellectual Property

Section 15.01 ***Infringement and misappropriation.***

(a) HMO warrants that all Deliverables provided by HMO will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) HMO will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys' fees and expenses, from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. HHSC will promptly notify HMO in writing of the claim, provide HMO a copy of all information received by HHSC with respect to the claim, and cooperate with HMO in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the HMO.

(c) In case the Deliverables, or any one or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to HMO to be likely to be brought, HMO will, at its own expense, either:

(1) Procure for HHSC the right to continue using the Deliverables; or

(2) Modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the HMO on commercially reasonable terms, HMO may require that HHSC return the allegedly infringing Deliverable(s) in which case HMO will refund all amounts paid for all such Deliverables.

Section 15.02 ***Exceptions.***

HMO is not responsible for any claimed breaches of the warranties set forth in Section 15.01 to the extent caused by:

(a) Modifications made to the item in question by anyone other than HMO or its Subcontractors, or modifications made by HHSC or its contractors working at HMO's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if HMO did not supply or approve for use with the item; or

(c) HHSC's failure to use any new or corrected versions of the item made available by HMO.

Section 15.03 ***Ownership and Licenses***

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

(1) "**Custom Software**" means any software developed by the HMO: for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include HMO Proprietary Software or Third Party Software.

(2) "**HMO Proprietary Software**" means software: (i) developed by the HMO prior to the Effective Date of the Contract, or (ii) software developed by the HMO after the Effective Date of the Contract that is not developed: for HHSC; in connection with the Contract; and with funds received from HHSC.

(3) "**Third Party Software**" means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables.

The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the HMO, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include HMO Proprietary Software or Third Party Software. HMO will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) HMO will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will

be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, HMO agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein (including renewals thereof) to HHSC.

(3) HMO will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. HMO agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. HMO also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

(d) License Rights

HHSC will have a royalty-free and non-exclusive license to access the HMO Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by HMO under or resulting from the Contract. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from HMO in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices

HMO will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by HMO on such copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments

In accordance with 45 C.F.R. §95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

Article 16. Liability

Section 16.01 ***Property damage.***

(a) HMO will protect HHSC's real and personal property from damage arising from HMO's, its agent's, employees' and Subcontractors' performance of the Contract, and HMO will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by HMO's, its agents', employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, HMO will notify the HHSC Project Manager thereof and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) HMO agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) HMO will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to HMO any special defect or unsafe condition encountered while on HHSC premises. HMO will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 16.02 ***Risk of Loss.***

During the period Deliverables are in transit and in possession of HMO, its carriers or HHSC prior to being accepted by HHSC, HMO will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of HMO's agents, employees or Subcontractors.

Section 16.03 ***Limitation of HHSC's Liability.***

HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.

HHSC'S LIABILITY TO HMO UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO HMO UNDER THE CONTRACT, INCLUDING CHANGE ORDER PRICES AGREED TO BY THE PARTIES OR OTHERWISE ADJUDICATED.

HMO's remedies are governed by the provisions in Article 12.

Article 17. Insurance & Bonding

Section 17.01 modified by Versions 1.2 and 1.5

Section 17.01 ***Insurance Coverage.***

(a) Statutory and General Coverage

HMO will maintain the following insurance coverage.

(1) Standard Worker's Compensation Insurance coverage;

(2) Automobile Liability;

(3) Comprehensive Liability Insurance including Bodily Injury coverage of $100,000.00 per each occurrence and Property Damage Coverage of $25,000.00 per each occurrence; and

(4) General Liability Insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate.

If HMO's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, HMO will obtain excess liability insurance to compensate for the difference in the coverage amounts.

(b) Professional Liability Coverage.

(1) HMO must maintain, or cause its Network Providers to maintain, Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate, or the limits required by the hospital at which the Network Provider has admitting privileges.

(2) HMO must maintain an Umbrella Professional Liability Insurance Policy for the greater of $3,000,000.00 or an amount (rounded to the nearest $100,000.00) that represents the number of Members enrolled in the HMO in the first month of the applicable State Fiscal Year multiplied by $150.00, not to exceed $10,000,000.00.

(c) General Requirements for All Insurance Coverage

(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC. HHSC's written approval is not required in the following situations:

(A) An HMO or a Network Provider is not required to obtain the insurance coverage described in Section 17.01 if the HMO or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to the provisions of, the Texas Tort Claims Act.

(B) An HMO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for a Network Provider of Community-based Long Term Care Services. An HMO may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-based Long Term Care Services, or if a Texas licensing entity requires the Network Provider to carry such Professional Liability coverage. An HMO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(2) HMO or the Network Provider is responsible for any and all deductibles stated in the insurance policies.

(3) Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.

(4) Insurance coverage must name HHSC as an additional insured with the following exceptions: Standard Workers' Compensation Insurance maintained by the HMO, and Professional Liability Insurance maintained by Network Providers.

(5) Insurance coverage kept by the HMO must be maintained throughout the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this Contract.

(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have extended reporting periods of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.

(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice to be given to HHSC at least thirty (30) calendar days before coverage is substantially changed, canceled, or non-renewed. HMO must submit a new coverage binder to HHSC to ensure no break in coverage.

(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by HMO will in no way expand or limit HMO's liabilities and responsibilities specified within the Contract documents or by applicable law.

(9) HMO expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by HMO under the Contract.

(10) If HMO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, HMO or its Network Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.

(d) Proof of Insurance Coverage

(1) Except as provided in Section 17.01(d)(2), the HMO must furnish the HHSC Project Manager original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the HMO must furnish the HHSC Project Manager renewal certificates of insurance, or such similar evidence, within five (5) Business Days of renewal. The failure of HHSC to obtain such evidence from HMO will not be deemed to be a waiver by HHSC and HMO will remain under continuing obligation to maintain and provide proof of insurance coverage.

(2) The HMO is not required to furnish the HHSC Project Manager proof of Professional Liability Insurance maintained by Network Providers on or before the Effective Date of the Contract, but must provide such information upon HHSC's request during the Term of the Contract.

Section 17.02 ***Performance Bond.***

(a) Beginning on the Operational Start Date of the Contract, and each year thereafter, the HMO must obtain a performance bond with a one (1) year term. The performance bond must continue to be in effect for one (1) year following the expiration of the one (1) year term. HMO must obtain and maintain the annual performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing HMO's faithful performance of the terms and conditions of this Contract. The annual performance bonds must comply with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. The annual performance bond(s) must be issued in the amount of $100,000.00 for each applicable HMO Program within each Service Area that the HMO covers under this Contract. All performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. HMO must deliver the initial performance bond to HHSC prior to the Operational Start Date of the Contract, and each renewal performance bond prior to the first day of the State Fiscal Year.

Section 17.02(b) added by Version 1.5

(b) Since the CHIP Perinatal Program is a sub-program of the CHIP Program, neither a separate performance bond for the CHIP Perinatal Program nor a combined performance bond for the CHIP and CHIP Perinatal Programs is required. The same bond that the HMO obtains for its CHIP Program within a particular Service Area also will cover the HMO's CHIP Perinatal Program, if applicable, in that same Service Area.

Section 17.03 ***TDI Fidelity Bond***

The HMO will secure and maintain throughout the life of the Contract a fidelity bond in compliance with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. The HMO must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

6. Premium Payment, Incentives, and Disincentives

This section documents how the Capitation Rates are developed and describes performance incentives and disincentives related to HHSC's value-based purchasing approach. For further information, HMOs should refer to the HHSC **Uniform Managed Care Contract Terms and Conditions**.

Under the HMO Contracts, health care coverage for Members will be provided on a fully insured basis. The HMO must provide the Services and Deliverables, including Covered Services to enrolled Members in order for monthly Capitation Payments to be paid by HHSC. Attachment B-1, **Section 8** includes the HMO's financial responsibilities regarding out-of-network Emergency Services and Medically Necessary Covered Services not available through Network Providers.

6.1 Capitation Rate Development

Refer to **Attachment A**, **HHSC Uniform Managed Care Contract Terms & Conditions, Article 10, "Terms & Conditions of Payment,"** for information concerning Capitation Rate development.

6.2 Financial Payment Structure and Provisions

HHSC will pay the HMO monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Member Months times the applicable monthly Capitation Rate by Member Rate Cell. The HMO must provide the Services and Deliverables, including Covered Services to Members, described in the Contract for monthly Capitation Payments to be paid by HHSC.

The HMO must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to HHSC, delays or denials of required approvals, cost of claims incorrectly paid by the HMO, and cost overruns not reasonably attributable to HHSC. The HMO must further agree that no other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the HMO to withhold Services or Deliverables due under the Contract.

6.2.1 Capitation Payments

The HMO must refer to the **HHSC Uniform Managed Care Contract Terms & Conditions** for information and Contract requirements on the:

1) Time and Manner of Payment,
2) Adjustments to Capitation Payments,

3) Delivery Supplemental Payment, and

4) Experience Rebate.

6.3 Performance Incentives and Disincentives

HHSC introduces several financial and non-financial performance incentives and disincentives through this Contract. These incentives and disincentives are subject to change by HHSC over the course of the Contract Period. The methodologies required to implement these strategies will be refined by HHSC after collaboration with contracting HMOs through a new incentives workgroup to be established by HHSC.

6.3.1 Non-financial Incentives

6.3.1.1 Performance Profiling

HHSC intends to distribute information on key performance indicators to HMOs on a regular basis, identifying an HMO's performance, and comparing that performance to other HMOs, and HHSC standards and/or external Benchmarks. HHSC will recognize HMOs that attain superior performance and/or improvement by publicizing their achievements. For example, HHSC may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public.

6.3.1.2 Auto-assignment Methodology for Medicaid HMOs

HHSC may also revise its auto-assignment methodology during the Contract Period for new Medicaid Members who do not select an HMO (Default Members). The new assignment methodology would reward those HMOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. In establishing the assignment methodology, HHSC will employ a subset of the performance indicators contained within the **Performance Indicator Dashboard**. At present, HHSC intends to recognize those HMOs that exceed the minimum geographic access standards defined within **Attachment B-1, Section 8 and the Performance Indicator Dashboard.** HHSC may also use its assessment of HMO performance on annual quality improvement goals (described in **Attachment B-1, Section 8**) in developing the assignment methodology. The methodology would disproportionately assign Default Members to the HMO(s) in a given Service Area that performed comparably favorably on the selected performance indicators.

HHSC anticipates that it will not implement a performance-based auto-assignment algorithm before September 1, 2007. HHSC will invite HMO comments on potential approaches prior to implementation of the new performance-based auto-assignment algorithm.

6.3.2 Financial Incentives and Disincentives

Section 6.3.2.1 modified by Versions 1.1 and 1.3

6.3.2.1 Experience Rebate Reward

HHSC historically has required HMOs to provide HHSC with an Experience Rebate (see the **Uniform Managed Care Contract Terms and Conditions, Article 10.11)** when there has been an aggregate excess of Revenues over Allowable Expenses. During the Contract Period, should the HMO experience an aggregate excess of Revenues over Allowable Expenses across STAR and CHIP HMO Programs and Service Areas, HHSC will allow the HMO to retain that portion of the aggregate excess of Revenues over Allowable Expenses that is equal to or less than 3.5% of the total Revenue for the period should the HMO demonstrate superior performance on selected performance indicators. The retention of 3.5% of revenue exceeds the retention of 3.0% of revenue that would otherwise be afforded to a HMO without demonstrated superior performance on these performance indicators relative to other HMOs. HHSC will develop the methodology for determining the level of performance necessary for an HMO to retain the additional 0.5% of revenue after consultation with HMOs. The finalized methodology will be added to the **Uniform Managed Care Manual**.

HHSC will calculate the Experience Rebate Reward after it has calculated the HMO's at-risk Capitation Rate payment, as described below in **Section 6.3.2.2**. HHSC will calculate whether a HMO is eligible for the Experience Rebate Reward prior to the 90-day Financial Statistical Report (FSR) filing.

HHSC anticipates that it will not implement the incentive for Rate Period 1 of the Contract. HHSC will invite HMO comments on potential approaches prior to implementation of the new performance-based Experience Rebate Reward. HHSC may also implement this incentive option for the STAR+PLUS and CHIP Perinatal programs in the future.

Section 6.3.2.2 modified by Versions 1.1, 1.2, and 1.3.

6.3.2.2 Performance-Based Capitation Rate

Beginning in State Fiscal Year 2007 of the Contract, HHSC will place each STAR and CHIP HMO at risk for 1% of the Capitation Rate(s). Beginning in State Fiscal Year 2008 of the Contract, HHSC will also place each STAR+PLUS HMO at risk for 1% of the Capitation Rate(s). HHSC retains the right to vary the percentage of the Capitation Rate placed at risk in a given Rate Period. HHSC will not place CHIP Perinatal HMOs at risk for 1% of the Capitation Rate(s) in State Fiscal Year 2007, but reserves this right in subsequent State Fiscal Years.

As noted in Section 6.2, HHSC will pay the HMO monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Member months times the applicable monthly Capitation Rate by Member rate cell. At the end of each Rate Period, HHSC will evaluate if the HMO has demonstrated that it has fully met the performance expectations for which the HMO is at risk. Should the HMO fall short on some or all of the performance expectations, HHSC will adjust a future monthly Capitation Payment by an appropriate portion of the 1% at-risk amount. HMOs will be able to earn variable percentages up to 100% of the 1% at-risk Capitation Rate. HHSC's objective is that all HMOs achieve performance levels that enable them to receive the full at-risk amount.

HHSC will determine the extent to which the HMO has met the performance expectations by assessing the HMO's performance for each applicable HMO Program relative to performance targets for the rate period. HHSC will conduct separate accounting for each HMO Program's at-risk Capitation Rate amount.

HHSC will identify no more than 10 performance indicators for each HMO Program. Some of the performance indicators will be standard across the HMO Programs while others may apply to only one of the HMO Programs.

HHSC's performance indicators may include some or all of the following measures. The specific performance indicators, periods of data collection, and associated points are detailed in the **HHSC Uniform Managed Care Manual.** The minimum percentage targets identified in this section were developed based, in part, on the HHSC HMO Program objective of ensuring access to care and quality of care, past performance of the HHSC HMOs, and performance of Medicaid and CHIP HMOs nationally on HEDIS and CAHPS measures of plan performance. **The Performance Indicator Dashboard** includes a more detailed explanation.

Standard Performance Indicators:

1. 98% of Clean Claims are properly Adjudicated within 30 calendar days.
2. The Member Services Hotline abandonment rate does not exceed 7%.
3. The Behavioral Health Hotline abandonment rate does not exceed 7%.[1]
4. The Provider Services Hotline abandonment rate does not exceed 7%.

Additional STAR Performance Indicators

1. 90% of child Members have access to at least one child-appropriate PCP with an Open Panel within 30 miles travel distance.
2. 90% of adult Members have access to at least one adult-appropriate PCP with an Open Panel within 30 miles travel distance.
3. 36% of age-qualified child Members receive six or more well-child visits (in the first 15 months of life.
4. 56% of age-qualified child Members receive at least one well-child visit in the 3rd, 4th, 5th, or 6th year of life.
5. 72% of pregnant women Members receive a prenatal care visit in the first trimester or within 42 days of enrollment.

Additional CHIP Performance Indicators

1. 90% of child Members have access to at least one child-appropriate PCP with an Open Panel within 30 miles travel distance.
2. 90% of child Members have access to at least one otolaryngologist (ENT) within 75 miles travel distance.

[1] Will not apply in the Dallas Core Service Area. Points will be allocated proportionately over the remaining standard performance indicators.

3. 56% of age-qualified child Members receive at least one well-child visit in the 3rd, 4th, 5th, or 6th year of life
4. 38% of adolescents receive an annual well visit.

Additional STAR+PLUS Performance Indicators

1. 57% of adult Members report no problem with delays in getting approval from the HMO
2. 90% of adult Members have access to at least one adult-appropriate PCP with an Open Panel within 30 miles travel distance
3. 62% of adult Members report no problem in getting a referral to a Specialty Physician
4. 47% of adult Members report no problem getting needed Special Therapy (physical therapy, occupational therapy, and speech therapy) from the HMO
5. 57% of adult Members report no problem getting needed Behavioral Health Services from the HMO

Failure to timely provide HHSC with necessary data related to the calculation of the performance indicators will result in HHSC's assignment of a zero percent performance rate for each related performance indicator.

Should Member survey-based indicators yield response rates deemed by HHSC to be too low to yield credible data, HHSC will reapportion points across the remaining measures.

Actual plan rates will be rounded to the nearest whole number. HHSC will calculate performance assessment for the at-risk portion of the capitation payments by summing all earned points and converting them to a percentage. For example, an HMO that earns 92 points will earn 92% of the at-risk Capitation Rate. HHSC will apply the premium assessment of 8% of the at-risk Capitation Rate as a reduction to the monthly Capitation Payment ninety days after the end of the contract period.

HMOs will report actual Capitation Payments received on the Financial Statistical Report (FSR). Actual Capitation Payments received include all of the at-risk Capitation Payment paid to the HMO. Any performance assessment based on performance for a contract period will appear on the second final (334-day) FSR for that contract period.

HHSC will evaluate the performance-based Capitation Rate methodology annually in consultation with HMOs. HHSC may then modify the methodology it deems necessary and appropriate to motivate, recognize, and reward HMOs for performance. The methodologies for Rate Periods 1 and 2 will be included in the **HHSC Uniform Managed Care Manual**.

6.3.2.3 Quality Challenge Award

Section 6.3.2.3 Modified by Versions 1.1 and 1.2
Data collection for the Quality Challenge Award will begin on September 1, 2006; however, the Quality Challenge Award will not be implemented until State Fiscal Year 2008. Should one or more HMOs be unable to earn the full amount of the performance-based at-risk portion of the Capitation Rate, HHSC will reallocate the funds through the HMO Program's Quality Challenge Award. HHSC will use these funds to reward HMOs that demonstrate superior clinical quality. HHSC will determine the number of HMOs that will receive Quality Challenge Award funds annually based on the amount of the funds to be reallocated. Separate Quality Challenge Award

payments will be made for each of the HMO programs. As with the performance-based Capitation Rate, each HMO will be evaluated separately for each HMO Program. HHSC intends to evaluate HMO performance annually on some combination of the following performance indicators in order to determine which HMOs demonstrate superior clinical quality. In no event will a distribution from the Quality Challenge Award, plus any other incentive payments made in accordance with the HMO Contract, when combined with the Capitation Rate payments, exceed 105% of the Capitation Rate payments to an HMO.

Information about the data collection period to be used for each indicator is found in the **HHSC Uniform Managed Care Manual**.

6.3.2.4 Remedies and Liquidated Damages

All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies and HHSC will assess either actual or liquidated damages. Refer to **Attachment A, HHSC Uniform Managed Care Contract Terms and Conditions** and **Attachment B-5** for performance standards that carry liquidated damage values.

Section 6.3.2.5 added by Version 1.1

6.3.2.5 STAR+PLUS Hospital Inpatient Performance-Based Capitation Rate: Hospital Inpatient Stay Cost Incentives & Disincentives

Section 6.3.2.5 modified by Version 1.6

Effective as of the STAR+PLUS Operational Start Date, HHSC will place at-risk a portion of the HMO's Medicaid-Only Capitation Rate. Settlements for Inpatient Stay costs will be calculated by the State after the end of each State Fiscal Year (SFY) using three (3) months of completed Hospital paid data for the preliminary settlement and 11 months of completed data for the final settlement. The SFY 2006 Fee-for-Service (FFS) Inpatient Hospital per-member-per-month (PMPM) rate will be projected for Rate Period 1 (February 1, 2007 through August 31, 2007) for the first settlement. Adjustments for the projection will include trending and risk adjustment. The base and final inpatient hospital PMPM rate will be calculated separately for each HMO, Service Area, and Rate Cell. Harris County is excluded from the Harris Service Area calculations.

Section 6.3.2.5.1 added by Version 1.1

6.3.2.5.1 STAR+PLUS Hospital Inpatient Disincentive—Administrative Fee at Risk

HHSC has assumed that STAR+PLUS HMOs will achieve a 22% reduction in projected FFS Hospital Inpatient Stay costs, for the Medicaid-Only population, through the implementation of the STAR+PLUS model. HMOs achieving savings beyond 22% will be eligible for the STAR+PLUS Shared Savings Award described in **Section 6.3.2.5.2**. The HMO will be at-risk for savings less than 22%.

The maximum risk to the HMO will be equal to 50% of the difference between 15% Hospital inpatient savings and 22% Hospital inpatient savings. The disincentive for savings above 15%, but still less than 22% will be equal to 50% of the difference between the level of achieved savings and 22%. HHSC retains the right to vary the disincentive percentage in a given Rate Period by Contract amendment.

Section 6.3.2.5.2 added by Version 1.1

6.3.2.5.2 STAR+PLUS Hospital Inpatient Incentive – Shared Savings Award

HMOs that exceed the 22% reduction in Inpatient Stay costs incurred by STAR+PLUS Members specified in **Section 6.3.2.5.1** will be eligible to obtain a 20% share of the savings achieved beyond the 22% target. HHSC will determine the extent to which the HMO has met and exceeded the performance expectation in the manner described within **Section 6.3.2.5**. Should HHSC determine that the HMO exceeded the 22% target, HHSC will adjust a future monthly Capitation Payment upward by 20% of the calculated savings. This shared savings award is limited to 5% of the HMO's capitation in accordance with Federal Balance Budget Act requirements and is calculated off of total of STAR+PLUS Capitation Payment. An HMO will be subject to contractual remedies and determined ineligible for the award, if a HHSC audit reveals that the HMO has inappropriately averted Medically Necessary Inpatient Stay admissions and potentially endangered Member safety.

7. Transition Phase Requirements

7.1 Introduction

This Section presents the scope of work for the Transition Phase of the Contract, which includes those activities that must take place between the time of Contract award and the Operational Start Date.

Section 7.1 modified by Version 1.1
The Transition Phase will include a Readiness Review of each HMO, which must be completed successfully prior to a HMO's Operational Start Date for each applicable HMO Program. HHSC may, at its discretion, postpone the Operational Start Date of the Contract for any such HMO that fails to satisfy all Transition Phase requirements.

If for any reason, a HMO does not fully meet the Readiness Review prior to the Operational Start Date, and HHSC has not approved a delay in the Operational Start Date or approved a delay in the HMO's compliance with the applicable Readiness Review requirement, then HHSC shall impose remedies and either actual or liquidated damages. If the HMO is a current HMO Contractor, HHSC may also freeze enrollment into the HMO's plan for any of its HMO Programs. Refer to the **HHSC Uniform Managed Care Contract Terms and Conditions (Attachment A)** and the **Liquidated Damages Matrix (Attachment B-5)** for additional information.

7.2 Transition Phase Scope for HMOs

Section 7.2 modified by Versions 1.1 and 1.3
STAR, STAR+PLUS and CHIP HMOs must meet the Readiness Review requirements established by HHSC no later than 90 days prior to the Operational Start Date for each applicable HMO Program. CHIP Perinatal HMOS must meet the Readiness Review requirements established by HHSC not later than 60 days prior to the Operational Start Date for the CHIP Perinatal Program. HMO agrees to provide all materials required to complete the readiness review by the dates established by HHSC and its Contracted Readiness Review Vendor.

7.3 Transition Phase Schedule and Tasks

Section 7.3 modified by Versions 1.1 and 1.3
The Transition Phase will begin after both Parties sign the Contract. The start date for the STAR and CHIP Transition Phase is November 15, 2005. The start date for the STAR+PLUS Transition Phase is June 30, 2006. The start date for the CHIP Perinate Transition Phase is September 1, 2006.

The Transition Phase must be completed no later than the agreed upon Operational Start Date(s) for each HMO Program and Service Area. The HMO may be subject to liquidated damages for failure to meet the agreed upon Operational Start Date (see **Attachment B-5**).

7.3.1 Transition Phase Tasks

The HMO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The HMO is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed.

7.3.1.1 Contract Start-Up and Planning

HHSC and the HMO will work together during the initial Contract start-up phase to:

- define project management and reporting standards;
- establish communication protocols between HHSC and the HMO;
- establish contacts with other HHSC contractors;
- establish a schedule for key activities and milestones; and
- clarify expectations for the content and format of Contract Deliverables.

The HMO will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Phase. An updated and detailed Transition /Implementation Plan will be due to HHSC.

Section 7.3.1.2 modified by Versions 1.1 and 1.3

7.3.1.2 Administration and Key HMO Personnel

No later than the Effective Date of the Contract, the HMO must designate and identify Key HMO Personnel that meet the requirements in **HHSC Uniform Managed Care Contract Terms & Conditions, Article 4.** The HMO will supply HHSC with resumes of each Key HMO Personnel as well as organizational information that has changed relative to the HMO's Proposal, such as updated job descriptions and updated organizational charts, (including updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart), if applicable. If the HMO is using a Material Subcontractor(s), the HMO must also provide the organizational chart for such Material Subcontractor(s).

No later than the Contract execution date, STAR+PLUS HMOs must update the information above and provide any additional information as it relates to the STAR+PLUS Program.

No later than the Contract execution date, CHIP Perinatal HMOs must update the information above and provide any additional information as it relates to the CHIP Perinatal Program.

Section 7.3.1.3 modified by Versions 1.1 and 1.3

7.3.1.3 Financial Readiness Review

In order to complete a Financial Readiness Review, HHSC will require that HMOs update information submitted in their proposals. Note: STAR+PLUS and/or CHIP Perinatal HMOs who have already submitted proposal updates for HHSC's review for STAR and/or CHIP, must either verify that the information has not changed and that it applies to STAR+PLUS and/or the CHIP Perinatal Program or provide updated information for STAR+PLUS by July 10, 2006 and for the CHIP Perinatal Program by September 1, 2006. This information will include the following:

Contractor Identification and Information

1. The Contractor's legal name, trade name, or any other name under which the Contractor does business, if any.
2. The address and telephone number of the Contractor's headquarters office.
3. A copy of its current Texas Department of Insurance Certificate of Authority to provide HMO or ANHC services in the applicable Service Area(s). The Certificate of Authority must include all counties in the Service Area(s) for which the Contractor is proposing to serve HMO Members.
4. Indicate with a "Yes-HMO", "Yes-ANHC" or "No" in the applicable cell(s) of the Column B of the following chart whether the Contractor is currently certified by TDI as an HMO or ANHC in **all** counties in each of the CSAs in which the Contractor proposes to participate in one or more of the HHSC HMO Programs. If the Contractor is not proposing to serve a CSA for a particular HMO Program, the Contractor should leave the applicable cells in the table empty.

Table 2: TDI Certificate of Authority in Proposed HMO Program CSAs

Column A Core Service Area (CSA)	Column B TDI Certificate of Authority	Column C Counties/Partial Counties without a TDI Certificate of Authority
Bexar		
Dallas		
El Paso		
Harris		
Lubbock		
Nueces		
Tarrant		
Travis		
Webb		

If the Contractor is **not** currently certified by TDI as an HMO or ANHC in any one or more counties in a proposed CSA, the Contractor must identify such entire counties in Column C for each CSA. For each county listed in Column C, the Contractor must document that it applied to TDI for such certification of authority prior to the submission of a Proposal for this RFP. The Contractor shall indicate the date that it applied for such certification and the status of its application to get TDI certification in the relevant counties in this section of its submission to HHSC.

5. For Contractors serving any CHIP and CHIP Perinatal OSAs, indicate with a "Yes-HMO", "Yes-ANHC" or "No" in the applicable cell(s) of the Column C of the following chart whether the Contractor is currently certified by TDI as an HMO or ANHC in the entire county in the OSA. If the Contractor is not proposing to serve an OSA, the Contractor should leave the applicable cells in the table empty.

Table 3: TDI Certificate of Authority in Proposed HMO Program OSAs

CHIP Program

Column A Core Service Area (CSA)	Column B Affiliated CHIP OSA	Column C TDI Certificate of Authority
Bexar		
El Paso		
Harris		
Lubbock		
Nueces		
Travis		

CHIP Perinatal Program

Column A Core Service Area (CSA)	Column B Affiliated CHIP OSA	Column C TDI Certificate of Authority
Bexar		
El Paso		
Harris		
Lubbock		
Nueces		
Travis		

For each county listed in Column C, the Contractor must document that it applied to TDI for such certification of authority prior to the submission of a Proposal for this RFP. The Contractor shall indicate the date that it applied for such certification and the status of its application to get TDI certification in the relevant counties in this section of its submission to HHSC.

6. If the Contractor proposes to participate in STAR or STAR+PLUS and seeks to be considered as an organization meeting the requirements of Section §533.004(a) or (e) of the Texas Government Code, describe how the Contractor meets the requirements of §§533.004(a)(1), (a)(2), (a)(3), or (e) for each proposed Service Areas.
7. The type of ownership (proprietary, partnership, corporation).
8. The type of incorporation (for profit, not-for-profit, or non-profit) and whether the Contractor is publicly or privately owned.
9. If the Contractor is an Affiliate or Subsidiary, identify the parent organization.
10. If any change of ownership of the Contractor’s company is anticipated during the 12 months following the Proposal due date, the Contractor must describe the circumstances of such change and indicate when the change is likely to occur.
11. The name and address of any sponsoring corporation or others who provide financial support to the Contractor and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.
12. The name and address of any health professional that has at least a five percent financial interest in the Contractor and the type of financial interest.
13. The names of officers and directors.

14. The state in which the Contractor is incorporated and the state(s) in which the Contractor is licensed to do business as an HMO. The Contractor must also indicate the state where it is commercially domiciled, if applicable.
15. The Contractor's federal taxpayer identification number.
16. The Contractor's Texas Provider Identifier (TPI) number if the Contractor is Medicaid-enrolled in Texas.
17. Whether the Contractor had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the Contractor must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Contractor must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.
18. A current Certificate of Good Standing issued by the Texas Comptroller of Public Accounts, or an explanation for why this form is not applicable to the Contractor.
19. Whether the Contractor has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
    - its current NCQA or URAC accreditation status;
    - if NCQA or URAC accredited, its accreditation term effective dates; and
    - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Contractor.

Material Subcontractor Information

A Material Subcontractor means any entity retained by the HMO to provide all or part of the HMO Administrative Services where the value of the subcontracted HMO Administrative Service(s) exceeds $100,000 per fiscal year. HMO Administrative Services are those services or functions other than the direct delivery of Covered Services necessary to manage the delivery of and payment for Covered Services. HMO Administrative Services include but are not limited to Network, utilization, clinical and/or quality management, service authorization, claims processing, Management Information System (MIS) operation and reporting. The term Material Subcontractor does not include Providers in the HMO's Provider Network.

Contractors must submit the following for each proposed Material Subcontractor, if any:

1. A signed letter of commitment from each Material Subcontractor that states the Material Subcontractor's willingness to enter into a Subcontractor agreement with the Contractor and a statement of work for activities to be subcontracted. Letters of Commitment must be provided on the Material Subcontractor's official company letterhead and signed by an official with the authority to bind the company for the subcontracted work. The Letter of Commitment must state, if applicable, the company's certified HUB status.
2. The Material Subcontractor's legal name, trade name, or any other name under which the Material Subcontractor does business, if any.
3. The address and telephone number of the Material Subcontractor's headquarters office.
4. The type of ownership (e.g., proprietary, partnership, corporation).
5. The type of incorporation (i.e., for profit, not-for-profit, or non-profit) and whether the Material Subcontractor is publicly or privately owned.
6. If a Subsidiary or Affiliate, the identification of the parent organization.

7. The name and address of any sponsoring corporation or others who provide financial support to the Material Subcontractor and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.
8. The name and address of any health professional that has at least a five percent (5%) financial interest in the Material Subcontractor and the type of financial interest.
9. The state in which the Material Subcontractor is incorporated, commercially domiciled, and the state(s) in which the organization is licensed to do business.
10. The Material Subcontractor's Texas Provider Identifier if Medicaid-enrolled in Texas.
11. The Material Subcontractor's federal taxpayer identification number.
12. Whether the Material Subcontractor had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the Contractor must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Contractor must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.
13. Whether the Material Subcontractor has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation or certification status, and if it has or is, indicate:
    - its current NCQA or URAC accreditation or certification status;
    - if NCQA or URAC accredited or certified, its accreditation or certification term effective dates; and
    - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Material Subcontractor.

Organizational Overview

1. Submit an organizational chart (labeled Chart A), showing the corporate structure and lines of responsibility and authority in the administration of the Bidder's business as a health plan.
2. Submit an organizational chart (labeled Chart B) showing the Texas organizational structure and how it relates to the proposed Service Area(s), including staffing and functions performed at the local level. If Chart A represents the entire organizational structure, label the submission as Charts A and B.
3. Submit an organizational chart (labeled Chart C) showing the Management Information System (MIS) staff organizational structure and how it relates to the proposed Service Area(s) including staffing and functions performed at the local level.
4. If the Bidder is proposing to use a Material Subcontractor(s), the Bidder shall include an organizational chart demonstrating how the Material Subcontractor(s) will be managed within the Bidder's Texas organizational structure, including the primary individuals at the Bidder's organization and at each Material Subcontractor organization responsible for overseeing such Material Subcontract. This information may be included in Chart B, or in a separate organizational chart(s).
5. Submit a brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Bidder's proposed management of the HMO Program(s), including its management of any proposed Material Subcontractors.

Other Information

1. Briefly describe any regulatory action, sanctions, and/or fines imposed by any federal or Texas regulatory entity or a regulatory entity in another state within the last 3 years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Please indicate which of these actions or fines, if any, were related to Medicaid or CHIP programs. HHSC may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Contractor.
2. No later than ten (10) days after the Contract Effective Date, submit documentation that demonstrates that the HMO has secured the required insurance and bonds in accordance with TDI requirements and Attachment B-1, Section 8.
3. Submit annual audited financial statement for fiscal years 2004 and 2005 (2005 to be submitted no later than six months after the close of the fiscal year).
4. Submit an Affiliate Report containing a list of all Affiliates and for HHSC's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the HMO by the Affiliate. Those should include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the HMO for such services during the Contract Period.

7.3.1.4 System Testing and Transfer of Data

The HMO must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems identified in **Attachment B-1, Section 8.1.18**. For example, the HMO's MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in **Section 8.1.18.4**.

During this Readiness Review task, the HMO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The HMO will install and test all hardware, software, and telecommunications required to support the Contract. The HMO will define and test modifications to the HMO's system(s) required to support the business functions of the Contract.

Section 7.3.1.4 modified by Versions 1.1 and 1.3
The HMO will produce data extracts and receive all electronic data transfers and transmissions. STAR and CHIP HMOs must be able to demonstrate the ability to produce an EQRO (currently, Institute for Child Health Policy (ICHP)) encounter file by April 1, 2006, and the 837-encounter file by August 1, 2006. STAR+PLUS HMOs must be able to demonstrate the ability to produce the STAR+PLUS encounter file by the STAR+PLUS Operational Start Date and the 837- encounter file by September 1, 2007. CHIP Perinatal HMOs who have already demonstrated the ability to produce an EQRO encounter file and 837-encounter file for the CHIP Program are not required to produce separate files for the CHIP Perinatal Program.

If any errors or deficiencies are evident, the HMO will develop resolution procedures to address problems identified. The HMO will provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required

telephone lines for Providers and Members and any necessary connections to the HHSC Administrative Services Contractor and the External Quality Review Organization. The HHSC Administrative Services Contractor will provide enrollment test files to new HMOs that do not have previous HHSC enrollment files. The HMO will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

7.3.1.5 System Readiness Review

The HMO must assure that systems services are not disrupted or interrupted during the Operations Phase of the Contract. The HMO must coordinate with HHSC and other contractors to ensure the business and systems continuity for the processing of all health care claims and data as required under this contract.

The HMO must submit to HHSC, descriptions of interface and data and process flow for each key business processes described in **Section 8.1.18.3**, System-wide Functions.

Section 7.3.1.5 modified by Versions 1.1 and 1.3
The HMO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The HMO must develop, and submit for State review and approval, the following information by December 14, 2005 for STAR and CHIP, by July 31, 2006 for STAR+PLUS:

1. Joint Interface Plan.
2. Disaster Recovery Plan
3. Business Continuity Plan
4. Risk Management Plan, and
5. Systems Quality Assurance Plan.

Separate plans are not required for CHIP Perinatal HMOs.

7.3.1.6 Demonstration and Assessment of System Readiness

Section 7.3.1.6 modified by Versions 1.1 and 1.3
The HMO must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA. The HMO shall also provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the HMO's proposed systems, including any SAS70 audits that have been conducted in the past three years. The HMO shall promptly make additional information on the detail of such system audits available to HHSC upon request.

In addition, HHSC will provide to the HMO a test plan that will outline the activities that need to be performed by the HMO prior to the Operational Start Date of the Contract. The HMO must be prepared to assure and demonstrate system readiness. The HMO must execute system readiness test cycles to include all external data interfaces, including those with Material Subcontractors.

HHSC, or its agents, may independently test whether the HMO's MIS has the capacity to administer the STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO business, as applicable to the HMO. This Readiness Review of a HMO's MIS may include a desk review and/or an

onsite review. HHSC may request from the HMO additional documentation to support the provision of STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO Services, as applicable to the HMO. Based in part on the HMO's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the HMO, and any review conducted by HHSC or its agents, HHSC will assess the HMO's understanding of its responsibilities and the HMO's capability to assume the MIS functions required under the Contract.

The HMO is required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten (10) calendar days after notification of any such deficiency by HHSC. If the HMO documents to HHSC's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by HHSC, no Corrective Action Plan is required.

Section 7.3.1.7 modified by Versions 1.1, 1.2, and 1.3

7.3.1.7 Operations Readiness

The HMO must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO Services, including coordination with contractors. The HMO will be responsible for developing and documenting its approach to quality assurance.

Readiness Review. Includes all plans to be implemented in one or more Service Areas on the anticipated Operational Start Date. At a minimum, the HMO shall, for each HMO Program:

1. Develop new, or revise existing, operations procedures and associated documentation to support the HMO's proposed approach to conducting operations activities in compliance with the contracted scope of work.
2. Submit to HHSC, a listing of all contracted and credentialed Providers, in a HHSC approved format including a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date.
3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum.
4. Prepare a Coordination Plan documenting how the HMO will coordinate its business activities with those activities performed by HHSC contractors and the HMO's Material Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Phase.
5. Develop and submit to HHSC the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for HHSC's review and approval. The materials must at a minimum meet the requirements specified in **Section 8.1.5** and include the Critical Elements to be defined in the **HHSC Uniform Managed Care Manual**.
6. Develop and submit to HHSC the HMO's proposed Member complaint and appeals processes for Medicaid, CHIP, and CHIP Perinatal as applicable to the HMO's Program participation.
7. Provide sufficient copies of the final Provider Directory to the HHSC Administrative Services Contractor in sufficient time to meet the enrollment schedule.

8. Demonstrate toll-free telephone systems and reporting capabilities for the Member Services Hotline, the Behavioral Health Hotline, and the Provider Services Hotline.
9. Submit a written Fraud and Abuse Compliance Plan to HHSC for approval no later than 30 days after the Contract Effective Date. See **Section 8.1.19**, Fraud and Abuse, for the requirements of the plan, including new requirements for special investigation units. As part of the Fraud and Abuse Compliance Plan, the HMO shall:
    - designate executive and essential personnel to attend mandatory training in fraud and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means HMO staff persons who supervise staff in the following areas: data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the fraud and abuse detection program within the HMO. The training will be conducted by the Office of Inspector General, Health and Human Services Commission, and will be provided free of charge. The HMO must schedule and complete training no later than 90 days after the Effective Date.
    - designate an officer or director within the organization responsible for carrying out the provisions of the Fraud and Abuse Compliance Plan.
    - The HMO is held to the same requirements and must ensure that, if this function is subcontracted to another entity, the subcontractor also meets all the requirements in this section and the Fraud and Abuse section as stated in **Attachment B-1, Section 8.**
    - Note: STAR+PLUS HMOs who have already submitted and received HHSC's approval for their Fraud and Abuse Compliance Plans must submit acknowledgement that the HMO's approved Fraud and Abuse Compliance Plan also applies to the STAR+PLUS program, or submit a revised Fraud and Abuse Compliance Plan for HHSC's approval, with an explanation of changes to be made to incorporate the STAR+PLUS program into the plan, by July 10, 2006.
    - CHIP Perinatal HMOs who have already submitted and received HHSC's approval for their Fraud and Abuse Compliance Plans must submit acknowledgement that the HMO's approved Fraud and Abuse Compliance Plan also applies to the CHIP Perinatal Program, or submit a revised Fraud and Abuse Compliance Plan for HHSC's approval, with an explanation of changes to be made to incorporate the CHIP Perinatal program into the plan, by September 15, 2006.
    - Complete hiring and training of STAR+PLUS Service Coordination staff, no later than 45 days prior to the STAR+PLUS Operational Start Date.

During the Readiness Review, HHSC may request from the HMO certain operating procedures and updates to documentation to support the provision of STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO Services. HHSC will assess the HMO's understanding of its responsibilities and the HMO's capability to assume the functions required under the Contract, based in part on the HMO's assurances of operational readiness, information contained in the Proposal, and in Transition Phase documentation submitted by the HMO.

The HMO is required to promptly provide a Corrective Action Plan and/or Risk Mitigation Plan as requested by HHSC in response to Operational Readiness Review deficiencies identified by the HMO or by HHSC or its agent. The HMO must promptly alert HHSC of deficiencies, and must correct a deficiency or provide a Corrective Action Plan and/or Risk Mitigation Plan no later than ten (10) calendar days after HHSC's notification of deficiencies. If the Contractor documents to HHSC's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.1.8 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in **Section 7.3.1**, the HMO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the HMO must assure that Key HMO Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

7.3.1.9 Post-Transition

The HMO will work with HHSC, Providers, and Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Members, as applicable, the steps the HMO is taking to resolve the problems.

If a HMO makes assurances to HHSC of its readiness to meet Contract requirements, including MIS and operational requirements, but fails to satisfy requirements set forth in this Section, or as otherwise required pursuant to the Contract, HHSC may, at its discretion do any of the following in accordance with the severity of the non-compliance and the potential impact on Members and Providers:

1. freeze enrollment into the HMO's plan for the affected HMO Program(s) and Service Area(s);
2. freeze enrollment into the HMO's plan for all HMO Programs or for all Service Areas of an affected HMO Program;
3. impose contractual remedies, including liquidated damages; or
4. pursue other equitable, injunctive, or regulatory relief.

8. OPERATIONS PHASE REQUIREMENTS

This Section is designed to provide HMOs with sufficient information to understand the HMOs' responsibilities. This Section describes scope of work requirements for the Operations Phase of the Contract.

Section 8 modified by Versions 1.1 and 1.3
Section 8.1 includes the general scope of work that applies to the STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMO Programs.

Section 8.2 includes the additional Medicaid scope of work that applies only to the STAR and STAR+PLUS HMOs.

Section 8.3 includes the additional scope of work that applies only to STAR+PLUS HMOs.

Section 8.4 includes the additional scope of work that applies only to CHIP HMOs.

Section 8.5 includes the additional scope of work that applies only to CHIP Perinatal HMOs.

The Section does not include detailed information on the STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMO Program requirements, such as the time frame and format for all reporting requirements. HHSC has included this information in the **Uniform Managed Care Contract Terms and Conditions** (**Attachment A**) and the **Uniform Managed Care Manual**. HHSC reserves the right to modify these documents as it deems necessary using the procedures set forth in the **Uniform Managed Care Contract Terms and Conditions**.

8.1 General Scope of Work

In each HMO Program Service Area, HHSC will select HMOs for each HMO Program to provide health care services to Members. The HMO must be licensed by the Texas Department of Insurance (TDI) as an HMO or an ANHC in all zip codes in the respective Service Area(s).

Section 8.1 modified by Versions 1.1, 1.3, and 1.6
Coverage for benefits will be available to enrolled Members effective on the Operational Start Date. The Operational Start Date is September 1, 2006 for STAR and CHIP HMOs, January 1, 2007 for CHIP Perinatal HMOs, and February 1, 2007 for the STAR+PLUS HMOs.

8.1.1 Administration and Contract Management

The HMO must comply, to the satisfaction of HHSC, with (1) all provisions set forth in this Contract, and (2) all applicable provisions of state and federal laws, rules, regulations, and waivers.

Section 8.1.1.1 modified by Versions 1.1, 1.2, and 1.3

8.1.1.1 Performance Evaluation

The HMO must identify and propose to HHSC, in writing, no later than May 1st of each State Fiscal Year (SFY) after the Operational Start Date, annual HMO Performance Improvement Goals for the next fiscal year, as well as measures and time frames for demonstrating that such goals are being met. Performance Improvement Goals must be based on HHSC priorities and identified opportunities for improvement (see **Attachment B-4, Performance Improvement Goals**). The Parties will negotiate such Performance Improvement Goals, the measures that will be used to assess goal achievement, and the time frames for completion, which will be incorporated into the Contract. If HHSC and the HMO cannot agree on the Performance Improvement Goals, measures, or time frames, HHSC will set the goals, measures, or time frames.

For State Fiscal Year 2007, HHSC has established three overarching goals for each Program. These overarching goals are as follows:

Goal 1 (STAR and CHIP) Improve Access to Primary Care Services for Members

Goal 2 (STAR and CHIP) Improve Access to Behavioral Health Services for Members,

Goal 3 (STAR Only) Improve Access to Clinically Appropriate Alternatives to Emergency Room Services Outside of Regular Office Hours (CHIP Only) Improve Current Member Understanding About the CHIP Benefit Renewal Processes

Note: The HMO is required to propose customized sub-goals specific to the HMO's Service Areas and Programs for all overarching goals. The sub-goals must be approved by HHSC as part of the negotiation process.

The specific percentages of expected achievement for each sub-goal will be negotiated by HHSC and the HMO before the Operational Start Date.

For STAR+PLUS HMOs, HHSC will negotiate and implement Performance Improvement Goals for the first full fiscal year following the STAR+PLUS Operational Start Date. One standard STAR+PLUS goal will relate to Consumer-Directed Services. STAR+PLUS improvement goals for SFY2008 will be included in **Attachment B-4.1**.

For CHIP Perinatal HMOs, HHSC will negotiate and implement Performance Improvement Goals for the first full State Fiscal Year following the CHIP Perinatal Operational Start Date.

The HMO must participate in semi-annual Contract Status Meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of annual Performance Improvement Goals and Contract requirements. HHSC may request additional CSMs, as it deems necessary to address areas of noncompliance. HHSC will provide the HMO with reasonable advance notice of additional CSMs, generally at least five (5) business days.

The HMO must provide to HHSC, no later than 14 business days prior to each semi-annual CSM, one electronic copy of a written update, detailing and documenting the HMO's progress toward meeting the annual Performance Improvement Goals or other areas of noncompliance.

HHSC will track HMO performance on Performance Improvement Goals. It will also track other key facets of HMO performance through the use of a **Performance Indicator Dashboard (see HHSC's Uniform Managed Care Manual)**. HHSC will compile the Performance Indicator Dashboard based on HMO submissions, data from the External Quality Review Organization (EQRO), and other data available to HHSC. HHSC will share the Performance Indicator Dashboard with the HMO on a quarterly basis.

8.1.2 Covered Services

Section 8.1.2 modified by Versions 1.1 and 1 3
The HMO is responsible for authorizing, arranging, coordinating, and providing Covered Services in accordance with the requirements of the Contract. The HMO must provide Medically Necessary Covered Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. STAR+PLUS HMOs must also provide Functionally Necessary Community Long-term Care Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. The HMO must not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any Member.

The HMO must provide full coverage for Medically Necessary Covered Services to all Members and, for STAR+PLUS Members, Functionally Necessary Community Long-term Care Services, without regard to the Member's:

1. previous coverage, if any, or the reason for termination of such coverage;
2. health status;
3. confinement in a health care facility; or
4. for any other reason.

Please Note:

(STAR HMOs): A Member cannot change from one STAR HMO to another STAR HMO during an inpatient hospital stay. The STAR HMO responsible for the hospital charges for STAR Members at the start of an Inpatient Stay remains responsible for hospital charges until the time of discharge or until such time that there is a loss of Medicaid eligibility. STAR HMOs are responsible for professional charges during every month for which the HMO receives a full capitation for a Member.

(STAR+PLUS HMOs): A Member cannot change from one STAR+PLUS HMO to another STAR+PLUS HMO during an inpatient hospital stay. The STAR+PLUS HMO is responsible for authorization and management of the inpatient hospital stay until the time of discharge, or until such time that there is a loss of Medicaid eligibility. STAR+PLUS HMOs are responsible for professional charges during every month for which the HMO receives a full capitation for a Member.

A Member cannot change from one STAR+PLUS HMO to another STAR+PLUS HMO during a nursing facility stay.

(CHIP HMOs): If a CHIP Member's Effective Date of Coverage occurs while the CHIP Member is confined in a hospital, HMO is responsible for the CHIP Member's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Member is disenrolled while the CHIP Member is confined in a hospital, HMO's responsibility for the CHIP Member's costs of Covered Services terminates on the Date of Disenrollment.

(CHIP Perinatal HMOs): If a CHIP Perinate's Effective Date of Coverage occurs while the CHIP Perinate is confined in a Hospital, HMO is responsible for the CHIP Perinate's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Perinate is disenrolled while the CHIP Perinate is confined in a Hospital, HMO's responsibility for the CHIP Perinate's costs of Covered Services terminates on the Date of Disenrollment.

The HMO must not practice discriminatory selection, or encourage segregation among the total group of eligible Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

Section 8.1.2 Modified by Version 1.5
Covered Services for all Medicaid HMO Members are listed in **Attachments B-2 and B-2.1 of the Contract (STAR and STAR+PLUS Covered Services)**. As noted in **Attachments B-2 and B-2.1**, all Medicaid HMOs must provide Covered Services described in the most recent **Texas Medicaid Provider Procedures Manual** (Provider Procedures Manual), the **THSteps Manual** (a supplement to the Provider Procedures Manual), and in all **Texas Medicaid Bulletins**, which update the Provider Procedures Manual except for those services identified in **Section 8.2.2.8** as non-capitated services. A description of CHIP Covered Services and exclusions is provided in **Attachment B-2 of the Contract**. A description of CHIP Perinatal Program Covered Services and exclusions is provided in **Attachment B-2.2 of the Contract**. Covered Services are subject to change due to changes in federal and state law, changes in Medicaid, CHIP or CHIP Perinatal Program policy, and changes in medical practice, clinical protocols, or technology.

8.1.2.1 Value-added Services

HMOs may propose additional services for coverage. These are referred to as "Value-added Services." Value-added Services must be actual health care services or benefits rather than gifts, incentives, educational classes or health assessments. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Section 8.1.2.1 modified by Versions 1.1, 1.2, and 1.3
If offered, Value-added Services must be offered to all mandatory STAR, and CHIP and CHIP Perinatal HMO Members within the applicable HMO Program and Service Area. For STAR+PLUS Acute Care services, the HMO may distinguish between the Dual Eligible and non-Dual Eligible populations. Value-added Services do not need to be consistent across more than one HMO Program or across more than one Service Area. Value-added Services that are approved by HHSC during the contracting process will be included in the Contract's scope of services.

The HMO must provide Value-added Services at no additional cost to HHSC. The HMO must not pass on the cost of the Value-added Services to Providers. The HMO must specify the conditions and parameters regarding the delivery of the Value-added Services in the HMO's Marketing Materials and Member Handbook, and must clearly describe any limitations or conditions specific to the Value-added Services.

Transition Phase. During the Transition Phase, HHSC will offer a one-time opportunity for the HMO to propose two additional Value-added Services to its list of current, approved Value-added Services. (See **Attachment B-3, Value-Added Services**). HHSC will establish the requirements and the timeframes for submitting the two additional proposed Value-added Services.

During this HHSC-designated opportunity, the HMO may propose either to add new Value-added Services or to enhance its current, approved Value-added Services. The HMO may propose two additional Value-added Services per HMO Program, and the services do not have to be the same for each HMO Program. HHSC will review the proposed additional services and, if appropriate, will approve the additional Value-added Services, which will be effective on the Operational Start Date. The HMO's Contract will be amended to reflect the additional, approved Value-added Services.

The HMO does not have to add Value-added Services during the HHSC-designated opportunity, but this will be the only time during the Transition Phase for the HMO to add Value-added Services. At no time during the Transition Phase will the HMO be allowed to delete, limit or restrict any of its current, approved Value-added Services.

Operations Phase. During the Operations Phase, Value-added Services can be added or removed only by written amendment of the Contract one time per fiscal year to be effective September 1 of the fiscal year, except when services are amended by HHSC during the fiscal year. This will allow HHSC to coordinate with annual revisions to HHSC's HMO Comparison Charts for Members. A HMO's request to add or delete a Value-added Service must be submitted to HHSC by May 1 of each year to be effective September 1 for the following contract period. (For STAR and CHIP, see **Attachment B-3, Value-Added Services**. For STAR+PLUS, see **Attachment B-3.1, STAR+PLUS Value-Added Services**. For CHIP Perinatal, see **Attachment B-3.2, CHIP Perinatal Value-Added Services.**)

A HMO's request to add a Value-added Service must:

a. Define and describe the proposed Value-added Service;

b. Specify the Service Areas and HMO Programs for the proposed Value-added Service;

c. Identify the category or group of mandatory Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all mandatory Members;

d. Note any limits or restrictions that apply to the Value-added Service;

e. Identify the Providers responsible for providing the Value-added Service;

f. Describe how the HMO will identify the Value-added Service in administrative (Encounter) data;

g. Propose how and when the HMO will notify Providers and mandatory Members about the availability of such Value-added Service;

h. Describe how a Member may obtain or access the Value-added Service; and

i. Include a statement that the HMO will provide such Value-added Service for at least 12 months from the September 1 effective date.

A HMO cannot include a Value-added Service in any material distributed to mandatory Members or prospective mandatory Members until the Parties have amended the Contract to include that Value-added Service. If a Value-added Service is deleted by amendment, the HMO must notify each mandatory Member that the service is no longer available through the HMO. The HMO must also revise all materials distributed to prospective mandatory Members to reflect the change in Value-added Services.

Section 8.1.2.2 modified by Versions 1.1 and 1.3

8.1.2.2 Case-by-Case Added Services

Except as provided below, the HMO may offer additional benefits that are outside the scope of services to individual Members on a case-by-case basis, based on Medical Necessity, cost-effectiveness, the wishes of the Member/Member's family, the potential for improved health status of the Member, and for STAR+PLUS Members based on functional necessity.

Section 8.1.2.2, Case-by-Case Added Services, does not apply to the CHIP Perinatal Program.

Section 8.1.3 modified by Versions 1.1 and 1.3

8.1.3 Access to Care

All Covered Services must be available to Members on a timely basis in accordance with medically appropriate guidelines, and consistent with generally accepted practice parameters, requirements in this Contract. The HMO must comply with the access requirements as established by the Texas Department of Insurance (TDI) for all HMOs doing business in Texas, except as otherwise required by this Contract. Medicaid HMOs must be responsive to the possibility of increased Members due to the phase-out of the PCCM model in Service Areas where adequate HMO coverage exists.

The HMO must provide coverage for Emergency Services to Members 24 hours a day and 7 days a week, without regard to prior authorization or the Emergency Service provider's contractual relationship with the HMO. The HMO's policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws and regulations, whether the provider is in-network or Out-of-Network. A HMO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers.

The HMO must also have an emergency and crisis Behavioral Health Services Hotline available 24 hours a day, 7 days a week, toll-free throughout the Service Area. The Behavioral Health Services Hotline must meet the requirements described in **Section 8.1.15.** For Medicaid Members, a HMO must provide coverage for Emergency Services in compliance with 42 C.F.R. §438.114, and as described in more detail in **Section 8.2.2.1**. The HMO may arrange Emergency Services and crisis Behavioral Health Services through mobile crisis teams.

For CHIP Members, Emergency Services, including emergency Behavioral Health Services, must be provided in accordance with the Texas Insurance Code and TDI regulations.

For the CHIP Perinatal Program, refer to Attachment B-2.2 for description of emergency services for CHIP Perinates and CHIP Perinate Newborns.

For the STAR, STAR+PLUS, and CHIP Programs, and for CHIP Perinate Newborns, HMO must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a day, 7 days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability that is consistent with, **Section 8.1.4.** CHIP Perinatal HMOs are not required to establish PCP Networks for CHIP Perinates.

The HMO must provide that if Medically Necessary Covered Services are not available through Network physicians or other Providers, the HMO must, upon the request of a Network physician or other Provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider. The HMO must fully reimburse the non-network provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC, and for CHIP, at the usual and customary rate defined by TDI in 28 T.A.C. Section 11.506.

The Member will not be responsible for any payment for Medically Necessary Covered Services, including Functionally Necessary Covered Services, other than:

(1) HHSC-specified co-payments for CHIP Members, where applicable; and

(2) STAR+PLUS Members who qualify for 1915(c) Nursing Facility Waiver services and enter a 24-hour setting will be required to pay the provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC. If the HMO provides Members who do not qualify for the 1915(c) Nursing Facility Waiver services in a 24-hour setting as an alternative to nursing facility or hospitalization, the Member will be required to pay the provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC.

8.1.3.1 Waiting Times for Appointments

Through its Provider Network composition and management, the HMO must ensure that appointments for the following types of Covered Services are provided within the time frames specified below. In all cases below, “day” is defined as a calendar day.

1. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;
2. Urgent care, including urgent specialty care, must be provided within 24 hours of request.
3. Routine primary care must be provided within 14 days of request;
4. Initial outpatient behavioral health visits must be provided within 14 days of request;
5. Routine specialty care referrals must be provided within 30 days of request;
6. Pre-natal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;
7. Preventive health services for adults must be offered to a Member within 90 days of request; and

8. Preventive health services for children, including well-child check-ups should be offered to Members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Please note that for Medicaid Members, HMOs should use the THSteps Program modifications to the AAP periodicity schedule. For newly enrolled Members under age 21, overdue or upcoming well-child checkups, including THSteps medical checkups, should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 60 days of enrollment for all other eligible child Members.

Section 8.1.3.2 modified by Versions 1.2 and 1.3

8.1.3.2 Access to Network Providers

The HMO's Network shall have within its Network, PCPs in sufficient numbers, and with sufficient capacity, to provide timely access to regular and preventive pediatric care and THSteps services to all child Members in accordance with the waiting times for appointments in **Section 8.1.3.1.**

PCP Access: At a minimum, the HMO must ensure that all Members have access to an age-appropriate PCP in the Provider Network with an Open Panel within 30 miles of the Member's residence. For the purposes of assessing compliance with this requirement, an internist who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age 21, and a pediatrician is not considered an age-appropriate choice for a Member age 21 and over. Note: This provision does not apply to CHIP Perinates, but it does apply to CHIP Perinate Newborns.

OB/GYN Access and CHIP Perinatal Program Provider Access: STAR, STAR+PLUS and CHIP Program Network: at a minimum, STAR, STAR+PLUS and CHIP HMOs must ensure that all female Members have access to an OB/GYN in the Provider Network within 75 miles of the Member's residence. (If the OB/GYN is acting as the Member's PCP, the HMO must follow the access requirements for the PCP.) The HMO must allow female Members to select an OB/GYN within its Provider Network. A female Member who selects an OB/GYN must be allowed direct access to the OB/GYN's health care services without a referral from the Member's PCP or a prior authorization. A pregnant Member with 12 weeks or less remaining before the expected delivery date must be allowed to remain under the Member's current OB/GYN care though the Member's post-partum checkup, even if the OB/GYN provider is, or becomes, Out-of-Network.

CHIP Perinatal Program Network: At a minimum, CHIP Perinatal HMOs must ensure that CHIP Perinates have access to a Provider of perinate services within 75 miles of the Member's residence if the Member resides in an urban area and within 125 miles of the Member's residence if the Member resides in a rural area.

Outpatient Behavioral Health Service Provider Access: At a minimum, the HMO must ensure that all Members except CHIP Perinates have access to an outpatient Behavioral Health Service Provider in the Network within 75 miles of the Member's residence. Outpatient Behavioral Health Service Providers must include Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient hospital departments. A Qualified Mental Health Provider (QMHP), as defined and credentialed by the Texas Department of State Health Services standards (T.A.C. Title 25, Part I, Chapter 412), is an acceptable outpatient behavioral health provider as long as the QMHP is working under the authority of an MHMR entity and is supervised by a licensed mental health professional or physician.

Other Specialist Physician Access: At a minimum, the HMO must ensure that all Members except CHIP Perinates have access to a Network specialist physician within 75 miles of the Member's residence for common medical specialties. For adult Members, common medical specialties shall include general surgery, cardiology, orthopedics, urology, and ophthalmology. For child Members, common medical specialties shall include orthopedics and otolaryngology.

Section 8.1.3.2 Modified by Version 1.6

Hospital Access: The HMO must ensure that all Members have access to an Acute Care hospital in the Provider Network within 30 miles of the Member's residence. For HMOs participating in the CHIP Perinatal Program, exceptions to this access standard may be requested on a case-by-case basis and must have HHSC approval.

All other Covered Services, except for services provided in the Member's residence: At a minimum, the HMO must ensure that all Members have access to at least one Network Provider for each of the remaining Covered Services described in **Attachment B-2,** within 75 miles of the Member's residence. This access requirement includes, but is not limited to, specialists, specialty hospitals, psychiatric hospitals, diagnostic and therapeutic services, and single or limited service health care physicians or Providers, as applicable to the HMO Program.

The HMO is not precluded from making arrangements with physicians or providers outside the HMO's Service Area for Members to receive a higher level of skill or specialty than the level available within the Service Area, including but not limited to, treatment of cancer, burns, and cardiac diseases. HHSC may consider exceptions to the above access-related requirements when an HMO has established, through utilization data provided to HHSC, that a normal pattern for securing health care services within an area does not meet these standards, or when an HMO is providing care of a higher skill level or specialty than the level which is available within the Service Area such as, but not limited to, treatment of cancer, burns, and cardiac diseases.

8.1.3.3 Monitoring Access

The HMO is required to systematically and regularly verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in **Sections 8.1.3.1 and 8.1.3.2**, and for Covered Services furnished by PCPs, the standards described in **Section 8.1.4.2**.

The HMO must enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the HMO to be out of compliance.

Section 8.1.4 Modified by Version 1.1 and 1.2

8.1.4 Provider Network

The HMO must enter into written contracts with properly credentialed Providers as described in this Section. The Provider contracts must comply with the **Uniform Managed Care Manual's** requirements.

The HMO must maintain a Provider Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The HMO must ensure its Providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the Contract.

The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, elderly, or disabled individuals, or other special population in the Service Areas and HMO Programs served by the HMO, including the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are deaf or hearing impaired.

The HMO must seek to obtain the participation in its Provider Network of qualified providers currently serving the Medicaid and CHIP Members in the HMO's proposed Service Area(s).

NOTE: The following Provider descriptions do not require STAR+PLUS HMOs to contract with Hospital providers for Inpatient Stay services. STAR+PLUS HMOs are required, however, to contract with Hospitals for Outpatient Hospital Services.

All Providers: All Providers must be licensed in the State of Texas to provide the Covered Services for which the HMO is contracting with the Provider, and not be under sanction or exclusion from the Medicaid program. All Acute Care Providers serving Medicaid Members must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). Long-term Care Providers are not required to have a TPIN but must have a LTC Provider number. Providers must also have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2007.)

Inpatient hospital and medical services: The HMO must ensure that Acute Care hospitals and specialty hospitals are available and accessible 24 hours per day, seven days per week, within the HMO's Network to provide Covered Services to Members throughout the Service Area.

Children's Hospitals/hospitals with specialized pediatric services: The HMO must ensure Members access to hospitals designated as Children's Hospitals by Medicare and hospitals with specialized pediatric services, such as teaching hospitals and hospitals with designated children's wings, so that these services are available and accessible 24 hours per day, seven days per week, to provide Covered Services to Members throughout the Service Area. The HMO must make Out-of-Network reimbursement arrangements with a designated Children's Hospital and/or hospital with specialized pediatric services in proximity to the Member's residence, and such arrangements must be in writing, if the HMO does not include such hospitals in its Provider Network. Provider Directories, Member materials, and Marketing materials must clearly distinguish between hospitals designated as Children's Hospitals and hospitals that have designated children's units.

Trauma: The HMO must ensure Members access to Texas Department of State Health Services (TDSHS) designated Level I and Level II trauma centers within the State or hospitals meeting the equivalent level of trauma care in the HMO's Service Area, or in close proximity to such Service Area. The HMO must make Out-of-Network reimbursement arrangements with the DSHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care, and such arrangements must be in writing, if the HMO does not include such a trauma center in its Provider Network.

Transplant centers: The HMO must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care. A list of HHSC-designated transplant centers can be found in the Procurement Library in Attachment H. The HMO must make Out-of-Network reimbursement arrangements with a designated transplant center or center meeting equivalent levels of care in proximity to the Member's residence, and such arrangements must be in writing, if the HMO does not include such a center in its Provider Network.

Hemophilia centers: The HMO must ensure Member access to hemophilia centers supported by the Centers for Disease Control (CDC). A list of these hemophilia centers can be found at http://www.cdc.gov/ncbddd/hbd/htc_list.htm. The HMO must make Out-of-Network reimbursement arrangements with a CDC-supported hemophilia center, and such arrangements must be in writing, if the HMO does not include such a center in its Provider Network.

Physician services: The HMO must ensure that Primary Care Providers are available and accessible 24 hours per day, seven days per week, within the Provider Network. The HMO must contract with a sufficient number of participating physicians and specialists within each Service Area to comply with the access requirements throughout **Section 8.1.3** and meet the needs of Members for all Covered Services.

The HMO must ensure that an adequate number of participating physicians have admitting privileges at one or more participating Acute Care hospitals in the Provider Network to ensure that necessary admissions are made. In no case may there be less than one in-network PCP with admitting privileges available and accessible 24 hours per day, seven days per week for each Acute Care hospital in the Provider Network.

The HMO must ensure that an adequate number of participating specialty physicians have admitting privileges at one or more participating hospitals in the HMO's Provider Network to ensure necessary admissions are made. The HMO shall require that all physicians who admit to hospitals maintain hospital access for their patients through appropriate call coverage.

Laboratory services: The HMO must ensure that in-network reference laboratory services must be of sufficient size and scope to meet the non-emergency and emergency needs of the enrolled population and the access requirements in **Section 8.1.3**. Reference laboratory specimen procurement services must facilitate the provision of clinical diagnostic services for physicians, Providers and Members through the use of convenient reference satellite labs in each Service Area, strategically located specimen collection areas in each Service Area, and the use of a courier system under the management of the reference lab. For Medicaid Members, THSteps requires that laboratory specimens obtained as part of a THSteps medical checkup visit must be sent to the TDSHS Laboratory.

Diagnostic imaging: The HMO must ensure that diagnostic imaging services are available and accessible to all Members in each Service Area in accordance with the access standards in **Section 8.1.3**. The HMO must ensure that diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

Home health services: The HMO must have a contract(s) with a home health Provider so that all Members living within the HMO's Service Area will have access to at least one such Provider for home health Covered Services. (These services are provided as part of the Acute Care Covered Services, not the Community Long-term Care Services.)

Community Long-term Care services: STAR+PLUS HMOs must have contracts with Community Long-term Care service Providers, so that all Members living within the Contractor's Service Area will have access to Medically Necessary and Functionally Necessary Covered Services.

8.1.4.1 Provider Contract Requirements

The HMO is prohibited from requiring a provider or provider group to enter into an exclusive contracting arrangement with the HMO as a condition for participation in its Provider Network.

The HMO's contract with health care Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include minimum requirements specified in the **Uniform Managed Care Contract Terms and Conditions (Attachment A)** and **HHSC's Uniform Managed Care Manual**.

The HMO must submit model Provider contracts to HHSC for review during Readiness Review. HHSC retains the right to reject or require changes to any model Provider contract that does not comply with HMO Program requirements or the HHSC-HMO Contract.

Section 8.1.4.2 modified by Versions 1.1 and 1.3

8.1.4.2 Primary Care Providers

The HMO's PCP Network may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; Obstetrics/Gynecology (OB/GYN); Certified Nurse Midwives (CNM) and Physician Assistants (PAs) practicing under the supervision of a physician; Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and similar community clinics; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions. Section 533.005(a)(13), Government Code, requires the HMO to use Pediatric and Family Advanced Practice Nurses practicing under the supervision of a physician as PCPs in its Provider Network for STAR and STAR+PLUS.

CHIP Perinatal HMOs are not required to develop PCP Networks for CHIP Perinates. CHIP Perinatal HMOs may use the same PCP Network for CHIP Members and CHIP Perinatal Newborns.

An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age 21. An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

1. the Provider assumes all HMO PCP responsibilities for such Members in a specific age group under age 21,

2. the Provider has a history of practicing as a PCP for the specified age group as evidenced by the Provider's primary care practice including an established patient population under age 20 and within the specified age range, and
3. the Provider has admitting privileges to a local hospital that includes admissions to pediatric units.

A pediatrician is not considered an age-appropriate choice for a Member age 21 and over.

The PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions may be a specialist physician who agrees to provide PCP services to the Member. The specialty physician must agree to perform all PCP duties required in the Contract and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request through the HMO for a specialist to serve as a PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions. The HMO shall handle such requests in accordance with 28 T.A.C. Part 1, Chapter 11, Subchapter J.

PCPs who provide Covered Services for STAR, CHIP, and CHIP Perinatal Newborns must either have admitting privileges at a Hospital that is part of the HMO's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. STAR+PLUS PCPs must either have admitting privileges at a Medicaid Hospital or make referral arrangements with a Provider who has admitting privileges to a Medicaid Hospital.

The HMO must require, through contract provisions, that PCPs are accessible to Members 24 hours a day, 7 days a week. The HMO is encouraged to include in its Network sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.

Acceptable after-hours coverage:

1. The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;
2. The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and
3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

1. The office telephone is only answered during office hours;
2. The office telephone is answered after-hours by a recording that tells patients to leave a message;

3. The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and
4. Returning after-hours calls outside of 30 minutes.

The HMO must require PCPs, through contract provisions or Provider Manual, to provide children under the age of 21 with preventive services in accordance with the AAP recommendations for CHIP Members and CHIP Perinate Newborns, and the THSteps periodicity schedule published in the THSteps Manual for Medicaid Members. The HMO must require PCPs, through contract provisions or Provider Manual, to provide adults with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The HMO must make best efforts to ensure that PCPs follow these periodicity requirements for children and adult Members. Best efforts must include, but not be limited to, Provider education, Provider profiling, monitoring, and feedback activities.

The HMO must require PCPs, through contract provisions or Provider Manual, to assess the medical needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral. The HMO must make best efforts to ensure that PCPs assess Member needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities and review of Provider referral patterns.

8.1.4.3 PCP Notification

The HMO must furnish each PCP with a current list of enrolled Members enrolled or assigned to that Provider no later than five (5) working days after the HMO receives the Enrollment File from the HHSC Administrative Services Contractor each month. The HMO may offer and provide such enrollment information in alternative formats, such as through access to a secure Internet site, when such format is acceptable to the PCP.

8.1.4.4 Provider Credentialing and Re-credentialing

The HMO must review, approve and periodically recertify the credentials of all participating physician Providers and all other licensed Providers who participate in the HMO's Provider Network. The HMO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC.

At a minimum, the scope and structure of a HMO's credentialing and re-credentialing processes must be consistent with recognized HMO industry standards such as those provided by NCQA and relevant state and federal regulations including 28 T.A.C. §11.1902, relating to credentialing of providers in HMOs, and as an additional requirement for Medicaid HMOs, 42 C.F.R. §438.214(b). The initial credentialing process, including application, verification of information, and a site visit (if applicable), must be completed before the effective date of the initial contract with the physician or Provider. The re-credentialing process must occur at least every three years.

The re-credentialing process must take into consideration Provider performance data including, but not be limited to, Member Complaints and Appeals, quality of care, and utilization management.

8.1.4.5 Board Certification Status

The HMO must maintain a policy with respect to Board Certification for PCPs and specialty physicians that encourage participation of board certified PCPs and specialty physicians in the Provider Network. The HMO must make information on the percentage of Board-certified PCPs in the Provider Network and the percentage of Board-certified specialty physicians, by specialty, available to HHSC upon request.

Section 8.1.4.6 modified by Version 1.3

8.1.4.6 Provider Manual, Materials and Training

The HMO must prepare and issue a Provider Manual(s), including any necessary specialty manuals (e.g., behavioral health) to all existing Network Providers. For newly contracted Providers, the HMO must issue copies of the Provider Manual(s) within five (5) working days from inclusion of the Provider into the Network. The Provider Manual must contain sections relating to special requirements of the HMO Program(s) and the enrolled populations in compliance with the requirements of this Contract.

HHSC or its designee must approve the Provider Manual, and any substantive revisions to the Provider Manual, prior to publication and distribution to Providers. The Provider Manual must contain the critical elements defined in the **Uniform Managed Care Manual**. HHSC's initial review of the Provider Manual is part of the Operational Readiness Review described in **Attachment B-1, Section 7.**

The HMO must provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The HMO's Medicaid, CHIP and/or CHIP Perinatal Program training must be completed within 30 days of placing a newly contracted Provider on active status. The HMO must provide on-going training to new and existing Providers as required by the HMO or HHSC to comply with the Contract. The HMO must maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.

The HMO must establish ongoing Provider training that includes, but is not limited to, the following issues:

1. Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., Early Intervention services, therapies and DME/Medical Supplies); and for Medicaid, making referrals and coordination with Non-capitated Services;
2. Relevant requirements of the Contract;
3. The HMO's quality assurance and performance improvement program and the Provider's role in such a program; and
4. The HMO's policies and procedures, especially regarding in-network and Out-of-Network referrals.

Provider Materials produced by the HMO, relating to Medicaid Managed Care, the CHIP Program, and/or the CHIP Perinatal Program must be in compliance with State and Federal laws and requirements of the **HHSC Uniform Managed Care Contract Terms and Conditions**. HMO must make available any provider materials to HHSC upon request.

8.1.4.7 Provider Hotline

The HMO must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for the Service Area, Monday through Friday, except for State-approved holidays. The Provider Hotline must be staffed with personnel who are knowledgeable about Covered Services and each applicable HMO Program, and for Medicaid, about Non-capitated Services.

The HMO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition. The HMO must have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition, provided, however, that the HMO and its Providers must not require such verification prior to providing Emergency Services.

The HMO must ensure that the Provider Hotline meets the following minimum performance requirements for all HMO Programs and Service Areas:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system is used;
2. no more than one percent of incoming calls receive a busy signal;
3. the average hold time is 2 minutes or less; and
4. the call abandonment rate is 7% or less.

The HMO must conduct ongoing call quality assurance to ensure these standards are met. The Provider Hotline may serve multiple HMO Programs if Hotline staff is knowledgeable about all of the HMO's Programs. The Provider Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Provider Network in such Service Areas.

The HMO must monitor its performance regarding Provider Hotline standards and submit performance reports summarizing call center performance for the Hotline as indicated in **Section 8.1.20**. If the HMO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to Behavioral Health Services, the BHO's Provider Hotline must meet the requirements in **Section 8.1.4.7**.

Section 8.1.4.8 modified by Version 1.1

8.1.4.8 Provider Reimbursement

The HMO must make payment for all Medically Necessary Covered Services provided to all Members for whom the HMO is paid a capitation. A STAR+PLUS HMO must also make payment for all Functionally Necessary Covered Services provided to all Members for whom the HMO is paid a capitation. The HMO must ensure that claims payment is timely and accurate as described in **Section 8.1.18.5.** The HMO must require tax identification numbers from all participating Providers. The HMO is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

8.1.4.9 Termination of Provider Contracts

Unless prohibited or limited by applicable law, at least 15 days prior to the effective date of the HMO's termination of contract of any participating Provider the HMO must notify the HHSC Administrative Services Contractor and notify affected current Members in writing. Affected Members include all Members in a PCP's panel and all Members who have been receiving ongoing care from the terminated Provider, where ongoing care is defined as two or more visits for home-based or office-based care in the past 12 months.

Section 8.1.4.9 modified by Version 1.3
For the CHIP and CHIP Perinatal Programs, the HMO's process for terminating Provider contracts must comply with the Texas Insurance Code and TDI regulations.

8.1.5 Member Services

The HMO must maintain a Member Services Department to assist Members and Members' family members or guardians in obtaining Covered Services for Members. The HMO must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities, see 8.1.5.6 Member Hotline Requirements.

8.1.5.1 Member Materials

Section 8.1.5.1 modified by Version 1.2
The HMO must design, print and distribute Member identification (ID) cards and a Member Handbook to Members. Within five business days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the HMO must mail a Member's ID card and Member Handbook to the Case Head or Account Name for each new Member. When the Case Head or Account Name is on behalf of two or more new Members, the HMO is only required to send one Member Handbook. The HMO is responsible for mailing materials only to those Members for whom valid address data are contained in the Enrollment File.

The HMO must design, print and distribute a Provider Directory to the HHSC Administrative Services Contractor as described in **Section 8.1.5.4.**

Member materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch reading ease test. Member materials must be available in English, Spanish, and the languages of other Major Population Groups making up 10% or more of the managed care eligible population in the HMO's Service Area, as specified by HHSC. HHSC will provide the HMO with reasonable notice when the enrolled population reaches 10% within the HMO's Service Area. All Member materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and audiotapes.

The HMO must submit member materials to HHSC for approval prior to use or mailing. HHSC will identify any required changes to the Member materials within 15 business days. If HHSC

has not responded to the Contractor by the fifteenth day, the Contractor may proceed to use the submitted materials. HHSC reserves the right to require discontinuation of any Member materials that violate the terms of the **Uniform Managed Care Terms and Conditions**, including but not limited to "Marketing Policies and Procedures" as described in the **Uniform Managed Care Manual**.

Section 8.1.5.2 modified by Version 1.3

8.1.5.2 Member Identification (ID) Card

All Member ID cards must, at a minimum, include the following information:

1. the Member's name;
2. the Member's Medicaid, CHIP or CHIP Perinatal Program number;
3. the effective date of the PCP assignment (excluding CHIP Perinates);
4. the PCP's name, address (optional for all products), and telephone number (excluding CHIP Perinates);
5. the name of the HMO;
6. the 24-hour, seven (7) day a week toll-free Member services telephone number and BH Hotline number operated by the HMO; and
7. any other critical elements identified in the **Uniform Managed Care Manual**.

The HMO must reissue the Member ID card if a Member reports a lost card, there is a Member name change, if the Member requests a new PCP, or for any other reason that results in a change to the information disclosed on the ID card. CHIP Perinatal HMOs must issue Member ID cards to both CHIP Perinates and CHIP Perinate Newborns.

8.1.5.3 Member Handbook

HHSC must approve the Member Handbook, and any substantive revisions, prior to publication and distribution. As described in **Attachment B-1, Section 7**, the HMO must develop and submit to HHSC the draft Member Handbook for approval during the Readiness Review and must submit a final Member Handbook incorporating changes required by HHSC prior to the Operational Start Date.

Section 8.1.5.3 modified by Version 1.3

The Member Handbook for each applicable HMO Program must, at a minimum, meet the Member materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **Uniform Managed Care Manual**. CHIP Perinatal HMOs must issue Member Handbooks to both CHIP Perinates and CHIP Perinate Newborns. The Member Handbook for CHIP Perinate Newborns may be the same as that used for CHIP.

The HMO must produce a revised Member Handbook, or an insert informing Members of changes to Covered Services upon HHSC notification and at least 30 days prior to the effective date of such change in Covered Services. In addition to modifying the Member materials for new Members, the HMO must notify all existing Members of the Covered Services change during the time frame specified in this subsection.

8.1.5.4 Provider Directory

The Provider Directory for each applicable HMO Program, and any substantive revisions, must be approved by HHSC prior to publication and distribution. The HMO is responsible for submitting draft Provider directory updates to HHSC for prior review and approval if changes other than PCP information or clerical corrections are incorporated into the Provider Directory.

As described in **Attachment B-1, Section 7**, during the Readiness Review, the HMO must develop and submit to HHSC the draft Provider Directory template for approval and must submit a final Provider Directory incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the deadlines established in **Attachment B-1, Section 7**.

The Provider Directory for each applicable HMO Program must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **Uniform Managed Care Manual**. The Provider Directory must include only Network Providers credentialed by the HMO in accordance with **Section 8.1.4.4**. If the HMO contracts with limited Provider Networks, the Provider Directory must comply with the requirements of 28 T.A.C. §11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.

Section 8.1.5.4 modified by Version 1.3
CHIP Perinatal HMOs must develop Provider Directories for both CHIP Perinates and CHIP Perinate Newborns. The Provider Directory for CHIP Perinate Newborns may be the same as that used for the CHIP Program.

The HMO must update the Provider Directory on a quarterly basis. The HMO must make such update available to existing Members on request, and must provide such update to the HHSC Administrative Services Contractor at the beginning of each state fiscal quarter. HHSC will consult with the HMOs and the HHSC Administrative Services Contractors to discuss methods for reducing the HMO's administrative costs of producing new Provider Directories, including considering submission of new Provider Directories on a semi-annual rather than a quarterly basis if a HMO has not made major changes in its Provider Network, as determined by HHSC. HHSC will establish weight limits for the Provider Directories. Weight limits may vary by Service Area. HHSC will require HMOs that exceed the weight limits to compensate HHSC for postage fees in excess of the weight limits.

The HMO must send the most recent Provider Directory, including any updates, to Members upon request. The HMO must, at least annually, include written and verbal offers of such Provider Directory in its Member outreach and education materials.

8.1.5.5 Internet Website

The HMO must develop and maintain, consistent with HHSC standards and Section 843.2015 of the Texas Insurance Code and other applicable state laws, a website to provide general information about the HMO's Program(s), its Provider Network, its customer services, and its Complaints and Appeals process. The HMO may develop a page within its existing website to meet the requirements of this section. The HMO must maintain a Provider Directory for its HMO Program(s) on the HMO's website with designation of open versus closed panels. The HMO's website must comply with the Marketing Policies and Procedures for each applicable HHSC HMO Program.

The website's HMO Program content must be:

1. Written in Major Population Group languages (which under this contract include only English and Spanish);
2. Culturally appropriate;
3. Written for understanding at the 6th grade reading level; and
4. Be geared to the health needs of the enrolled HMO Program population.

To minimize download and "wait times," the website must avoid tools or techniques that require significant memory or disk resources or require special intervention on the customer side to install plug-ins or additional software. Use of proprietary items that would require a specific browser are not allowed. HHSC strongly encourages the use of tools that take advantage of efficient data access methods and reduce the load on the server or bandwidth.

Section 8.1.5.6 modified by Versions 1.2 and 1.3

8.1.5.6 Member Hotline

The HMO must operate a toll-free hotline that Members can call 24 hours a day, seven (7) days a week. The Member Hotline must be staffed with personnel who are knowledgeable about its HMO Program(s) and Covered Services, between the hours of 8:00 a.m. to 5:00 p.m. local time for the Service Area, Monday through Friday, excluding state-approved holidays.

The HMO must ensure that after hours, on weekends, and on holidays the Member Services Hotline is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. All recordings must be in English and in Spanish. A voice mailbox must be available after hours for callers to leave messages. The HMO's Member Services representatives must return member calls received by the automated system on the next working day.

If the Member Hotline does not have a voice-activated menu system, the HMO must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button.

The HMO must ensure that its Member Service representatives treat all callers with dignity and respect the callers' need for privacy. At a minimum, the HMO's Member Service representatives must be:

1. Knowledgeable about Covered Services;
2. Able to answer non-technical questions pertaining to the role of the PCP, as applicable;
3. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;
4. Able to give information about Providers in a particular area;
5. Knowledgeable about Fraud, Abuse, and Waste and the requirements to report any conduct that, if substantiated, may constitute Fraud, Abuse, or Waste in the HMO Program;
6. Trained regarding Cultural Competency;

Section 8.1.5.6 modified by Version 1.3

7. Trained regarding the process used to confirm the status of persons with Special Health Care Needs;
8. For Medicaid members, able to answer non-clinical questions pertaining to accessing Non-capitated Services; and
9. For CHIP Members, able to give correct cost-sharing information relating to premiums, co-pays or deductibles, as applicable. (Cost-sharing does not apply to CHIP Perinates or CHIP Perinate Newborns.)

Hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking (and particularly, Spanish-speaking) callers, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the HMO must employ bilingual Spanish-speaking Member Services representatives and must secure the services of other contractors as necessary to meet these requirements.

The HMO must process all incoming Member correspondence and telephone inquiries in a timely and responsive manner. The HMO cannot impose maximum call duration limits but must allow calls to be of sufficient length to ensure adequate information is provided to the Member. The HMO must ensure that the toll-free Member Hotline meets the following minimum performance requirements for all HMO Programs and Service Areas:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system;
2. no more than one percent (1%) of incoming calls receive a busy signal;
3. at least 80% of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option; and
4. the call abandonment rate is 7% or less.

The HMO must conduct ongoing quality assurance to ensure these standards are met.

The Member Services Hotline may serve multiple HMO Programs if Hotline staff is knowledgeable about all of the HMO's Medicaid and/or CHIP Programs. The Member Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Provider Network in each Service Area.

The HMO must monitor its performance regarding HHSC Member Hotline standards and submit performance reports summarizing call center performance for the Member Hotline as indicated in **Section 8.1.20** and the **Uniform Managed Care Manual.**

Section 8.1.5.7 modified by Version 1.3

8.1.5.7 Member Education

The HMO must, at a minimum, develop and implement health education initiatives that educate Members about:

1. How the HMO system operates, including the role of the PCP;
2. Covered Services, limitations and any Value-added Services offered by the HMO;
3. The value of screening and preventive care, and
4. How to obtain Covered Services, including:
   a. Emergency Services;
   b. Accessing OB/GYN and specialty care;

c. Behavioral Health Services;

d. Disease Management programs;

e. Service Coordination, treatment for pregnant women, Members with Special Health Care Needs, including Children with Special Health Care Needs; and other special populations;

f. Early Childhood Intervention (ECI) Services;

g. Screening and preventive services, including well-child care (THSteps medical checkups for Medicaid Members);

h. For CHIP Members, Member co-payments

i. Suicide prevention; and

j. Identification and health education related to Obesity.

The HMO must provide a range of health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The HMO must propose, implement, and assess innovative Member education strategies for wellness care and immunization, as well as general health promotion and prevention. The HMO must conduct wellness promotion programs to improve the health status of its Members. The HMO may cooperatively conduct health education classes for all enrolled Members with one or more HMOs also contracting with HHSC in the Service Area. The HMO must work with its Providers to integrate health education, wellness and prevention training into the care of each Member.

The HMO also must provide condition and disease-specific information and educational materials to Members, including information on its Service Management and Disease Management programs described in **Section 8.1.13 and Section 8.1.** Condition- and disease-specific information must be oriented to various groups within the managed care eligible population, such as children, the elderly, persons with disabilities and non-English speaking Members, as appropriate to the HMO's Medicaid, CHIP and/or CHIP Perinatal Program(s).

8.1.5.8 Cultural Competency Plan

The HMO must have a comprehensive written Cultural Competency Plan describing how the HMO will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency Plan must describe how the individuals and systems within the HMO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The HMO must submit the Cultural Competency Plan to HHSC for Readiness Review. Modifications and amendments to the plan must be submitted to HHSC no later than 30 days prior to implementation. The Plan must also be made available to the HMO's Network of Providers.

8.1.5.9 Member Complaint and Appeal Process

The HMO must develop, implement and maintain a system for tracking, resolving, and reporting Member Complaints regarding its services, processes, procedures, and staff. The HMO must ensure that Member Complaints are resolved within 30 calendar days after receipt. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions and Attachment B-5, Deliverables/Liquidated Damages Matrix.**

The HMO must develop, implement and maintain a system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Within this process, the HMO must respond fully and completely to each Appeal and establish a tracking mechanism to document the status and final disposition of each Appeal.

The HMO must ensure that Member Appeals are resolved within 30 calendar days, unless the HMO can document that the Member requested an extension or the HMO shows there is a need for additional information and the delay is in the Member's interest. The HMO is subject to liquidated damages if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.**

Section 8.1.5.8 modified by Version 1.3
Medicaid HMOs must follow the Member Complaint and Appeal Process described in **Section 8.2.6**. CHIP and CHIP Perinatal HMOs must comply with the CHIP Complaint and Appeal Process described in **Sections 8.4.2** and **8.5.2,** respectively.

8.1.6 Marketing and Prohibited Practices

The HMO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in the Contract, and the **HHSC Uniform Managed Care Manual**.

8.1.7 Quality Assessment and Performance Improvement

The HMO must provide for the delivery of quality care with the primary goal of improving the health status of Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The HMO must work in collaboration with Providers to actively improve the quality of care provided to Members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The HMO must provide mechanisms for Members and Providers to offer input into the HMO's quality improvement activities.

8.1.7.1 QAPI Program Overview

The HMO must develop, maintain, and operate a quality assessment and performance improvement (QAPI) Program consistent with the Contract, and TDI requirements, including 28 T.A.C. §11.1901(a)(5) and §11.1902. Medicaid HMOs must also meet the requirements of 42 C.F.R. §438.240.

The HMO must have on file with HHSC an approved plan describing its QAPI Program, including how the HMO will accomplish the activities required by this section. The HMO must submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its

designee. The HMO must keep participating physicians and other Network Providers informed about the QAPI Program and related activities. The HMO must include in Provider contracts a requirement securing cooperation with the QAPI.

The HMO must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

1. Evaluate performance using objective quality indicators;
2. Foster data-driven decision-making;
3. Recognize that opportunities for improvement are unlimited;
4. Solicit Member and Provider input on performance and QAPI activities;
5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;
6. Support programmatic improvements of clinical and non-clinical processes based on findings from on-going measurements; and
7. Support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

8.1.7.2 QAPI Program Structure

The HMO must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The HMO must designate a senior executive responsible for the QAPI Program and the Medical Director must have substantial involvement in QAPI Program activities. At a minimum, the HMO must ensure that the QAPI Program structure:

1. Is organization-wide, with clear lines of accountability within the organization;
2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;
3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and
4. Evaluates the effectiveness of clinical and non-clinical initiatives.

8.1.7.3 Clinical Indicators

The HMO must engage in the collection of clinical indicator data. The HMO must use such clinical indicator data in the development, assessment, and modification of its QAPI Program.

8.1.7.4 QAPI Program Subcontracting

If the HMO subcontracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the HMO must maintain a file of the subcontractors. The file must be available for review by HHSC or its designee upon request.

8.1.7.5 Behavioral Health Integration into QAPI Program

Section 8.1.7.5 modified by Version 1.3

If the HMO provides Behavioral Health Services within the Covered Services as defined in **Attachments B-2, B-2.1, and B-2.2**, it must integrate behavioral health into its QAPI Program and include a systematic and on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. The HMO must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.

8.1.7.6 Clinical Practice Guidelines

The HMO must adopt not less than two evidence-based clinical practice guidelines for each applicable HMO Program. Such practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the HMO's Members, be adopted in consultation with contracting health care professionals, and be reviewed and updated periodically, as appropriate. The HMO must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

The HMO may coordinate the development of clinical practice guidelines with other HHSC HMOs to avoid providers in a Service Area receiving conflicting practice guidelines from different HMOs.

The HMO must disseminate the practice guidelines to all affected Providers and, upon request, to Members and potential Members.

The HMO must take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until such point that 90% or more of the Providers are consistently in compliance, based on HMO measurement findings. The HMO must employ substantive Provider motivational incentive strategies, such as financial and non-financial incentives, to improve Provider compliance with clinical practice guidelines. The HMO's decisions regarding utilization management, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the HMO's clinical practice guidelines.

8.1.7.7 Provider Profiling

The HMO must conduct PCP and other Provider profiling activities at least annually. As part of its QAPI Program, the HMO must describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers.

Provider profiling activities must include, but not be limited to:

Section 8.1.7.7 modified by Versions 1.1 and 1.3

1. Developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

2. Establishing PCP, Provider, group, Service Area or regional Benchmarks for areas profiled, where applicable, including STAR, STAR+PLUS, CHIP and CHIP Perinatal Program-specific Benchmarks, where appropriate; and
3. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

8.1.7.8 Network Management

The HMO must:

1. Use the results of its Provider profiling activities to identify areas of improvement for individual PCPs and Providers, and/or groups of Providers;
2. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established HMO standards or improvement goals;
3. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and
4. At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards such improvement goals.

8.1.7.9 Collaboration with the EQRO

The HMO will collaborate with HHSC's external quality review organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for HMO improvement. To facilitate this process, the HMO will supply claims data to the EQRO in a format identified by HHSC in consultation with HMOs, and will supply medical records for focused clinical reviews conducted by the EQRO. The HMO must also work collaboratively with HHSC and the EQRO to annually measure selected HEDIS measures that require chart reviews. During the first year of operations, HHSC anticipates that the selected measures will include, at a minimum, well-child visits and immunizations, appropriate use of asthma medications, measures related to Members with diabetes, and control of high blood pressure.

8.1.8 Utilization Management

The HMO must have a written utilization management (UM) program description, which includes, at a minimum:

1. Procedures to evaluate the need for Medically Necessary Covered Services;
2. The clinical review criteria used, the information sources, the process used to review and approve the provision of Covered Services;
3. The method for periodically reviewing and amending the UM clinical review criteria; and
4. The staff position functionally responsible for the day-to-day management of the UM function.

The HMO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations.

The HMO must issue coverage determinations, including adverse determinations, according to the following timelines:

- Within three (3) business days after receipt of the request for authorization of services;
- Within one (1) business day for concurrent hospitalization decisions; and
- Within one (1) hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the HMO must not require prior authorization.

The HMO's UM Program must include written policies and procedures to ensure:

1. Consistent application of review criteria that are compatible with Members' needs and situations;
2. Determinations to deny or limit services are made by physicians under the direction of the Medical Director;
3. Appropriate personnel are available to respond to utilization review inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, with a telephone system capable of accepting utilization review inquiries after normal business hours. The HMO must respond to calls within one business day;
4. Confidentiality of clinical information; and
5. Quality is not adversely impacted by financial and reimbursement-related processes and decisions.

For HMOs with preauthorization or concurrent review programs, qualified medical professionals must supervise preauthorization and concurrent review decisions.

The HMO UM Program must include polices and procedures to:

1. Routinely assess the effectiveness and the efficiency of the UM Program;
2. Evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;
3. target areas of suspected inappropriate service utilization;
4. Detect over- and under-utilization;
5. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;
6. Compare Member and Provider utilization with norms for comparable individuals;
7. Routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services;
8. Ensure that when Members are receiving Behavioral Health Services from the local mental health authority that the HMO is using the same UM guidelines as those prescribed for use by Local Mental Health Authorities by MHMR which are published at: http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/RDMClinGuide.html ; and

9. Refer suspected cases of provider or Member Fraud, Abuse, or Waste to the Office of Inspector General (OIG) as required by **Section 8.1.19**.

8.1.9 Early Childhood Intervention (ECI)

The HMO must ensure that Network Providers are educated regarding their responsibility under federal laws (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) to identify and refer any Member age three (3) or under suspected of having a developmental disability or delay, or who is at risk of delay, to the designated ECI program for screening and assessment within two (2) working days from the day the Provider identifies the Member. The HMO must use written educational materials developed or approved by the Department of Assistive and Rehabilitative Services – Division for Early Childhood Intervention Services for these "child find" activities. Eligibility for ECI services will be determined by the local ECI program using the criteria contained in 40 T.A.C. §108.25.

The HMO must contract with qualified ECI Providers to provide ECI services to Members under age three who have been determined eligible for ECI services. The HMO must permit Members to self refer to local ECI Service Providers without requiring a referral from the Member's PCP. The HMO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to ECI providers.

The HMO must coordinate and cooperate with local ECI programs in the development and implementation of the Individual Family Service Plan (IFSP), including on-going case management and other non-capitated services required by the Member's IFSP. The IFSP is an agreement developed by the interdisciplinary team that consists of the ECI Case Manager/Service Coordinator, the Member/family, and other professionals who participated in the Member's evaluation or are providing direct services to the Member, and may include the Member's Primary Care Physician (PCP) with parental consent. The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP shall be transmitted by the ECI Provider to the HMO and the PCP with parental consent to enhance coordination of the plan of care. The IFSP may be included in the Member's medical record.

Cooperation with the ECI program includes covering medical diagnostic procedures and providing medical records required to perform developmental assessments and developing the IFSP within the 45-day timeline established in federal rule (34 C.F.R. §303.342(a)). The HMO must require compliance with these requirements through Provider contract provisions. The HMO must not withhold authorization for the provision of such medical diagnostic procedures. The HMO must promptly provide to the ECI program, relevant medical records available to the HMO.

The interdisciplinary team will determine Medical Necessity for health and Behavioral Health Services as approved by the Member's PCP. The HMO must require, through contract provisions, that all Medically Necessary health and Behavioral Health Services contained in the Member's IFSP are provided to the Member in the amount, duration, scope and service setting established by the IFSP. The HMO must allow services to be provided by a non-network provider if a Network Provider is not available to provide the services in the amount, duration, scope and

service setting as required by the IFSP. The HMO cannot modify the plan of care or alter the amount, duration, scope, or service setting required by the Member's IFSP. The HMO cannot create unnecessary barriers for the Member to obtain IFSP services, including requiring prior authorization for the ECI assessment or establishing insufficient authorization periods for prior authorized services.

8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)—Specific Requirements

The HMO must, by contract, require its Providers to coordinate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. The HMO must make referrals to WIC for Members potentially eligible for WIC. The HMO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.11 Coordination with Texas Department of Family and Protective Services

The HMO must cooperate and coordinate with the Texas Department of Family and Protective Services (TDFPS) (formerly the Department of Protective and Regulatory Services) for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS.

The HMO must comply with all provisions related to Covered Services, including Behavioral Health Services, in the following documents:

- A court order (Order) entered by a Court of Continuing Jurisdiction placing a child under the protective custody of TDFPS.
- A TDFPS Service Plan entered by a Court of Continuing Jurisdiction placing a child under the protective custody of TDFPS.
- A TDFPS Service Plan voluntarily entered into by the parents or person having legal custody of a Member and TDFPS.

The HMO cannot deny, reduce, or controvert the Medical Necessity of any health or Behavioral Health Services included in an Order. The HMO may participate in the preparation of the medical and behavioral care plan prior to TDFPS submitting the health care plan to the Court. Any modification or termination of court-ordered services must be presented and approved by the court having jurisdiction over the matter.

A Member or the parent or guardian whose rights are subject to an Order or Service Plan cannot use the HMO's Complaint or Appeal processes, or the HHSC Fair Hearing process to Appeal the necessity of the Covered Services.

The HMO must include information in its Provider Manuals and training materials regarding:

1. Providing medical records to TDFPS;

2. Scheduling medical and Behavioral Health Services appointments within 14 days unless requested earlier by TDFPS; and
3. Recognition of abuse and neglect, and appropriate referral to TDFPS.

The HMO must continue to provide all Covered Services to a Member receiving services from, or in the protective custody of, TDFPS until the Member has been disenrolled from the HMO due to loss of Medicaid managed care eligibility or placed into foster care.

Section 8.1.12 modified by Versions 1.1 and 1.3

8.1.12 Services for People with Special Health Care Needs

This section applies to STAR, STAR+PLUS, CHIP HMOs. It applies to CHIP Perinatal HMOs with respect to their Perinate Newborn Members only.

8.1.12.1 Identification

The HMO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN), including people with disabilities or chronic or complex medical and behavioral health conditions and Children with Special Health Care Needs (CSHCN)[1].

The HMO must contact Members pre-screened by the HHSC Administrative Services Contractor as MSHCN to determine whether they meet the HMO's MSHCN assessment criteria, and to determine whether the Member requires special services described in this section. The HMO must provide information to the HHSC Administrative Services Contractor that identifies Members who the HMO has assessed to be MSHCN, including any Members pre-screened by the HHSC Administrative Services Contractor and confirmed by the HMO as a MSHCN. The information must be provided, in a format and on a timeline to be specified by HHSC in the **Uniform Managed Care Manual**, and updated with newly identified MSHCN by the 10th day of each month. In the event that a MSHCN changes HMOs, the HMO must provide the receiving contractor information concerning the results of the HMO's identification and assessment of that Member's needs, to prevent duplication of those activities.

Section 8.1.12.2 modified by Version 1.1

8.1.12.2 Access to Care and Service Management

Once identified, the HMO must have effective systems to ensure the provision of Covered Services to meet the special preventive, primary Acute Care, and specialty health care needs appropriate for treatment of the individual Member's condition(s). All STAR+PLUS Members are considered to be MSHCN.

[1] CSHCN is a term often used to refer to a services program for children with special health care needs administered by DSHS, and described in 25 TAC, Part 1, Section 38.1. Although children served through this program may also be served by Medicaid or CHIP, the reference to "CSHCN" in this Contract does not refer to children served through this program.

The HMO must provide access to identified PCPs and specialty care Providers with experience serving MSHCN. Such Providers must be board-qualified or board-eligible in their specialty. The HMO may request exceptions from HHSC for approval of traditional providers who are not board-qualified or board-eligible but who otherwise meet the HMO's credentialing requirements.

For services to CSHCN, the HMO must have Network PCPs and specialty care Providers that have demonstrated experience with CSHCN in pediatric specialty centers such as children's hospitals, teaching hospitals, and tertiary care centers.

The HMO is responsible for working with MSHCN, their families and legal guardians if applicable, and their health care providers to develop a seamless package of care in which primary, Acute Care, and specialty service needs are met through a Service Plan that is understandable to the Member, or, when applicable, the Member's legal guardian.

The HMO is responsible for providing Service Management to develop a Service Plan and ensure MSHCN, including CSHCN, have access to treatment by a multidisciplinary team when the Member's PCP determines the treatment is Medically Necessary, or to avoid separate and fragmented evaluations and service plans. The team must include both physician and non-physician providers determined to be necessary by the Member's PCP for the comprehensive treatment of the Member. The team must:

1. Participate in hospital discharge planning;
2. Participate in pre-admission hospital planning for non-emergency hospitalizations;
3. Develop specialty care and support service recommendations to be incorporated into the Service Plan; and
4. Provide information to the Member, or when applicable, the Member's legal guardian concerning the specialty care recommendations.

MSHCN, their families, or their health providers may request Service Management from the HMO. The HMO must make an assessment of whether Service Management is needed and furnish Service Management when appropriate. The HMO may also recommend to a MSHCN, or to a CSHCN's family, that Service Management be furnished if the HMO determines that Service Management would benefit the Member.

The HMO must provide information and education in its Member Handbook and Provider Manual about the care and treatment available in the HMO's plan for Members with Special Health Care Needs, including the availability of Service Management.

The HMO must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician. The HMO must also provide MSHCN with access to non-primary care physician specialists as PCPs, as required by 28 T.A.C. §11.900 and **Section 8.1**.

The HMO must implement a systematic process to coordinate Non-capitated Services, and enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important to the health and wellbeing of Members. The HMO also must make a best effort to establish relationships with State and local programs and community organizations, such as those listed below, in order to make referrals for MSHCN and other Members who need community services:

- Community Resource Coordination Groups (CRCGs);
- Early Childhood Intervention (ECI) Program;

- Local school districts (Special Education);
- Texas Department of Transportation's Medical Transportation Program (MTP);
- Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
- Texas Department of State Health (DSHS) services, including community mental health programs, the Title V Maternal and Child Health and Children with Special Health Care Needs (CSHCN) Programs, and the Program for Amplification of Children of Texas (PACT);
- Other state and local agencies and programs such as food stamps, and the Women, Infants, and Children's (WIC) Program;
- Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population.

Section 8.1.13 modified by Versions 1.1 and 1.3

8.1.13 Service Management for Certain Populations

The HMO must have service management programs and procedures for the following populations, as applicable to the HMO's Medicaid and/or CHIP Program(s) (See CHIP Perinatal Program Covered Services, **Attachment B-2.2**, for the applicability of these services to the CHIP Perinatal Program):

1. High-cost catastrophic cases;
2. Women with high-risk pregnancies (STAR and STAR+PLUS Programs only); and
3. Individuals with mental illness and co-occurring substance abuse.

Section 8.1.14 modified by Version 1.1

8.1.14 Disease Management (DM)

The HMO must provide, or arrange to have provided to Members, comprehensive disease management services consistent with state statutes and regulations. Such DM services must be part of person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. The HMO must develop and implement DM services that relate to chronic conditions that are prevalent in HMO Program Members. In the first year of operations, STAR, STAR+PLUS and CHIP HMOs must have DM Programs that address Members with chronic conditions to be identified by HHSC and included within the **Uniform Managed Care Manual**. HHSC will not identify the Members with chronic conditions. The HMO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a program to provide such DM services. The HMO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with chronic conditions identified by HHSC and included within the **Uniform Managed Care Manual**. The HMO must ensure that all Members identified for DM are enrolled into a DM Program with the opportunity to opt out of these services within 30 days while still maintaining access to all other Covered Services.

The DM Program(s) must include:

1. Patient self-management education;
2. Provider education;
3. Evidence-based models and minimum standards of care;
4. Standardized protocols and participation criteria;
5. Physician-directed or physician-supervised care;
6. Implementation of interventions that address the continuum of care;
7. Mechanisms to modify or change interventions that are not proven effective; and
8. Mechanisms to monitor the impact of the DM Program over time, including both the clinical and the financial impact.

The HMO must maintain a system to track and monitor all DM participants for clinical, utilization, and cost measures.

The HMO must provide designated staff to implement and maintain DM Programs and to assist participating Members in accessing DM services. The HMO must educate Members and Providers about the HMO's DM Programs and activities. Additional requirements related to the HMO's Disease Management Programs and activities are found in the **HHSC Uniform Managed Care Manual**.

8.1.14.1 DM Services and Participating Providers

At a minimum, the HMO must:

1. Implement a system for Providers to request specific DM interventions;
2. Give Providers information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning such Members' adherence to a service plan; and
3. For Members enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP.

8.1.14.2 HMO DM Evaluation

HHSC or its EQRO will evaluate the HMO's DM Program.

Section 8.1.15 modified by Version 1.3

8.1.15 Behavioral Health (BH) Network and Services

The requirements in this sub-section pertain to all HMOs except: (1) the STAR HMOs in the Dallas CSA, whose Members receive Behavioral Health Services through the NorthSTAR Program, and (2) the CHIP Perinatal Program HMOs with respect to their Perinate Members.

The HMO must provide, or arrange to have provided, to Members all Medically Necessary Behavioral Health (BH) Services as described in **Attachments B-2, B-2.1, and B-2.2**. All BH Services must be provided in conformance with the access standards included in **Section 8.1.3**. For Medicaid HMOs, BH Services are described in more detail in the **Texas Medicaid Provider Procedures Manual** and the **Texas Medicaid Bulletins**. When assessing Members for BH

Services, the HMO and its Network Behavioral Health Service Providers must use the DSM-IV multi-axial classification. HHSC may require use of other assessment instrument/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and assessment/outcome information in the Member's medical record.

8.1.15.1 BH Provider Network

The HMO must maintain a Behavioral Health Services Provider Network that includes psychiatrists, psychologists, and other Behavioral Health Service Providers. The Provider Network must include Behavioral Health Service Providers with experience serving special populations among the HMO Program(s)' enrolled population, including, as applicable, children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities, to ensure accessibility and availability of qualified Providers to all Members in the Service Area.

8.1.15.2 Member Education and Self-referral for Behavioral Health Services

The HMO must maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.

The HMO must permit Members to self refer to any in-network Behavioral Health Services Provider without a referral from the Member's PCP. The HMOs' policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self- referral to BH services.

The HMO must permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and must provide the Member with information on accessible in-network Providers with relevant experience.

8.1.15.3 Behavioral Health Services Hotline

This Section includes Hotline functions pertaining to Members. Requirements for Provider Hotlines are found in **Section 8.1.4.7**. The HMO must have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel 24 hours a day, 7 days a week, toll-free throughout the Service Area. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess behavioral health emergencies. Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. It is not acceptable for an emergency intake line to be answered by an answering machine.

The HMO must operate a toll-free hotline as described in **Section 8.1.5.6** to handle Behavioral Health-related calls. The HMO may operate one hotline to handle emergency and crisis calls and routine Member calls. The HMO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.

The Behavioral Health Services Hotline may serve multiple HMO Programs Hotline staff is knowledgeable about all of the HMO Programs. The Behavioral Health Services Hotline may

serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area. The HMO must ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all HMO Programs and Service Areas:

Section 8.1.15.3 modified by Version 1.2

1. 99% of calls are answered by the fourth ring or an automated call pick-up system;
2. No incoming calls receive a busy signal;
3. At least 80% of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option; and
4. The call abandonment rate is 7% or less.

The HMO must conduct on-going quality assurance to ensure these standards are met.

The HMO must monitor the HMO's performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated in **Section 8.1.20** and the **Uniform Managed Care Manual.**

8.1.15.4 Coordination between the BH Provider and the PCP

The HMO must require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.

The HMO must provide training to network PCPs on how to screen for and identify behavioral health disorders, the HMO's referral process for Behavioral Health Services and clinical coordination requirements for such services. The HMO must include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.

The HMO shall develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs. The HMO must require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement must be specified in all Provider Manuals.

The HMO must require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement must be specified in all Provider Manuals.

8.1.15.5 Follow-up after Hospitalization for Behavioral Health Services

The HMO must require, through Provider contract provisions, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment

prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. The HMO must ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments.

8.1.15.6 Chemical Dependency

The HMO must comply with 28 T.A.C. §3.8001 *et seq*., regarding utilization review for Chemical Dependency Treatment. Chemical Dependency Treatment must conform to the standards set forth in 28 T.A.C. Part 1, Chapter 3, Subchapter HH.

8.1.15.7 Court-Ordered Services

"Court-Ordered Commitment" means a commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C.

The HMO must provide inpatient psychiatric services to Members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to Court-Ordered Commitments to psychiatric facilities. The HMO is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.

The HMO cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court-ordered Commitment for Members under age 21. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.

A Member who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code can only Appeal the commitment through the court system.

8.1.15.8 Local Mental Health Authority (LMHA)

The HMO must coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facility regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric facility.

Medicaid HMOs are required to comply with additional Behavioral Health Services requirements relating to coordination with the LMHA and care for special populations. These Medicaid HMO requirements are described in **Section 8.2.8**.

8.1.16 Financial Requirements for Covered Services

The HMO must pay for or reimburse Providers for all Medically Necessary Covered Services provided to all Members. The HMO is not liable for cost incurred in connection with health care rendered prior to the date of the Member's Effective Date of Coverage in that HMO. A Member may receive collateral health benefits under a different type of insurance such as workers compensation or personal injury protection under an automobile policy. If a Member is entitled to

coverage for specific services payable under another insurance plan and the HMO paid for such Covered Services, the HMO may obtain reimbursement from the responsible insurance entity not to exceed 100% of the value of Covered Services paid.

8.1.17 Accounting and Financial Reporting Requirements

The HMO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Generally Accepted Accounting Principles (GAAP) and the cost principles contained in the Cost Principles Document in the **Uniform Managed Care Manual**. The State will not recognize or pay services that cannot be properly substantiated by the HMO and verified by HHSC.

The HMO must:

1. Maintain accounting records for each applicable HMO Program separate and apart from other corporate accounting records;
2. Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;
3. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts; and
4. Within 60 days after Contract execution, submit an accounting policy manual that includes all proposed policies and procedures the HMO will follow during the duration of the Contract. Substantive modifications to the accounting policy manual must be approved by HHSC.

The HMO agrees to pay for all reasonable costs incurred by HHSC to perform an examination, review or audit of the HMO's books pertaining to the Contract.

8.1.17.1 General Access to Accounting Records

The HMO must provide authorized representatives of the Texas and federal government full access to all financial and accounting records related to the performance of the Contract.

The HMO must:

1. Cooperate with the State and federal governments in their evaluation, inspection, audit, and/or review of accounting records and any necessary supporting information;
2. Permit authorized representatives of the State and federal governments full access, during normal business hours, to the accounting records that the State and the Federal government determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the HMO;

3. Make copies of any accounting records or supporting documentation relevant to the Contract available to HHSC or its agents within ten (10) business days of receiving a written request from HHSC for specified records or information. If such documentation is not made available as requested, the HMO agrees to reimburse HHSC for all costs, including, but not limited to, transportation, lodging, and subsistence for all State and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions at the location(s) of such accounting records; and
4. Pay any and all additional costs incurred by the State and federal government that are the result of the HMO's failure to provide the requested accounting records or financial information within ten (10) business days of receiving a written request from the State or federal government.

Section 8.1.17.2 modified by Versions 1.2 and 1.3

8.1.17.2 Financial Reporting Requirements

HHSC will require the HMO to provide financial reports by HMO Program and by Service Area to support Contract monitoring as well as State and Federal reporting requirements. HHSC will consult with HMOs regarding the format and frequency of such reporting. All financial information and reports that are not Member-specific are property of HHSC and will be public record. Any deliverable or report in Section 8.1.17.2 without a specified due date is due quarterly on the last day of the month. Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

CHIP Perinatal Program data must be reported, and the data will be integrated into existing CHIP Program financial reports. Except for the Financial Statistical Report, no separate CHIP Perinatal Program reports are required. For all other CHIP financial reports, where appropriate, HHSC will designate specific attributes within the CHIP Program financial reports that the CHIP Perinatal HMOs must complete to allow HHSC to extract financial data particular to the CHIP Perinatal Program.

HHSC's **Uniform Managed Care Manual** will govern the timing, format and content for the following reports.

Audited Financial Statement –The HMO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The HMO must provide the most recent annual financial statements, as required by the Texas Department of Insurance for each year covered under the Contract, no later than March 1.

Affiliate Report – The HMO must submit an Affiliate Report to HHSC if this information has changed since the last report submission. The report must contain the following:

1. A list of all Affiliates, and
2. For HHSC's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the HMO by the Affiliate. Those should include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the HMO for such services during the Contract Period.

Employee Bonus and/or Incentive Payment Plan – If a HMO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the HMO must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC so it may determine whether such payments are allowable administrative expenses in accordance with Cost Principles Document in the **Uniform Managed Care Manual.** The written plan must include a description of the HMO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the HMO substantively revises the Employee Bonus and/or Incentive Payment Plan, the HMO must submit the revised plan to HHSC for prior review and approval.

Claims Lag Report—The HMO must submit Claims Lag Report as a Contract year-to-date report. The report must be submitted quarterly by the last day of the month following the reporting period. The report must be submitted to HHSC in a format specified by HHSC. The report format is contained in the **Uniform Managed Care Manual** Chapter 5, Section 5.6.2. The report must disclose the amount of incurred claims each month and the amount paid each month by categories of service, such as inpatient facility, out-patient facility, professional and other services, if applicable. The report must include total claims incurred and paid by month.

DSP Report—The HMO must submit a monthly Delivery Supplemental Payment (DSP) Report that includes the data elements specified by HHSC in the format specified by HHSC. HHSC will consult with contracted HMOs prior to revising the DSP Report data elements and requirements. The DSP Report must include only unduplicated deliveries and only deliveries for which the HMO has made a payment, to either a hospital or other provider.

Form CMS-1513—The HMO must file an original Form CMS-1513 prior to beginning operations regarding the HMO's control, ownership, or affiliations. An updated Form CMS-1513 must also be filed no later than 30 days after any change in control, ownership, or affiliations.

FSR Reports – The HMO must file quarterly and annual Financial-Statistical Reports (FSR) in the format and timeframe specified by HHSC. HHSC will include FSR format and directions in the **Uniform Managed Care Manual**. The HMO must incorporate financial and statistical data of delegated networks (e.g., IPAs, ANHCs, Limited Provider Networks), if any, in its FSR Reports. Administrative expenses reported in the FSRs must be reported in accordance with the Cost Principles Document in the **Uniform Managed Care Manual**. Quarterly FSR reports are due no later than 30 days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR report must reflect expenses incurred through the 90th day after the end of the fiscal year. The first annual report must be filed on or before the 120th day after the end of each fiscal year and accompanied by an actuarial opinion by a qualified actuary who is in good standing with the American Academy of Actuaries. Subsequent annual reports must reflect data completed through the 334th day after the end of each fiscal year and must be filed on or before the 365th day following the end of each fiscal year.

CHIP Perinatal HMOs are required to submit separate FSRs for the CHIP Perinatal Program following the instructions outlined above and in the **Uniform Managed Care Manual**.

Out-of-Network Utilization Reports – The HMO must file quarterly Out-of Network Utilization Reports in the format and timeframe specified by HHSC. HHSC will include the report format and directions in the **Uniform Managed Care Manual**. Quarterly reports are due 30 days after the end of each quarter.

HUB Reports – Upon contract award, the HMO must attend a post award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services HUB Subcontracting Plan for inclusion and the HMO's good faith efforts to notify HUBs of subcontracting opportunities. The HMO must maintain its HUB Subcontracting Plan and submit monthly reports documenting the HMO's Historically Underutilized Business (HUB) program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the HMO's program efforts and a financial report reflecting payments made to HUBs. HMOs must use the formats included in HHSC's **Uniform Managed Care Manual** for the HUB monthly reports. The HMO must comply with HHSC's standard Client Services HUB Subcontracting Plan requirements for all subcontractors.

IBNR Plan—The HMO must furnish a written IBNR Plan to manage incurred-but-not-reported (IBNR) expenses, and a description of the method of insuring against insolvency, including information on all existing or proposed insurance policies. The Plan must include the methodology for estimating IBNR. The plan and description must be submitted to HHSC no later than 60 days after the Effective Date of the Contract. Substantive changes to a HMO's IBNR plan and description must be submitted to HHSC no later than 30 days before the HMO implements changes to the IBNR plan.

Medicaid Disproportionate Share Hospital (DSH) Reports – Medicaid HMOs must file preliminary and final Medicaid DSH reports, required by HHSC to identify and reimburse hospitals that qualify for Medicaid DSH funds. The preliminary and final DSH reports must include the data elements and be submitted in the form and format specified by HHSC in the **Uniform Managed Care Manual**. The preliminary DSH reports are due on or before June 1 of the year following the state fiscal reporting year. The final DSH reports are due no later than July 15 of the year following the state fiscal reporting year. This reporting requirement does not apply to CHIP or CHIP Perinatal Program HMOs. For STAR+PLUS, HMOs will include only outpatient services in the DSH report.

TDI Examination Report—The HMO must furnish a copy of any TDI Examination Report, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses, no later than 10 days after receipt of the final report from TDI.

TDI Filings – The HMO must submit annual figures for controlled risk-based capital, as well as its quarterly financial statements, both as required by TDI.

Registration Statement (also known as the "Form B")—If the HMO is a part of an insurance holding company system, the HMO must submit to HHSC a complete registration statement, also known as Form B, and all amendments to this form, and any other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

Section 1318 Financial Disclosure Report—The HMO must file an original CMS Public Health Service (PHS) Section 1318 Financial Disclosure Report prior to the start of Operations and an

updated CMS PHS Section 1318 Financial Disclosure Report no later than 30 days after the end of each Contract Year and no later than 30 days after entering into, renewing, or terminating a relationship with an affiliated party.

Third Party Recovery (TPR) Reports—The HMO must file TPR Reports in accordance with the format developed by HHSC in the **Uniform Managed Care Manual**. HHSC will require the HMO to submit TPR reports no more often than quarterly. TPR reports must include total dollars recovered from third party payers for each HMO Program for services to the HMO's Members, and the total dollars recovered through coordination of benefits, subrogation, and worker's compensation. For CHIP HMOs, the TPR Reports only apply if the HMO chooses to engage in TPR activities.

8.1.18 Management Information System Requirements

The HMO must maintain a Management Information System (MIS) that supports all functions of the HMO's processes and procedures for the flow and use of HMO data. The HMO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment/Eligibility Subsystem;
2. Provider Subsystem;
3. Encounter/Claims Processing Subsystem;
4. Financial Subsystem;
5. Utilization/Quality Improvement Subsystem;
6. Reporting Subsystem;
7. Interface Subsystem; and
8. TPR Subsystem, as applicable to each HMO Program.

The MIS must enable the HMO to meet the Contract requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for HMO administration.

HHSC will provide the HMO with pharmacy data on the HMO's Members on a weekly basis through the HHSC Vendor Drug Program, or should these services be outsourced, through the Pharmacy Benefit Manager. HHSC will provide a sample format of pharmacy data to contract awardees.

The HMO must have a system that can be adapted to changes in Business Practices/Policies within the timeframes negotiated by the Parties. The HMO is expected to cover the cost of such systems modifications over the life of the Contract.

The HMO is required to participate in the HHSC Systems Work Group.

The HMO must provide HHSC prior written notice of major systems changes, generally within 90 days, and implementations, including any changes relating to Material Subcontractors, in accordance with the requirements of this Contract and the **Uniform Managed Care Terms and Conditions.**

The HMO must provide HHSC any updates to the HMO's organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of the change. The HMO must provide HHSC official points of contact for MIS issues on an on-going basis.

HHSC, or its agent, may conduct a Systems Readiness Review to validate the HMO's ability to meet the MIS requirements as described in **Attachment B-1, Section 7**. The System Readiness Review may include a desk review and/or an onsite review and must be conducted for the following events:

1. A new plan is brought into the HMO Program;
2. An existing plan begins business in a new Service Area;
3. An existing plan changes location;
4. An existing plan changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions; and
5. An existing plan in one or two HHSC HMO Programs is initiating a Contract to participate in any additional HMO Programs.

If for any reason, a HMO does not fully meet the MIS requirements, then the HMO must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address such deficiency as requested by HHSC. Immediately upon identifying a deficiency, HHSC may impose remedies and either actual or liquidated damages according to the severity of the deficiency. HHSC may also freeze enrollment into the HMO's plan for any of its HMO Programs until such deficiency is corrected. Refer to the **Uniform Managed Care Terms and Conditions** and **Attachment B-5** for additional information.

8.1.18.1 Encounter Data

The HMO must provide complete Encounter Data for all Covered Services, including Value-added Services. Encounter Data must follow the format, and data elements as described in the HIPAA-compliant 837 format. HHSC will specify the method of transmission, and the submission schedule, in the **Uniform Managed Care Manual**. The HMO must submit monthly Encounter Data transmissions, and include all Encounter Data and Encounter Data adjustments processed by the HMO. Encounter Data quality validation must incorporate assessment standards developed jointly by the HMO and HHSC. The HMO must make original records available for inspection by HHSC for validation purposes. Encounter Data that do not meet quality standards must be corrected and returned within a time period specified by HHSC.

In addition to providing Encounter Data in the 837 format described above, HMOs must submit an Encounter Data file to HHSC's EQRO, in the format provided in the **Uniform Managed Care Manual**. This additional submission requirement is time-limited and may not be required for the entire term of the Contract.

For reporting Encounters and fee-for-service claims to HHSC, the HMO must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the HMO requesting an exception. The HMO must also use the provider numbers as directed by HHSC for both Encounter and fee-for-service claims submissions, as applicable.

8.1.18.2 HMO Deliverables related to MIS Requirements

At the beginning of each state fiscal year, the HMO must submit for HHSC's review and approval any modifications to the following documents:

1. Joint Interface Plan;
2. Disaster Recovery Plan;
3. Business Continuity Plan;
4. Risk Management Plan; and
5. Systems Quality Assurance Plan.

The HMO must submit such modifications to HHSC according to the format and schedule identified the HHSC **Uniform Managed Care Manual**.

8.1.18.3 System-wide Functions

Section 8.1.18.3 modified by Version 1.3
The HMO's MIS system must include key business processing functions and/or features, which must apply across all subsystems as follows:

1. Process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates;
2. Track Covered Services received by Members through the system, and accurately and fully maintain those Covered Services as HIPAA-compliant Encounter transactions;
3. Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;
4. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
6. Employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter transactions produced;
7. Accommodate the coordination of benefits;
8. Produce standard Explanation of Benefits (EOBs);
9. Pay financial transactions to Providers in compliance with federal and state laws, rules and regulations;
10. Ensure that all financial transactions are auditable according to GAAP guidelines.
11. Relate and extract data elements to produce report formats (provided within the **Uniform Managed Care Manual**) or otherwise required by HHSC;
12. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS; 13. Maintain and cross-reference all Member-related information with the most current Medicaid, CHIP or CHIP Perinatal Program Provider number; and
14. Ensure that the MIS is able to integrate pharmacy data from HHSC's Drug Vendor file (available through the Virtual Private Network (VPN)) into the HMO's Member data.

8.1.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance

The HMO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified. The HMO must comply with HIPAA EDI requirements. HMO's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 837/835 format.

The HMO must provide its Members with a privacy notice as required by HIPAA. The HMO must provide HHSC with a copy of its privacy notice for filing.

8.1.18.5 Claims Processing Requirements

Section 8.1.18.5 modified by Versions 1.2 and 1.3
The HMO must process and adjudicate all provider claims for Medically Necessary Covered Services that are filed within the time frames specified in the **Uniform Managed Care Manual**. The HMO is subject to remedies, including liquidated damages and interest, if the HMO does not process and adjudicate claims within the timeframes listed in the **Uniform Managed Care Manual**.

The HMO must administer an effective, accurate, and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, the Contract, and the **Uniform Managed Care Manual**. In addition, a Medicaid HMO must be able to accept and process provider claims in compliance with the Medicaid Provider Procedures Manual and The Texas Medicaid Bulletin.

The HMO must maintain an automated claims processing system that registers the date a claim is received by the MCO, the detail of each claim transaction (or action) at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. The claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

The HMO's claims system must maintain online and archived files. The HMO must keep online automated claims payment history for the most current 18 months. The HMO must retain other financial information and records, including all original claims forms, for the time period established in **Attachment A, Section 9.01**. All claims data must be easily sorted and produced in formats as requested by HHSC.

The HMO must offer its Providers/Subcontractors the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.

The HMO may deny a claim submitted by a provider for failure to file in a timely manner as provided for in the **Uniform Managed Care Manual**. The HMO must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, CHIP or CHIP Perinatal programs for Fraud, Abuse, or Waste. The HMO must not pay any claim submitted by a Provider that is on payment hold under the authority of HHSC or its authorized agent(s), or who has pending accounts receivable with HHSC.

The HMO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code Section 843.349 (e) and (f).

The HMO must notify HHSC of major claim system changes in writing no later than 90 days prior to implementation. The HMO must provide an implementation plan and schedule of proposed changes. HHSC reserves the right to require a desk or on-site readiness review of the changes.

The HMO must inform all Network Providers about the information required to submit a claim at least 30 days prior to the Operational Start Date and as a provision within the HMO/Provider contract. The HMO must make available to Providers claims coding and processing guidelines for the applicable provider type. Providers must receive 90 days notice prior to the HMO's implementation of changes to claims guidelines.

8.1.19 Fraud and Abuse

Section 8.1.19 modified by Version 1.3
A HMO is subject to all state and federal laws and regulations relating to Fraud, Abuse, and Waste in health care and the Medicaid and CHIP programs. The HMO must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected Fraud, Abuse or Waste. The HMO must provide originals and/or copies of all records and information requested and allow access to premises and provide records to the Inspector General for the Texas Health and Human Services System, HHSC or its authorized agent(s), the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, TDI, or other units of state government. The HMO must provide all copies of records free of charge.

The HMO must submit a written Fraud and Abuse compliance plan to the Office of Inspector General at HHSC for approval (See **Attachment B-1, Section 7** for requirements regarding timeframes for submitting the original plan.) The plan must ensure that all officers, directors, managers and employees know and understand the provisions of the HMO's Fraud and Abuse compliance plan. The plan must include the name, address, telephone number, electronic mail address, and fax number of the individual(s) responsible for carrying out the plan.

The written Fraud and Abuse compliance plan must:

1. Contain procedures designed to prevent and detect potential or suspected Abuse, Fraud and Waste in the administration and delivery of services under the Contract;
2. Contain a description of the HMO's procedures for educating and training personnel to prevent Fraud, Abuse, or Waste;
3. Include provisions for the confidential reporting of plan violations to the designated person within the HMO's organization and ensure that the identity of an individual reporting violations is protected from retaliation;

4. Include provisions for maintaining the confidentiality of any patient information relevant to an investigation of Fraud, Abuse, or Waste;
5. Provide for the investigation and follow-up of any allegations of Fraud, Abuse, or Waste and contain specific and detailed internal procedures for officers, directors, managers and employees for detecting, reporting, and investigating Fraud and Abuse compliance plan violations;
6. Require that confirmed violations be reported to the Office of Inspector General (OIG); and
7. Require any confirmed violations or confirmed or suspected Fraud, Abuse, or Waste under state or federal law be reported to OIG.

If the HMO contracts for the investigation of allegations of Fraud, Abuse, or Waste and other types of program abuse by Members or Providers, the plan must include a copy of the subcontract; the names, addresses, telephone numbers, electronic mail addresses, and fax numbers of the principals of the subcontracted entity; and a description of the qualifications of the subcontracted entity. Such subcontractors must be held to the requirements stated in this Section.

The HMO must designate executive and essential personnel to attend mandatory training in Fraud and Abuse detection, prevention and reporting. Designated executive and essential personnel means the HMO staff persons who supervise staff in the following areas: data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the Fraud and Abuse detection program within the HMO. The training will be conducted by the OIG free of charge. The HMO must schedule and complete training no later than 90 days after the Effective Date of the Contract. If the HMO updates or modifies its written Fraud and Abuse compliance plan, the HMO must train its executive and essential personnel on these updates or modifications no later than 90 days after the effective date of the updates or modifications.

The HMO must designate an officer or director in its organization with responsibility and authority to carry out the provisions of the Fraud and Abuse compliance plan. A HMO's failure to report potential or suspected Fraud or Abuse may result in sanctions, cancellation of the Contract, and/or exclusion from participation in the Medicaid, CHIP or CHIP Perinatal HMO Programs. The HMO must allow the OIG, HHSC, its agents, or other governmental units to conduct private interviews of the HMO's personnel, subcontractors and their personnel, witnesses, and Members with regard to a confirmed violation. The HMO's personnel and it subcontractors must reasonably cooperate, to the satisfaction of HHSC, by being available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations, at the HMO's and subcontractors' own expense.

8.1.20 Reporting Requirements

Section 8.1.20 modified by Version 1.2
The HMO must provide and must require its subcontractors to provide:

1. All information required under the Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities hereunder as reasonably requested by the HHSC; and

2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other Federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions as specified by HHSC. Where practicable, HHSC may consult with HMOs to establish time frames and formats reasonably acceptable to both parties.

Any deliverable or report in Section 8.1.20 without a specified due date is due quarterly on the last day of the month following the end of the reporting period. Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

The HMO's Chief Executive and Chief Financial Officers, or persons in equivalent positions, must certify that financial data, Encounter Data and other measurement data has been reviewed by the HMO and is true and accurate to the best of their knowledge after reasonable inquiry.

8.1.20.1 HEDIS and Other Statistical Performance Measures

The HMO must provide to HHSC or its designee all information necessary to analyze the HMO's provision of quality care to Members using measures to be determined by HHSC in consultation with the HMO. Such measures must be consistent with HEDIS or other externally based measures or measurement sets, and involve collection of information beyond that present in Encounter Data. The **Performance Indicator Dashboard**, found in the **Uniform Managed Care Manual** provides additional information on the role of the HMO and the EQRO in the collection and calculation of HEDIS, CAHPS, and other performance measures.

8.1.20.2 Reports

The HMO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.17** and those reporting requirements listed elsewhere in the Contract. The **HHSC Uniform Managed Care Manual** will include a list of all required reports, and a description of the format, content, file layout and submission deadlines for each report.

For the following reports, CHIP Perinatal Program data will be integrated into existing CHIP Program reports. Generally, no separate CHIP Perinatal Program reports are required. Where appropriate, HHSC will designate specific attributes within the CHIP Program reports that the CHIP Perinatal HMOs must complete to allow HHSC to extract data particular to the CHIP Perinatal Program.

Section 8.1.20.2 modified by Versions 1.2 and 1.3
Claims Summary Report - The HMO must submit quarterly Claims Summary Reports to HHSC by HMO Program, Service Area and claims processing subcontractor by the 30th day following the end of the reporting period unless otherwise specified. The format for the Claims Summary Report is contained in Chapter 5, Section 5.6.1 of the **Uniform Managed Care Manual**.

QAPI Program Annual Summary Report - The HMO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the Uniform Managed Care Manual.

Fraudulent Practices Report - Utilizing the HHSC-Office of Inspector General (OIG) fraud referral form, the HMO's assigned officer or director must report and refer all possible acts of waste, abuse or fraud to the HHSC-OIG within 30 working days of receiving the reports of possible acts of waste, abuse or fraud from the HMO's Special Investigative Unit (SIU). The report and referral must include: an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; the estimated overpayment identified; a summary of the interviews conducted; the encounter data submitted by the provider for the time period in question; and all supporting documentation obtained as the result of the investigation. This requirement applies to all reports of possible acts of waste, abuse and fraud.

Additional reports required by the Office of the Inspector General relating to waste, abuse or fraud are listed in the **HHSC Uniform Managed Care Manual**.

Provider Termination Report: (CHIP (including integrated CHIP Perinatal Program data) & STAR)

MCO must submit a quarterly report that identifies any providers who cease to participate in MCO's provider network, either voluntarily or involuntarily. The report must be submitted to HHSC in the format specified by HHSC, no later than 30 days after the end of the reporting period.

PCP Network & Capacity Report: (CHIP only (including integrated CHIP Perinatal Program data))

For the CHIP Program, MCO must submit a quarterly report listing all unduplicated PCPs in the MCO's Provider Network. For the CHIP Perinatal Program, the Perinatal Newborns are assigned PCPs that are part of the CHIP PCP Network. The report must be submitted to HHSC in the format specified by HHSC, no later than 30 days after the end of the reporting quarter.

Section 8.1.20.2 modified by Version 1.5

Summary Report of Member Complaints and Appeals - The HMO must submit quarterly Member Complaints and Appeals reports. The HMO must include in its reports Complaints and Appeals submitted to its subcontracted risk groups (e.g., IPAs) and any other subcontractor that provides Member services. The HMO must submit the Complaint and Appeals reports electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **HHSC Uniform Managed Care Manual,** Chapter 5.4.2.

HHSC may direct the CHIP Perinatal HMOs to provide segregated Member Complaints and Appeals reports on an as-needed basis.

Section 8.1.20.2 modified by Version 1.5

Summary Report of Provider Complaints - The HMO must submit Provider complaints reports on a quarterly basis. The HMO must include in its reports complaints submitted by providers to its subcontracted risk groups (e.g., IPAs) and any other subcontractor that provides Provider services. The complaint reports must be submitted electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **HHSC Uniform Managed Care Manual,** Chapter 5.4.2.

HHSC may direct the CHIP Perinatal HMOs to provide segregated Provider Complaints and Appeals reports on an as-needed basis.

Hotline Reports - The HMO must submit, on a quarterly basis, a status report for the Member Hotline, the Behavioral Health Services Hotline, and the Provider Hotline in comparison with the performance standards set out in **Sections 8.1.5.6, 8.1.14.3, and 8.1.4.7**. The HMO shall submit such reports using a format to be prescribed by HHSC in consultation with the HMOs.

If the HMO is not meeting a hotline performance standard, HHSC may require the HMO to submit monthly hotline performance reports and implement corrective actions until the hotline performance standards are met. If a HMO has a single hotline serving multiple Service Areas, multiple HMO Programs, or multiple hotline functions, (i.e. Member, Provider, Behavioral Health Services hotlines), HHSC may request on an annual basis that the HMO submit certain hotline response information by HMO Program, by Service Area, and by hotline function, as applicable to the HMO. HHSC may also request this type of hotline information if a HMO is not meeting a hotline performance standard.

The HMO must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for HHSC's Administrative Services Contractor, External Quality Review Organization (EQRO) and HHSC Medicaid Claims Administrator. The JIPs can be accessed through the Uniform Managed Care Manual.

8.2 Additional Medicaid HMO Scope of Work

Section 8.2 modified by Version 1.1
The following provisions apply to any HMO participating in the STAR or STAR+PLUS HMO Program.

8.2.1 Continuity of Care and Out-of-Network Providers

The HMO must ensure that the care of newly enrolled Members is not disrupted or interrupted. The HMO must take special care to provide continuity in the care of newly enrolled Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted.

The HMO must allow pregnant Members with 12 weeks or less remaining before the expected delivery date to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The HMO must pay a Member's existing Out-of-Network providers for Medically Necessary Covered Services until the Member's records, clinical information and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled in that HMO, whichever is shorter. Payment to Out-of-Network providers must be made within the time period required for Network Providers. The HMO must comply with out-of-network provider reimbursement rules as adopted by HHSC.

This Article does not extend the obligation of the HMO to reimburse the Member's existing Out-of-Network providers for on-going care for:

1. More than 90 days after a Member enrolls in the HMO's Program, or
2. For more than nine (9) months in the case of a Member who, at the time of enrollment in the HMO, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the HMO.

The HMO's obligation to reimburse the Member's existing Out-of-Network provider for services provided to a pregnant Member with 12 weeks or less remaining before the expected delivery date extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.

The HMO must provide or pay Out-of-Network providers who provide Medically Necessary Covered Services to Members who move out of the Service Area through the end of the period for which capitation has been paid for the Member.

The HMO must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and covered benefits not available within the network, in accordance with 42 C.F.R. §438.206(b)(4). The HMO will not be obligated to provide a Member with access to Out-of-Network services if such services become available from a Network Provider.

The HMO must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. §438.206(b)(3).

8.2.2 Provisions Related to Covered Services for Medicaid Members

8.2.2.1 Emergency Services

HMO policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. §438.114, whether the provider is in-network or Out-of-Network. HMO policies and procedures must be consistent with the prudent layperson definition of an Emergency Medical Condition and the claims adjudication processes required under the Contract and 42 C.F.R. §438.114.

The HMO must pay for the professional, facility, and ancillary services that are Medically Necessary to perform the medical screening examination and stabilization of a Member presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition to the hospital emergency department, 24 hours a day, 7 days a week, rendered by either the HMO's Network or Out-of-Network providers.

The HMO cannot require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. The HMO

cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The HMO cannot refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's PCP or the HMO of the Member's screening and treatment within 10 calendar days of presentation for Emergency Services. The HMO may not hold the Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The HMO must accept the emergency physician or provider's determination of when the Member is sufficiently stabilized for transfer or discharge.

A medical screening examination needed to diagnose an Emergency Medical Condition must be provided in a hospital based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 C.F.R. §§489.20, 489.24 and 438.114(b)&(c)). The HMO must pay for the emergency medical screening examination, as required by 42 U.S.C. §1395dd. The HMO must reimburse for both the physician's services and the hospital's Emergency Services, including the emergency room and its ancillary services.

When the medical screening examination determines that an Emergency Medical Condition exists, the HMO must pay for Emergency Services performed to stabilize the Member. The emergency physician must document these services in the Member's medical record. The HMO must reimburse for both the physician's and hospital's emergency stabilization services including the emergency room and its ancillary services.

The HMO must cover and pay for Post-Stabilization Care Services in the amount, duration, and scope necessary to comply with 42 C.F.R. §438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii). The HMO is financially responsible for post-stabilization care services obtained within or outside the Network that are not pre-approved by a Provider or other HMO representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

1. The HMO does not respond to a request for pre-approval within 1 hour;
2. The HMO cannot be contacted; or
3. The HMO representative and the treating physician cannot reach an agreement concerning the Member's care and a Network physician is not available for consultation. In this situation, the HMO must give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the patient until an HMO physician is reached. The HMO's financial responsibility ends as follows: the HMO physician with privileges at the treating hospital assumes responsibility for the Member's care; the HMO physician assumes responsibility for the Member's care through transfer; the HMO representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

8.2.2.2 Family Planning - Specific Requirements

The HMO must require, through Provider contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The HMO must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The HMO must ensure that Members have the right to choose any Medicaid participating family planning provider, whether the provider chosen by the Member is in or outside the Provider Network. The HMO must provide Members access to information about available providers of family planning services and the Member's right to choose any Medicaid family planning provider. The HMO must provide access to confidential family planning services.

The HMO must provide, at minimum, the full scope of services available under the Texas Medicaid program for family planning services. The HMO will reimburse family planning agencies the Medicaid fee-for service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies not covered by the Vendor Drug Program and will reimburse Out-of-Network family planning providers in accordance with HHSC's administrative rules.

The HMO must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The HMO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a subcontractor.

The HMO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers and Members, specifically regarding State and federal laws governing Member confidentiality (including minors). Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The HMO must require, through contractual provisions, that subcontractors have mechanisms in place to ensure Member's (including minor's) confidentiality for family planning services.

8.2.2.3 Texas Health Steps (EPSDT)

The HMO must develop effective methods to ensure that children under the age of 21 receive THSteps services when due and according to the recommendations established by the AAP and the THSteps periodicity schedule for children. The HMO must arrange for THSteps services for all eligible Members except when a Member knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision.

HMO must have mechanisms in place to ensure that all newly enrolled newborns receive an appointment for a THSteps checkup within 14 days of enrollment and all other eligible child Members receive a THSteps checkup within 60 days of enrollment, if one is due according to the AAP periodicity schedule.

The HMO must ensure that Members are provided information and educational materials about the services available through the THSteps Program, and how and when they may obtain the services. The information should tell the Member how they can obtain dental benefits, transportation services through the Texas Department of Transportation's Medical Transportation Program, and advocacy assistance from the HMO.

The HMO must provide appropriate training to all Network Providers and Provider staff in the Providers' area of practice regarding the scope of benefits available and the THSteps Program. Training must include:

1. THSteps benefits,
2. The periodicity schedule for THSteps medical checkups and immunizations,
3. The required elements of THSteps medical checkups,
4. Providing or arranging for all required lab screening tests (including lead screening), and Comprehensive Care Program (CCP) services available under the THSteps program to Members under age 21 years.

HMO must also educate and train Providers regarding the requirements imposed on HHSC and contracting HMOs under the Consent Decree entered in Frew v. Hawkins, et. al., Civil Action No. 3:93CV65, in the United States District Court for the Eastern District of Texas, Paris Division. Providers should be educated and trained to treat each THSteps visit as an opportunity for a comprehensive assessment of the Member.

The HMO must provide outreach to Members to ensure they receive prompt services and are effectively informed about available THSteps services. Each month, the HMO must retrieve from the HHSC Administrative Services Contractor Bulletin Board System a list of Members who are due and overdue THSteps services. Using these lists and its own internally generated list, the HMO will contact such Members to obtain the service as soon as possible. The HMO outreach staff must coordinate with DSHS THSteps outreach staff to ensure that Members have access to the Medical Transportation Program, and that any coordination with other agencies is maintained.

The HMO must cooperate and coordinate with the State, outreach programs and THSteps regional program staff and agents to ensure prompt delivery of services to children of migrant farm workers and other migrant populations who may transition into and out of the HMO's Program more rapidly and/or unpredictably than the general population.

The HMO must have mechanisms in place to ensure that all newborn Members have an initial newborn checkup before discharge from the hospital and again within two weeks from the time of birth. The HMO must require Providers to send all THSteps newborn screens to the DSHS Bureau of Laboratories or a DSHS certified laboratory. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the hospital with screens performed at the two-week follow-up.

All laboratory specimens collected as a required component of a THSteps checkup (see Medicaid Provider Procedures Manual for age-specific requirements) must be submitted to the DSHS Laboratory for analysis. The HMO must educate Providers about THSteps Program requirements for submitting laboratory tests to the DSHS Bureau of Laboratories.

The HMO must make an effort to coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is both familiar and convenient to the Members. The HMO must make a good faith effort to comply with Head Start's requirement that Members participating in Head Start receive their THSteps checkup no later than 45 days after enrolling into either program.

The HMO must educate Providers on the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the ACIP Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; and the DSHS Periodicity Schedule for Medicaid Members. The HMO shall educate Providers that Medicaid Members under age 21 must be immunized during the THSteps checkup according to the DSHS routine immunization schedule. The HMO shall also educate Providers that the screening provider is responsible for administration of the immunization and should not refer children to Local Health Departments to receive immunizations.

The HMO must educate Providers about, and require Providers to comply with, the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac), to include parental consent on the Vaccine Information Statement.

The HMO must require all THSteps Providers to submit claims for services paid (either on a capitated or fee-for service basis) on the HCFA 1500 claim form and use the HIPAA compliant code set required by HHSC.

Encounter Data will be validated by chart review of a random sample of THSteps eligible enrollees against monthly Encounter Data reported by the HMO. HHSC or its designee will conduct chart reviews to validate that all screens are performed when due and as reported, and that reported data is accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the HMO and/or Network Providers being investigated for potential Fraud, Abuse, or Waste without notice to the HMO or the Provider.

8.2.2.4 Perinatal Services

The HMO’s perinatal health care services must ensure appropriate care is provided to women and infant Members of the HMO from the preconception period through the infant’s first year of life. The HMO’s perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 T.A.C. Chapter 37, Subchapter M.

The HMO must have a perinatal health care system in place that, at a minimum, provides the following services:

1. Pregnancy planning and perinatal health promotion and education for reproductive- age women;
2. Perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and infants up to one year of age;
3. Access to appropriate levels of care based on risk assessment, including emergency care;
4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

The HMO must have a process to expedite scheduling a prenatal appointment for an obstetrical exam for a TP40 Member no later than two weeks after receiving the daily Enrollment File verifying the Member's enrollment into the HMO.

The HMO must have procedures in place to contact and assist a pregnant/delivering Member in selecting a PCP for her baby either before the birth or as soon as the baby is born.

The HMO must provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery.

The HMO must Adjudicate provider claims for services provided to a newborn Member in accordance with HHSC's claims processing requirements using the proxy ID number or State-issued Medicaid ID number. The HMO cannot deny claims based on a provider's non-use of State-issued Medicaid ID number for a newborn Member. The HMO must accept provider claims for newborn services based on mother's name and/or Medicaid ID number with accommodations for multiple births, as specified by the HMO.

The HMO must notify providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network providers and hospitals) of the HMO's prior authorization requirements. The HMO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises.

8.2.2.5 Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)

The HMO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The HMO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The HMO must allow Members access to STD services and HIV diagnosis services without prior authorization or referral by a PCP.

The HMO must comply with Texas Family Code Section 32.003, relating to consent to treatment by a child. The HMO must provide all Covered Services required to form the basis for a diagnosis by the Provider as well as the STD/HIV treatment plan.

The HMO must make education available to Providers and Members on the prevention, detection and effective treatment of STDs, including HIV.

Section 8.2.2.5 modified by Version 1.5
The HMO must require Providers to report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 T.A.C. §§97.131 - 97.134, using the required forms and procedures for reporting STDs. The HMO must require the Providers to coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia and HIV receive risk reduction and partner elicitation/notification counseling.

The HMO must have established procedures to make Member records available to public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow up activities.

The HMO must require that Providers have procedures in place to protect the confidentiality of Members provided STD/HIV services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared. The HMO must inform and require its Providers who provide STD/HIV services to comply with all state laws relating to communicable disease reporting requirements. The HMO must implement policies and procedures to monitor Provider compliance with confidentiality requirements.

The HMO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STD/HIV services.

8.2.2.6 Tuberculosis (TB)

The HMO must provide Members and Providers with education on the prevention, detection and effective treatment of tuberculosis (TB). The HMO must establish mechanisms to ensure all procedures required to screen at-risk Members and to form the basis for a diagnosis and proper prophylaxis and management of TB are available to all Members, except services referenced in **Section 8.2.2.8** as Non-Capitated Services. The HMO must develop policies and procedures to ensure that Members who may be or are at risk for exposure to TB are screened for TB. An at-risk Member means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions. The HMO must consult with the local TB control program to ensure that all services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), the Centers for Disease Control and Prevention (CDC), and DSHS policies and standards.

The HMO must implement policies and procedures requiring Providers to report all confirmed or suspected cases of TB to the local TB control program within one working day of identification, using the most recent DSHS forms and procedures for reporting TB. The HMO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request.

The HMO must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The HMO must require, through contract provisions, that Providers report to DSHS or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat. The HMO must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.

The HMO must have a mechanism for coordinating a post-discharge plan for follow-up DOT with the local TB program. The HMO must coordinate with the DSHS South Texas Hospital and Texas Center for Infectious Disease for voluntary and court-ordered admission, discharge plans, treatment objectives and projected length of stay for Members with multi-drug resistant TB.

8.2.2.7 Objection to Provide Certain Services

In accordance with 42 C.F.R. §438.102, the HMO may file an objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a Covered Service based on moral or religious grounds. The HMO must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Covered Services. The work plan will include timeframes for completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the HMO and enrollment materials needing revision, and notifications to Members.

In order to meet the requirements of this section, the HMO must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection, no less than 120 days prior to the proposed effective date of the policy change.

8.2.2.8 Medicaid Non-capitated Services

Section 8.2.2.8 modified by Version 1.1
The following Texas Medicaid programs and services have been excluded from HMO Covered Services. Medicaid Members are eligible to receive these Non-capitated Services on a Fee-for-Service basis from Texas Medicaid providers. HMOs should refer to relevant chapters in the **Provider Procedures Manual** and the **Texas Medicaid Bulletins** for more information.

1. THSteps dental (including orthodontia);
2. Early Childhood Intervention (ECI) case management/service coordination;
3. DSHS targeted case management;
4. DSHS mental health rehabilitation;
5. DSHS case management for Children and Pregnant Women;
6. Texas School Health and Related Services (SHARS);
7. Department of Assistive and Rehabilitative Services Blind Children’s Vocational Discovery and Development Program;
8. Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation);
9. Vendor Drug Program (out-of-office drugs);
10. Texas Department of Transportation Medical Transportation;
11. DADS hospice services (all Members are disenrolled from their health plan upon enrollment into hospice except STAR+PLUS members receiving 1915(c) Nursing Facility Waiver services that are not covered by the Hospice Program);
12. Audiology services and hearing aids for children (under age 21) (hearing screening services are provided through the THSteps Program and are capitated) through PACT (Program for Amplification for Children of Texas).
13. For STAR+PLUS, Inpatient Stays are Non-capitated Services.

8.2.2.9 Referrals for Non-capitated Services

Section 8.2.2.9 modified by Version 1.1
Although Medicaid HMOs are not responsible for paying or reimbursing for Non-capitated Services, HMOs are responsible for educating Members about the availability of Non-capitated Services, and for providing appropriate referrals for Members to obtain or access these services.

8.2.2.10 Cooperation with Immunization Registry

Section 8.2.2.10 added by Version 1.2
The HMO must work with HHSC and health care providers to improve the immunization rate of Medicaid clients and the reporting of immunization information for inclusion in the Texas Immunization Registry, called "ImmTrac."

8.2.2.11 Case Management for Children and Pregnant Women

Section 8.2.2.11 added by Version 1.2
The HMO must educate Members and Providers on the services available through Case Management for Children and Pregnant Women (CPW) as described on the program's website at http://www.dshs.state.tx.us/caseman/default.shtm. An HMO may provide information about CPW's website and basic information about CPW services in order to meet this requirement. CPW information and materials must be included in the HMO's Provider Manual, Member Handbook and Provider orientations. The information and materials must also inform Providers that the disclosure of medical records or information between Providers, HMO's and CPW case managers does not require a medical release form from the Member.

The HMO must coordinate services with CPW regarding a Member's health care needs that are identified by CPW and referred to the HMO. Upon receipt of a referral or assessment from a CPW case manager, the HMO's designated staff are required to review the assessment and determine, based on the HMO's policies, the appropriate level of health care and services. The HMO's staff must also coordinate with the Member's family, Member's Primary Care Provider (PCP), in and Out-of-Network Providers, agencies, and the HMO's utilization management staff to ensure that the health care and services identified are properly referred, authorized, scheduled and provided within a timely manner.

The HMO must ensure that access to medically necessary health care needed by the Member is available within the standards established by HHSC for respective care. HMOs are not required to arrange or provide for any covered or non-covered services identified in the CPW assessment. The decision whether to authorize these services is made by the HMO. Within five (5) business days of identifying any non-covered health care services or other services that the Member may need, the HMO's staff must report to the CPW case manager which items/services will not be performed by the HMO. Additionally, within ten (10) business days after all of the authorized services have been provided, the HMO's staff must follow-up with CPW case manager to report the provision of services. The HMO's staff must ensure that all services provided to a Member by an HMO Provider are reported to the Member's PCP.

The CPW program requires its contracted case managers to coordinate with the HMO and the HMO's PCPs. The HMO should report problems regarding CPW referrals, assessments or coordination activities to HHSC for follow-up with CPW program staff.

8.2.3 Medicaid Significant Traditional Providers

Section 8.2.3 modified by Version 1.1
In the first three (3) years of a Medicaid HMO Program operating in a Service Area, the HMO must seek participation in its Network from all Medicaid Significant Traditional Providers (STPs) defined by HHSC in the applicable Service Area for the applicable HMO Program. For STAR HMOs, the Medicaid STP requirements only apply in the Nueces Service Area. For STAR+PLUS HMOs, the Medicaid STP requirements apply to all Service Areas, except Harris County within the Harris Service Area.

Medicaid STPs are defined as PCPs and, for STAR+PLUS, Community-based Long Term Care providers in a county, that, when listed by provider type by county in descending order by unduplicated number of clients, served the top 80% of unduplicated clients. Hospitals receiving Disproportionate Share Hospital (DSH) funds are also considered STPs in the Service Area in which they are located. Note that STAR+PLUS HMOs are not required to contract with Hospitals for Inpatient Stays, but are required to contract with Hospitals for Outpatient Hospital Services. The HHSC website includes a list of Medicaid STPs by Service Area.

Because the STP lists were produced in FY2005, HHSC has developed an updated list for Long Term Care Providers. The list will be provided to HMOs and posted on HHSC's website.

The STP requirement will be in place for three years after the program has been implemented. During that time, providers who believe they meet the STP requirements may contact HHSC request HHSC's consideration for STP status. STAR+PLUS HMOs will be notified when Providers are added to the list of STPs for a Service Area.

The HMO must give STPs the opportunity to participate in its Network for at least three (3) years commencing on the implementation date of Medicaid managed care in the Service Area. However, the STP provider must:

1. Agree to accept the HMO's Provider reimbursement rate for the provider type; and
2. Meet the standard credentialing requirements of the HMO, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is not the sole grounds for exclusion from the Provider Network.

8.2.4 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

Section 8.2.4 Modified by Version 1.5
The HMO must make reasonable efforts to include FQHCs and RHCs (freestanding and hospital-based) in its Provider Network. The HMO must reimburse FQHCs and RHCs for health care services provided outside of regular business hours, as defined by HHSC in rules, including weekend days or holidays, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the Member does not have a referral from their PCP. FQHCs or RHCs will receive a cost settlement from HHSC and must agree to accept initial payments from the HMO in an amount that is equal to or greater than the HMO's payment terms for other Providers providing the same or similar services. Cost settlements will not be applicable to the Nueces Service Area and the STAR+PLUS Service Areas. The HMOs serving those Areas will pay the full encounter rates to the FQHCs and RHCs when claims payments are made.

The HMO must submit monthly FQHC and RHC encounter and payment reports to all contracted FQHCs and RHCs, and FQHCs and RHCs with which there have been encounters, not later than 21 days from the end of the month for which the report is submitted. The format will be developed by HHSC and provided in the **Uniform Managed Care Manual**. The FQHC and RHC must validate the encounter and payment information contained in the report(s). The HMO and the FQHC/RHC must both sign the report(s) after each party agrees that it accurately reflects encounters and payments for the month reported. The HMO must submit the signed FQHC and RHC encounter and payment reports to HHSC not later than 45 days from the end of the reported month. Encounter and payment reports will not be necessary for the Nueces Service Area and the STAR+PLUS Service Areas since the HMOs in those Areas will be paying the full encounter rates to the FQHCs and RHCs.

8.2.5 Provider Complaints and Appeals

8.2.5.1 Provider Complaints

Section 8.2.5.1 modified by Version 1.2
Medicaid HMOs must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider complaints. Within this process, the HMO must respond fully and completely to each complaint and establish a tracking mechanism to document the status and final disposition of each Provider complaint. The HMO must resolve Provider Complaints within 30 days from the date the Complaint is received.

8.2.5.2 Appeal of Provider Claims

Medicaid HMOs must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider appeals related to claims payment. Within this process, the Provider must respond fully and completely to each Medicaid Provider’s claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Medicaid Provider’s claims payment appeal.

Medicaid HMOs must contract with physicians who are not Network Providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider appeal. The determination of the physician resolving the dispute must be binding on the HMO and the Provider. The physician resolving the dispute must hold the same specialty or a related specialty as the appealing Provider. HHSC reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

8.2.6 Member Rights and Responsibilities

In accordance with 42 C.F.R. §438.100, all Medicaid HMOs must maintain written policies and procedures for informing Members of their rights and responsibilities, and must notify their Members of their right to request a copy of these rights and responsibilities. The Member Handbook must include notification of Member rights and responsibilities.

8.2.7 Medicaid Member Complaint and Appeal System

The HMO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 C.F.R. §431.200, 42 C.F.R. Part 438, Subpart F, "Grievance System," and the provisions of 1 T.A.C. Chapter 357 relating to Medicaid managed care organizations.

The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

8.2.7.1 Member Complaint Process

The HMO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives. For purposes of this **Section 8.2.7**, an "authorized representative" is any person or entity acting on behalf of the Member and with the Member's written consent. A Provider may be an authorized representative.

The HMO must resolve Complaints within 30 days from the date the Complaint is received. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.** The Complaint procedure must be the same for all Members under the Contract. The Member or Member's authorized representative may file a Complaint either orally or in writing. The HMO must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the HMO's complaint process.

The HMO must designate an officer of the HMO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of **Section 8.2.7.2**, an "officer" of the HMO means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The HMO must have a routine process to detect patterns of Complaints. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The HMO's Complaint procedures must be provided to Members in writing and through oral interpretive services. A written description of the HMO's Complaint procedures must be available in prevalent non-English languages for Major Population Groups identified by HHSC, at no more than a 6th grade reading level.

The HMO must include a written description of the Complaint process in the Member Handbook. The HMO must maintain and publish in the Member Handbook, at least one local and one toll-free telephone number with TeleTypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints.

The HMO's process must require that every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. Date;
2. Identification of the individual filing the Complaint;
3. Identification of the individual recording the Complaint;
4. Nature of the Complaint;
5. Disposition of the Complaint (i.e., how the HMO resolved the Complaint);
6. Corrective action required; and
7. Date resolved.

The HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

If the Member makes a request for disenrollment, the HMO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The HMO will cooperate with the HHSC's Administrative Services Contractor and HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees.

The HMO must provide designated Member Advocates to assist Members in understanding and using the HMO's Complaint system as described in **Section 8.2.7.9**. The HMO's Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the HMO's Complaint process until the issue is resolved.

8.2.7.2 Medicaid Standard Member Appeal Process

The HMO must develop, implement and maintain an Appeal procedure that complies with state and federal laws and regulations, including 42 C.F.R.§ 431.200 and 42 C.F.R. Part 438, Subpart F, "Grievance System." An Appeal is a disagreement with an HMO Action as defined in **HHSC's Uniform Contract Terms and Conditions**. The Appeal procedure must be the same for all Members. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the HMO must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member must file a request for an Appeal with the HMO within 30 days from receipt of the notice of the Action. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions and Attachment B-5, Deliverables/Liquidated Damages Matrix.** To ensure continuation of currently authorized services, however, the Member must file the Appeal on or before the later of 10 days following

the HMO's mailing of the notice of the Action, or the intended effective date of the proposed Action. The HMO must designate an officer who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the 30-day time limit.

The provisions of Article 21.58A, Texas Insurance Code, (to be recodified as Texas Insurance Code, Title 14, Chapter 4201), relating to a Member's right to Appeal an Adverse Determination made by the HMO or a utilization review agent to an independent review organization, do not apply to a Medicaid recipient. Article 21.58A is pre-empted by federal Fair Hearings requirements.

The HMO must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Action. The Medical Director must have a significant role in monitoring, investigating and hearing Appeals. In accordance with 42 C.F.R.§ 438.406, the HMO's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical expertise in treating the Member's condition or disease.

The HMO must provide designated Member Advocates, as described in **Section 8.2.7.9**, to assist Members in understanding and using the Appeal process. The HMO's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the HMO's Appeal process until the issue is resolved.

The HMO must have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

The HMO's Appeal procedures must be provided to Members in writing and through oral interpretive services. A written description of the Appeal procedures must be available in prevalent non-English languages identified by HHSC, at no more than a 6th grade reading level. The HMO must include a written description of the Appeals process in the Member Handbook. The HMO must maintain and publish in the Member Handbook at least one local and one toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Appeal of an Action.

The HMO's process must require that every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution. All Appeals must be recorded in a written record and logged with the following details:

1) Date notice is sent;
2) Effective date of the Action;
3) Date the Member or his or her representative requested the Appeal;
4) Date the Appeal was followed up in writing;
5) Identification of the individual filing;
6) Nature of the Appeal; and
7) Disposition of the Appeal, and notice of disposition to Member.

The HMO must send a letter to the Member within five (5) business days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal as provided in **Section 8.2.7.3**, the HMO must complete the entire standard Appeal process within 30 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for a standard Appeal may be extended up to 14 calendar days if the Member or his or her representative requests an extension; or the HMO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the HMO must give the Member written notice of the reason for delay if the Member had not requested the delay. The HMO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the HMO's written policies.

During the Appeal process, the HMO must provide the Member a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The HMO must inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

The HMO must provide the Member and his or her representative opportunity, before and during the Appeal process, to examine the Member's case file, including medical records and any other documents considered during the Appeal process. The HMO must include, as parties to the Appeal, the Member and his or her representative or the legal representative of a deceased Member's estate.

In accordance with 42 C.F.R.§ 438.420, the HMO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The Member or his or her representative files the Appeal timely as defined in this Contract:
2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
3. The services were ordered by an authorized provider;
4. The original period covered by the original authorization has not expired; and
5. The Member requests an extension of the benefits.

If, at the Member's request, the HMO continues or reinstates the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member withdraws the Appeal;
2. Ten (10) days pass after the HMO mails the notice resolving the Appeal against the Member, unless the Member, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or
3. A state Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service has been met.

In accordance with 42 C.F.R.§ 438.420(d), if the final resolution of the Appeal is adverse to the Member and upholds the HMO's Action, then to the extent that the services were furnished to comply with the Contract, the HMO may recover such costs from the Member.

If the HMO or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the HMO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If the HMO or 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 HMO is responsible for the payment of services.

The HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

8.2.7.3 Expedited Medicaid HMO Appeals

In accordance with 42 C.F.R. §438.410, the HMO must establish and maintain an expedited review process for Appeals, when the HMO determines (for a request from a Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The HMO must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.2.7.2**), except where differences are specifically noted. The HMO must accept oral or written requests for Expedited Appeals.

Members must exhaust the HMO's Expedited Appeal process before making a request for an expedited Fair Hearing. After the HMO receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within 3 business days, except that the HMO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member's request for Expedited Appeal is received.

Except for an Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member requests an extension or the HMO shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the HMO must give the Member written notice of the reason for delay if the Member had not requested the delay.

If the decision is adverse to the Member, the HMO must follow the procedures relating to the notice in **Section 8.2.7.5**. The HMO is responsible for notifying the Member of his or her right to access an expedited Fair Hearing from HHSC. The HMO will be responsible for providing documentation to the State and the Member, indicating how the decision was made, prior to HHSC's expedited Fair Hearing.

The HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited Appeal. The HMO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.

If the HMO denies a request for expedited resolution of an Appeal, it must:

(1) Transfer the Appeal to the timeframe for standard resolution, and

(2) Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

8.2.7.4 Access to Fair Hearing for Medicaid Members

The HMO must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the HMO. In the case of an expedited Fair Hearing process, the HMO must inform the Member that he or she must first exhaust the HMO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The HMO must notify Members that they may be represented by an authorized representative in the Fair Hearing process.

8.2.7.5 Notices of Action and Disposition of Appeals for Medicaid Members

The HMO must notify the Member, in accordance with 1 T.A.C. Chapter 357, whenever the HMO takes an Action. The notice must, at a minimum, include any information required by 1 T.A.C. Chapter 357 that relates to a managed care organization's notice of Action and any information required by 42 C.F.R. §438.404 as directed by HHSC, including but not limited to:

1. The Action the HMO has taken or intends to take;

2. The reasons for the Action;

3. The Member's right to access the HMO's Appeal process.

4. The procedures by which the Member may Appeal the HMO's Action;

5. The circumstances under which expedited resolution is available and how to request it;

6. The circumstances under which a Member may continue to receive benefits 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;

7. The date the Action will be taken;

8. A reference to the HMO policies and procedures supporting the HMO's Action;

9. An address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative, file an Appeal, or request a Fair Hearing;

10. An explanation that Members may represent themselves, or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;

11. A statement that if the Member wants a Fair Hearing on the Action, the Member must make the request for a Fair Hearing within 90 days of the date on the notice or the right to request a hearing is waived;

12. A statement explaining that the HMO must make its decision within 30 days from the date the Appeal is received by the HMO, or 3 business days in the case of an Expedited Appeal; and

13. A statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested.

8.2.7.6 Timeframe for Notice of Action

In accordance with 42 C.F.R.§ 438.404(c), the HMO must mail a notice of Action within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 C.F.R.§§ 431.211, 431.213, and 431.214;
2. For denial of payment, at the time of any Action affecting the claim;
3. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R.§ 438.210(d)(1);
4. If the HMO extends the timeframe in accordance with 42 C.F.R. §438.210(d)(1), it must:
5. give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an Appeal if he or she disagrees with that decision; and 6. issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires;
7. For service authorization decisions not reached within the timeframes specified in 42 C.F.R.§ 438.210(d) (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire; and
8. For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. 438.210(d).

8.2.7.7 Notice of Disposition of Appeal

In accordance with 42 C.F.R.§ 438.408(e), the HMO must provide written notice of disposition of all Appeals including Expedited Appeals. The written resolution notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain:

1. The right to request a Fair Hearing;

2. How to request a Fair Hearing;
3. The circumstances under which the Member may continue to receive benefits pending a Fair Hearing;
4. How to request the continuation of benefits;
5. If the HMO's Action is upheld in a Fair Hearing, the Member may be liable for the cost of any services furnished to the Member while the Appeal is pending; and
6. Any other information required by 1 T.A.C. Chapter 357 that relates to a managed care organization's notice of disposition of an Appeal.

8.2.7.8 Timeframe for Notice of Resolution of Appeals

In accordance with 42 C.F.R.§ 438.408, the HMO must provide written notice of resolution of Appeals, including Expedited Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines as provided in this Section for Standard or Expedited Appeals. For expedited resolution of Appeals, the HMO must make reasonable efforts to give the Member prompt oral notice of resolution of the Appeal, and follow up with a written notice within the timeframes set forth in this Section for Expedited Appeals. If the HMO denies a request for expedited resolution of an Appeal, the HMO must transfer the Appeal to the timeframe for standard resolution as provided in this Section, and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

8.2.7.9 Medicaid Member Advocates

The HMO must provide Member Advocates to assist Members. Member Advocates must be physically located within the Service Area unless an exception is approved by HHSC. Member Advocates must inform Members of the following:

1. Their rights and responsibilities,
2. The Complaint process,
3. The Appeal process,
4. Covered Services available to them, including preventive services, and
5. Non-capitated Services available to them.

Member Advocates must assist Members in writing Complaints and are responsible for monitoring the Complaint through the HMO's Complaint process.

Member Advocates are responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. Member Advocates are also responsible for helping or referring Members to community resources available to meet Member needs that are not available from the HMO as Medicaid Covered Services.

8.2.8 Additional Medicaid Behavioral Health Provisions

8.2.8.1 Local Mental Health Authority (LMHA)

Section 8.2.8.1 modified by Version 1.1
Assessment to determine eligibility for rehabilitative and targeted DSHS case management services is a function of the LMHA. Covered Services must be provided to Members with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), when Medically Necessary, whether or not they are also receiving targeted case management or rehabilitation services through the LMHA.

The HMO must enter into written agreements with all LMHAs in the Service Area that describe the process(es) that the HMO and LMHAs will use to coordinate services for Medicaid Members with SPMI or SED. The agreements will:

1. Describe the Behavioral Health Services indicated in detail in the **Provider Procedures Manual** and in the **Texas Medicaid Bulletin**, include the amount, duration, and scope of basic and Value-added Services, and the HMO's responsibility to provide these services;
2. Describe criteria, protocols, procedures and instrumentation for referral of Medicaid Members from and to the HMO and the LMHA;
3. Describe processes and procedures for referring Members with SPMI or SED to the LMHA for assessment and determination of eligibility for rehabilitation or targeted case management services;
4. Describe how the LMHA and the HMO will coordinate providing Behavioral Health Services to Members with SPMI or SED;
5. Establish clinical consultation procedures between the HMO and LMHA including consultation to effect referrals and on-going consultation regarding the Member's progress;
6. Establish procedures to authorize release and exchange of clinical treatment records;
7. Establish procedures for coordination of assessment, intake/triage, utilization review/utilization management and care for persons with SPMI or SED;
8. Establish procedures for coordination of inpatient psychiatric services (including Court- ordered Commitment of Members under 21) in state psychiatric facilities within the LMHA's catchment area;
9. Establish procedures for coordination of emergency and urgent services to Members;
10. Establish procedures for coordination of care and transition of care for new Members who are receiving treatment through the LMHA; and 11. Establish that when Members are receiving Behavioral Health Services from the Local Mental Health Authority that the HMO is using the same UM guidelines as those prescribed for use by local mental health authorities by DSHS which are published at: http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservicesRDMClinGuide.html.

The HMO must offer licensed practitioners of the healing arts (defined in 25 T.A.C., Part 2, Chapter 419, Subchapter L), who are part of the Member's treatment team for rehabilitation services, the opportunity to participate in the HMO's Network. The practitioner must agree to accept the HMO's Provider reimbursement rate, meet the credentialing requirements, and comply with all the terms and conditions of the HMO's standard Provider contract.

HMOs must allow Members receiving rehabilitation services to choose the licensed practitioners of the healing arts who are currently a part of the Member's treatment team for rehabilitation services to provide Covered Services. If the Member chooses to receive these services from licensed practitioners of the healing arts who are part of the Member's rehabilitation services treatment team but are not part of the HMO's Network, the HMO must reimburse the Local Mental Health Authority through Out-of-Network reimbursement arrangements.

Nothing in this section diminishes the potential for the Local Mental Health Authority to seek best value for rehabilitative services by providing these services under arrangement, where possible, as specified is 25 T.A.C. §419.455.

8.2.9 Third Party Liability and Recovery

Medicaid HMOs are responsible for establishing a plan and process for recovering costs for services that should have been paid through a third party in accordance with State and Federal law and regulations. To recognize this requirement, capitation payments to the HMOs are reduced by the projected amount of TPR that the HMO is expected to recover.

The HMOs must provide required reports as stated in **Section 8.1.17.2,** Financial Reporting Requirements.

After 120-days from the date of service on any claim, encounter, or other Medicaid related payment by the HMO subject to Third Party Recovery, HHSC may attempt recovery independent of any HMO action. HHSC will retain, in full, all funds received as a result of the state initiated recovery or subrogation action.

HMOs shall provide a Member quarterly file, which contains the following information if available to the HMO: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file shall be used for the purpose of matching the Texas Medicaid eligibility file against the HMO Member file to identify Medicaid clients enrolled in the HMO, which may not be known the Medicaid Program.

8.2.10 Coordination With Public Health Entities

8.2.10.1 Reimbursed Arrangements with Public Health Entities

The HMO must make a good faith effort to enter into a subcontract for Covered Services with Public Health Entities. Possible Covered Services that could be provided by Public Health Entities include, but are not limited to, the following services:

1. Sexually Transmitted Diseases (STDs) services;
2. Confidential HIV testing;
3. Immunizations;
4. Tuberculosis (TB) care;
5. Family Planning services;

6. THSteps medical checkups, and
7. Prenatal services.

These subcontracts must be available for review by HHSC or its designated agent(s) on the same basis as all other subcontracts. If the HMO is unable to enter into a contract with Public Health Entities, the HMO must document efforts to contract with Public Health Entities, and make such documentation available to HHSC upon request.

HMO Contracts with Public Health Entities must specify the scope of responsibilities of both parties, the methodology and agreements regarding billing and reimbursements, reporting responsibilities, Member and Provider educational responsibilities, and the methodology and agreements regarding sharing of confidential medical record information between the Public Health Entity and the HMO or PCP.

The HMO must:

1. Identify care managers who will be available to assist public health providers and PCPs in efficiently referring Members to the public health providers, specialists, and health-related service providers either within or outside the HMO's Network; and
2. Inform Members that confidential healthcare information will be provided to the PCP, and educate Members on how to better utilize their PCPs, public health providers, emergency departments, specialists, and health-related service providers.

8.2.10.2 Non-Reimbursed Arrangements with Local Public Health Entities

Section 8.2.10.2 modified by Version 1.2
The HMO must coordinate with Public Health Entities in each Service Area regarding the provision of essential public health care services. In addition to the requirements listed above in Section 8.2.2, or otherwise required under state law or this contract, the HMO must meet the following requirements:

1. Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law;
2. Notify the local Public Health Entity, as defined by state law, of communicable disease outbreaks involving Members;
3. Educate Members and Providers regarding WIC services available to Members; and
4. Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

8.2.11 Coordination with Other State Health and Human Services (HHS) Programs

Section 8.2.11 modified by Version 1.2
The HMO must coordinate with other state HHS Programs in each Service Area regarding the provision of essential public health care services. In addition to the requirements listed above in Section 8.2.2. or otherwise required under state law or this contract, the HMO must meet the following requirements:

1. Require Providers to use the DSHS Bureau of Laboratories for specimens obtained as part of a THSteps medical checkup, including THSteps newborn screens, lead testing, and hemoglobin/hematocrit tests;

2. Notify Providers of the availability of vaccines through the Texas Vaccines for Children Program;
3. Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry;
4. Educate Providers and Members about the Department of State Health Services (DSHS) Case Management for Children and Pregnant Women (CPW) services available;
5. Coordinate services with CPW specifically in regard to an HMO Member's health care needs that are identified by CPW and referred to the HMO;
6. Participate, to the extent practicable, in the community-based coalitions with the Medicaid-funded case management programs in the Department of Assistive and Rehabilitative Services (DARS), the Department of Aging and Disability Services (DADS), and DSHS;
7. Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community based needs assessment; and
8. Report all blood lead results, coordinate and follow-up of suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program in DSHS.

8.2.12 Advance Directives

Federal and state law require HMOs and providers to maintain written policies and procedures for informing all adult Members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives (see Social Security Act §1902(a)(57) and §1903(m)(1)(A)). The HMO's policies and procedures must include written notification to Members and comply with provisions contained in 42 C.F.R. §434.28 and 42 C.F.R. § 489, Subpart I, relating to advance directives for all hospitals, critical access hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices, as well as the following state laws and rules:

1. A Member's right to self-determination in making health care decisions;
2. The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:
    a. A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition;
    b. A Member's right to make written and non-written out-of-hospital do-not-resuscitate (DNR) orders;
    c. A Member's right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the Member's behalf if the Member becomes incompetent; and
3. The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes: a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

The HMO must maintain written policies for implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if the HMO or a Provider cannot or will not implement a Member's advance directive.

The HMO cannot require a Member to execute or issue an advance directive as a condition of receiving health care services. The HMO cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The HMO's policies and procedures must require the HMO and subcontractors to comply with the requirements of state and federal law relating to advance directives. The HMO must provide education and training to employees and Members on issues concerning advance directives.

All materials provided to Members regarding advance directives must be written at a 7th—8th grade reading comprehension level, except where a provision is required by state or federal law and the provision cannot be reduced or modified to a 7th—8th grade reading level because it is a reference to the law or is required to be included "as written" in the state or federal law.

The HMO must notify Members of any changes in state or federal laws relating to advance directives within 90 days from the effective date of the change, unless the law or regulation contains a specific time requirement for notification.

8.3 Additional STAR+PLUS Scope of Work

8.3.1 Covered Community-Based Long-Term Care Services

Section 8.3 added by Version 1.1

The HMO must ensure that STAR+PLUS Members needing Community Long-term Care Services are identified and that services are referred and authorized in a timely manner. The HMO must ensure that Providers of Community Long-term Care Services are licensed to deliver the service they provide. The inclusion of Community Long-term Care Services in a managed care model presents challenges, opportunities and responsibilities.

Community Long-term Care Services may be necessary as a preventative service to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community Long-term Care Services should also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. A Member's need for Community Long-term Care Services to assist with the activities of daily living must be considered as important as needs related to a medical condition. HMOs must provide Functionally Necessary Covered Services to Community Long-term Care Service Members.

8.3.1.1 Community Based Long-Term Care Services Available to All Members

The HMO shall enter into written contracts with Providers of Personal Assistance Services and Day Activity and Health Services (DAHS) to make them available to all STAR+PLUS Members. These Providers must at a minimum, meet all of the following state licensure and certification requirements for providing the services in **Attachment B-2.1, Covered Services**.

Community Long-Term Care Services Available to All Members

Service	Licensure and Certification Requirements
Personal Attendant Services	The Provider must be licensed by the Texas Department of Human Services as a Home and Community Support Services Agency. The level of licensure required depends on the type of service delivered. NOTE: For primary home care and client managed attendant care, the agency may have only the Personal Assistance Services level of licensure.
Day Activity and Health Services (DAHS)	The Provider must be licensed by the Texas Department of Human Services, Long Term Care Regulatory Division, as an adult day care provider. To provide DAHS, the Provider must provide the range of services required for DAHS.

8.3.1.2 1915(c) Nursing Facility Waiver Services Available to Members Who Qualify for 1915 (c) Nursing Facility Waiver Services

The 1915(c) Nursing Facility Waiver provides Community Long-term Care Services to Medicaid Eligibles who are elderly and to adults with disabilities as a cost-effective alternative to living in a nursing facility. These Members must be age 21 or older, be a Medicaid recipient or be otherwise financially eligible for waiver services. To be eligible for 1915(c) Nursing Facility Waiver Services, a Member must meet income and resource requirements for Medicaid nursing facility care, and receive a determination from HHSC on the medical necessity of the nursing facility care. The HMO must make available to STAR+PLUS Members who meet the eligibility requirements the array of services allowable through HHSC's CMS-approved 1915(c) Nursing Facility Waiver (see **Appendix B-2.1, STAR+PLUS Covered Services**).

Community Long-Term Care Services Under the 1915(c) Nursing Facility Waiver

Service	Licensure and Certification Requirements
Personal Attendant Services	The Provider must be licensed by the Texas Department of Human Services as a Home and Community Support Services Agency. The level of licensure required depends on the type of service delivered. For Primary Home Care and Client Managed Attendant Care, the agency may have only the Personal Assistance Services level of licensure.
Assisted Living	The Provider must be licensed by the Texas Department of Aging and Disability Services, Long Term Care Regulatory Division. The type of licensure determines what services may be provided.
Emergency Response Service Provider	Texas Department of Aging and Disability Services (DADS) Standards for Emergency Response Services at 40 T.A.C. §52.201(a), and be licensed by the Texas Board of Private Investigators and Private Security Agencies, unless exempt from licensure.
Adult Foster Home	TDSHS Provider standards for Adult Foster Care and TDSHS Rules at 40 T.A.C. §48.6032. Four bed homes also licensed under TDSHS

Community Long-Term Care Services Under the 1915(c) Nursing Facility Waiver

Service	Licensure and Certification Requirements
	Rules at 40 T.A.C. §481.8906.
	DFPS licensure in accordance with 24-hour Care Licensing requirements found in T.A.C., Title 40, Part 19, Chapter 720.
Home Delivered Meals	T.A.C., Title 40, Part 1, Chapter 55.
Physical Therapy	Licensed Physical Therapist through the Texas Board of Physical Therapy Examiners, Chapter 453.
Occupational Therapy	Licensed Occupational Therapist through the Texas Board of Occupational Therapy Examiners, Chapter 454.
Speech Therapy	Licensed Speech Therapist Through the Department of State Health Services.
Consumer Directed Services	Home and Community Support Services Agency (HCSSA)
Transition Assistance Services	No licensure or certification requirements.
Minor Home Modification	No licensure or certification requirements.
Adaptive Aids and Medicaid	No licensure or certification requirements.
Equipment Medical supplies	No licensure or certification requirements.

8.3.2 Service Coordination

The HMO must furnish a Service Coordinator to all STAR+PLUS Members who request one. The HMO should also furnish a Service Coordinator to a STAR+PLUS Member when the HMO determines one is required through an assessment of the Member's health and support needs. The HMO must ensure that each STAR+PLUS Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, long-term care and Behavioral Health Services.

The Service Coordinator must work as a team with the PCP, and coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services with the PCP. This requirement applies whether or not the PCP is in the HMO's Network, as some STAR+PLUS Members dually eligible for Medicare may have a PCP that is not in the HMO's Provider Network. In order to integrate the Member's Acute Care and primary care, and stay abreast of the Member's needs and condition, the Service Coordinator must also actively involve and coordinate with the Member's primary and specialty care providers, including Behavioral Health Service providers, and providers of Non-capitated Services.

STAR+PLUS Members dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. The Texas Vendor Drug Program will pay for a limited number of medications not covered by Medicare.

The HMO must identify and train Members or their families to coordinate their own care, to the extent of the Member's or the family's capability and willingness to coordinate care.

8.3.2.1 Service Coordinators

The HMO must employ as Service Coordinators persons experienced in meeting the needs of vulnerable populations who have Chronic or Complex Conditions. Such Service Coordinators are Key HMO Personnel as described in **Attachment A**, **HHSC's Uniform Managed Care Contract Terms and Conditions, Section 4.02,** and must meet the requirements set forth in **Section 4.04.1** of **HHSC's Uniform Managed Care Contract Terms and Conditions**.

8.3.2.2 Referral to Community Organizations

The HMO must provide information about and referral to community organizations that may not be providing STAR+PLUS Covered Services, but are otherwise important to the health and well being of Members. These organizations include, but are not limited to:

1. State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health/retardation, rehabilitation, developmental disabilities, income support, nutritional assistance, family support agencies, etc.);
2. social service agencies (e.g., Area Agencies on Aging, residential support agencies, independent living centers, supported employment agencies, etc.);
3. city and county agencies (e.g., welfare departments, housing programs, etc.);
4. civic and religious organizations; and
5. consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.).

8.3.2.3 Discharge Planning

The HMO must have a protocol for quickly assessing the needs of Members discharged from a Hospital or other care or treatment facility.

The HMO's Service Coordinator must work with the Member's PCP, the hospital discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge. When long-term care is needed, the HMO must ensure that the Member's discharge plan includes arrangements for receiving community-based care whenever possible. The HMO must ensure that the Member, the Member's family, and the Member's PCP are all well informed of all service options available to meet the Member's needs in the community.

8.3.2.4 Transition Plan for New STAR+PLUS Members

Section 8.3.2.4 Modified by Version 1.5
The HMO must provide a transition plan for Members enrolled in the STAR+PLUS Program. HHSC, and/or the previous STAR+PLUS HMO contractor, will provide the HMO with detailed Care Plans, names of current providers, etc., for newly enrolled Members already receiving long-term care services at the time of enrollment. The HMO must ensure that current providers are paid for Medically Necessary Covered Services that are delivered in accordance with the Member's existing treatment/long-term care services plan after the Member has become enrolled in the HMO and until the transition plan is developed.

The transition planning process must include, but is not limited to, the following:

1. review of existing DADS long-term care services plans;
2. preparation of a transition plan that ensures continuous care under the Member's existing Care Plan during the transfer into the HMO's Network while the HMO conducts an appropriate assessment and development of a new plan, if needed;
3. if durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the time of enrollment, coordination and follow-through to ensure that the Member receives the necessary supportive equipment and supplies without undue delay; and
4. payment to the existing provider of service under the existing authorization until the HMO has completed the assessment and service plans and issued new authorizations.

The HMO must review any existing care plan and develop a transition plan within 30 days of receiving the Member's enrollment. The transition plan will remain in place until the HMO contacts the Member and coordinates modifications to the Member's current treatment/long-term care services plan. The HMO must ensure that the existing services continue and that there are no breaks in services. For initial implementation of the STAR+PLUS program in a Service Area, the HMO must complete this process within 90-days of the Member's enrollment.

The HMO must ensure that the Member is involved in the assessment process and fully informed about options, is included in the development of the care plan, and is in agreement with the plan when completed.

8.3.2.5 Centralized Medical Record and Confidentiality

The Service Coordinator shall be responsible for maintaining a centralized record related to Member contacts, assessments and service authorizations. The HMO shall ensure that the organization of and documentation included in the centralized Member record meets all applicable professional standards ensuring confidentiality of Member records, referrals, and documentation of information.

The HMO must have a systematic process for generating or receiving referrals and sharing confidential medical, treatment, and planning information across providers.

8.3.2.6 Nursing Facilities

Nursing facility care, although a part of the care continuum, presents a challenge for managed care. Because of the process for becoming eligible for Medicaid assistance in a nursing facility, there is frequently a significant time gap between entry into the nursing home and determination of Medicaid eligibility. During this gap from entry to Medicaid eligibility, the resident has "nested" in the facility and many of the community supports are no longer available. To require participation of all nursing facility residents would result in the HMO maintaining a Member in the nursing facility without many options for managing their health. For this reason, persons who qualify for Medicaid as a result of nursing facility residency are not enrolled in STAR+PLUS.

The STAR+PLUS HMO must participate in the Promoting Independence initiative for such individuals. Promoting Independence (PI) is a philosophy that aged and disabled individuals remain in the most integrated setting to receive long-term care services. PI is Texas' response to the U.S. Supreme Court ruling in *Olmstead v. L.C.* that requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

- the state's treatment professionals determine that such placement is appropriate;
- the affected persons do not oppose such treatment; and
- the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services.

In accordance with legislative direction, the HMO must designate a point of contact to receive referrals for nursing facility residents who may potentially be able to return to the community through the use of 1915(c) Nursing Facility Waiver services. To be eligible for this option, an individual must reside in a nursing facility until a written plan of care for safely moving the resident back into a community setting has been developed and approved.

A STAR+PLUS Member who enters a nursing facility will remain a STAR+PLUS Member for a total of four months. The nursing facility will bill the state directly for covered nursing facility services delivered while the Member is in the nursing facility. See **Section 8.3.2.7** for further information.

The HMO is responsible for the Member at the time of nursing facility entry and must utilize the Service Coordinator staff to complete an assessment of the Member within 30 days of entry in the nursing facility, and develop a plan of care to transition the Member back into the community if possible. If at this initial review, return to the community is possible, the Service Coordinator will work with the resident and family to return the Member to the community using 1915(c) Waiver Services.

If the initial review does not support a return to the community, the Service Coordinator will conduct a second assessment 90 days after the initial assessment to determine any changes in the individual's condition or circumstances that would allow a return to the community. The Service Coordinator will develop and implement the transition plan.

The HMO will provide these services as part of the Promoting Independence initiative. The HMO must maintain the documentation of the assessments completed and make them available for state review at any time.

It is possible that the STAR+PLUS HMO will be unaware of the Member's entry into a nursing facility. It is the responsibility of the nursing facility to review the Member's Medicaid card upon entry into the facility and notify the HMO. The nursing facility is also required to notify HHSC of the entry of a new resident.

8.3.2.7 HMO Four-Month Liability for Nursing Facility Care

A STAR+PLUS Member who enters a nursing facility will remain a STAR+PLUS Member for a total of four months. The four months do not have to be consecutive. Upon completion of four months of nursing facility care, the individual will be disenrolled from the STAR+PLUS Program and the Medicaid Fee-for-Service program will provide Medicaid benefits. A STAR+PLUS Member may not change HMOs while in a nursing facility.

Tracking the four months of liability is done through a counter system. The four-month counter starts with the Medicaid admission or on the 21st day of a Medicare stay. A partial month counts as a full month. In other words, the month in which the Medicaid admission occurs or the month on which the 21st day of the Medicare stay occurs, is counted as one of the four months.

An amount will be included in the capitation rates to cover the cost of four months of nursing facility services (based upon experience from STAR+PLUS in Harris County) for the historical average number of admissions to nursing facilities. Nursing facility costs for STAR+PLUS in Harris County have accounted for less than one percent of premiums in recent years. HHSC believes that these costs will not deviate substantially from this experience.

The HMO will be liable for the cost of care in a nursing facility care and, for Medicaid-only Members, the cost of all other Covered Services. The HMO will not maintain nursing facilities in its Network and will not reimburse the nursing facilities directly. Nursing facilities will use the traditional Fee-for-Service system of billing HHSC rather than billing the HMO. The HMO's liability will be established based on the amount paid through the Fee-for-Service billing system on behalf of the Member. HHSC will recoup those costs from the HMO by an offset to the monthly Capitation Payment. The offset will be recognized as a nursing facility expense. The HMO will record the nursing facility liability recoupment as nursing facility expense on its Financial-Statistical Reports (FSR). The HMO will be responsible for direct payment of all non-nursing facility Medicaid expenses on behalf of the Member.

8.3.3 STAR+PLUS Assessment Instruments

The HMO must have and use functional assessment instruments to identify Members with significant health problems, Members requiring immediate attention, and Members who need or are at risk of needing long-term care services. The HMO, a subcontractor, or a Provider may complete assessment instruments, but the HMO remains responsible for the data recorded.

HMOs must use the DHS Form 2060, as amended or modified, to assess a Member's need for Functionally Necessary Personal Attendant Services. The HMO may adapt the form to reflect the HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment.

Section 8.3.3 Modified by Version 1.5
The DHS Form 2060 must be completed if a need or a change in Personal Attendant Services is warranted at the initial contact, at the annual reassessment, and anytime a Member requests the services or requests a change in services. The DHS Form 2060 must also be completed if the HMO determines the Member requires the services or requires a change in the Personal Attendant Services that are authorized.

For Members and applicants seeking or needing the 1915(c) Nursing Facility Waiver services, the HMOs must use the DADS CARE Form 3652, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations. The HMO must also complete the Individual Service Plan (ISP), Form 3671 for each Member receiving 1915(c) Nursing Facility Waiver Services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change. Both of these forms (Form 3652 and Form 3671) must be completed annually at reassessment. The HMO is responsible for tracking the end dates of the ISP to ensure that the Member is reassessed prior to the expiration date. Note that the DADS CARE Form 3652 cannot be submitted earlier than 90 days prior to the expiration date of the ISP.

HHSC has adopted a Minimum Data Set for Home Care (MDS-HC), which can be found in the HHSC Uniform Managed Care Manual. HHSC may adopt new versions of this instrument as appropriate or as directed by CMS. The MDS-HC instrument must be completed and electronically submitted to HHSC in the specified format within 30 days of enrollment for every Member receiving Community-based Long-term Care Services, and then each year by the anniversary of the Member's date of enrollment.

The MDS-HC instrument must be completed and electronically submitted to HHSC in the specified format within 30 days of enrollment for every Member receiving Community-based Long-term Care Services. Because of the large number of Members the HMOs will be receiving initially during the implementation period of the STAR+PLUS Program, HHSC is allowing the following:

- For the 1915(c) Nursing Facility Waiver Members, the MDS-HC instrument must be completed in conjunction with the annual reassessment. The MDS-HC instrument must be completed annually at the time of reassessment for these Members.
- For the non-1915(c) Nursing Facility Waiver Members that are receiving Community-based Long-term Care Services, the HMO must submit a schedule for HHSC's approval that provides a plan of how the MDS-HC instruments will be completed for these Members over a twelve-month period beginning on February 1, 2007.

Section 8.3.3 Modified by Version 1.6
In addition to submitting the MDS-HC instrument to HHSC, the HMO may also submit other supplemental assessment instruments it elects to use. As specialized MDS instruments are developed or adopted by HHSC for other living arrangements (e.g., assisted living), HHSC will notify HMO of the availability of the instrument and the date the HMO is required to begin using such instrument in the HHSC Uniform Managed Care Manual. Any additional assessment instruments used by the HMO must be approved by HHSC.

8.3.4 1915(c) Nursing Facility Waiver Service Eligibility

Section 8.3.4 modified by Version 1.5
Recipients of 1915(c) Nursing Facility Waiver services must meet nursing facility criteria for participation in the waiver and must have a plan of care at initial determination of eligibility in which the plan's annualized cost is equal to or less than the annualized cost of care if the individual were to enter a nursing facility.

8.3.4.1 For Members

The HMO must notify HHSC when it initiates 1915(c) Nursing Facility Waiver eligibility testing on a STAR+PLUS Member. The HMO must apply risk criteria, complete the Form 3652 for Medical Necessity determination, complete the assessment documentation, and prepare a 1915(c) Nursing Facility Waiver Individual Service Plan (ISP) for each Member requesting 1915(c) Nursing Facility Waiver services and for Members the HMO has identified as needing 1915(c) Nursing Facility Waiver services. The HMO must provide HHSC the results of the assessment activities within 45 days of initiating the assessment process.

HHSC will notify the Member and the HMO of the eligibility determination, which will be based on the information provided by the HMO. If the STAR+PLUS Member is eligible for 1915(c) Nursing Facility Waiver services, HHSC will notify the Member of the effective date of eligibility. If the Member is not eligible for 1915(c) Nursing Facility Waiver services, HHSC will provide the Member information on right to Appeal the Adverse Determination. Regardless of the 1915(c) Nursing Facility Waiver eligibility determination, HHSC will send a copy of the Member notice to the HMO.

8.3.4.2 For Medical Assistance Only (MAO) Non-Member Applicants

Non-Member persons who are not eligible for Medicaid in the community may apply for participation in the 1915(c) Nursing Facility Waiver program under the financial and functional eligibility requirements for MAO. HHSC will inform the applicant that services are provided through an HMO and allow the applicant to select the HMO. HHSC will authorize the selected HMO to initiate pre-enrollment assessment services required under the 1915(c) Nursing Facility Waiver for the non-member. The HMO must complete Form 3652 for Medical Necessity determination, complete the assessment documentation, and prepare a 1915(c) Nursing Facility Waiver service plan for each applicant referred by HHSC. The initial home visit with the applicant must occur within 14 days of the receipt of the referral. The HMO must provide HHSC the results of the assessment activities within 45 days of the receipt of the referral.

HHSC will notify the applicant and the HMO of the results of its eligibility determination. If the applicant is eligible, HHSC will notify the applicant and the HMO will be notified of the effective date of eligibility, which will be the first day of the month following the determination of eligibility. The HMO must initiate the Individual Service Plan (ISP) on the date of enrollment.

If the applicant is not eligible, the HHSC notice will provide information on the applicant's right to Appeal the Adverse Determination. HHSC will also send notice to the HMO if the applicant is not eligible for 1915(c) Nursing Facility Waiver services.

8.3.4.3 Annual Reassessment

Prior to the end date of the annual ISP, the HMO must initiate an annual reassessment to determine and validate continued eligibility for 1915(c) Nursing Facility Waiver services for each Member receiving such services. The HMO will be expected to complete the same activities for the annual reassessment as required for the initial eligibility determination, with the following exception: the HMO does not need to obtain a physician's signature on the Form 3652 for the annual reassessment. Existing 1915(c) Nursing Facility Waiver clients may not be denied 1915(c) Nursing Facility Waiver services solely on the basis that the proposed cost of the ISP will exceed the cost of care if the Member were in a nursing home if the following conditions are met:

Section 8.3.4.3 Modified by Version 1.5

1. those services are required for that individual to live in the most integrated setting appropriate to his or her needs;
2. the cost for the needed services, averaged and excluding the cost of minor home modifications and adaptive aids, does not exceed 133.3% of the Nursing Facility Cost Ceiling; and
3. HHSC continues to comply with the cost-effectiveness requirements from the CMS.

If an ongoing client has a change in needs that would cause the cost for needed services, under the client's ISP, to exceed 100% of the cost ceiling, the HMO with HHSC approval may consider the client's request if there is a change in:

1. the client's medical condition, functional needs, or environment;
2. the caregiver support or third-party resources that have been providing service to the client; or
3. the need for a service or support to adequately support the client living in the most integrated setting appropriate to his or her needs.

If the client's needs cannot be met within the cost limit of 133% described above, then the client is no longer eligible for services, unless the client meets the criteria in the next paragraph. All available non-waiver support systems and resources must be accessed in the development of the ISP.

HMO will continue services to those individuals receiving services in a waiver program, when continuation of the services is necessary for the individual to live in the most integrated setting appropriate to his or her needs and HHSC continues to comply with CMS cost-effectiveness requirements.

Individuals receiving waiver services through the Medically Dependent Children Program are covered by the provisions in this Section when they apply for transition to the 1915(c) waiver program at age 21.

8.3.5 Personal Attendant Services

Section 8.3.5 replaced by Version 1.5
There are three options available to STAR+PLUS Members desiring the delivery of Personal Attendant Services (PAS): 1) Self-Directed; 2) Agency Model, Self-Directed; and 3) Agency Model. The HMO must provide information to all eligible Members on the three options and must provide Member orientation in the option selected by the Member. The HMO will provide the information to any STAR+PLUS Member receiving Personal Attendant Services:

- at initial assessment;
- at annual reassessment or annual contact with the STAR+PLUS Member;
- at any time when a STAR+PLUS Member receiving PAS requests the information; and
- in the Member Handbook.

The HMO must contract with providers who are able to offer PAS and must also educate/train the HMO Network Providers regarding the three PAS options. To participate as a PAS Network Provider, the Provider must have a contract with DADS for the delivery of PAS. The HMO must assure compliance with the Texas Administrative Code in Title 40, Part 1, Chapter 41, Sections 41.101, 41.103, and 41.105. The HMO must include the requirements in the Provider Manual and in the STAR+PLUS Provider training.

8.3.5.1 Personal Attendant Services Delivery Option – Self-Directed Model

In the Self-Directed Model, the Member or the Member's legal guardian is the employer of record and retains control over the hiring, management, and termination of an individual providing Personal Attendant Services. The Member is responsible for assuring that the employee meets the requirements for Personal Attendant Services, including the criminal history check. The Member uses a Home and Community Support Services (HCSS) agency to handle the employer-related administrative functions such as payroll, substitute (back-up), and filing tax-related reports of Personal Attendant Services.

8.3.5.2 Personal Attendant Services Delivery Option – Agency Model, Self-Directed

In the Agency Model, Self-Directed, the Member or the Member's legal guardian chooses a Home and Community Support Services (HCSS) agency in the HMO Provider Network who is the employer of record. In this model, the Member selects the personal attendant from the HCSS agency's personal attendant employees. The personal attendant's schedule is set up based on the Member input, and the Member manages the Personal Attendant Services. The Member retains the right to supervise and train the personal attendant. The Member may request a different personal attendant and the HCSS agency would be expected to honor the request. The HCSS agency establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of personal attendant services.

8.3.5.3 Personal Attendant Services Delivery Option – Agency Model

In the Agency Model, the Member chooses a Home and Community Support Services (HCSS) agency to hire, manage, and terminate the individual providing Personal Attendant Services. The HCSS agency is selected by the Member from the HCSS agencies in the HMO Provider Network. The Service Coordinator and Member develop the schedule and send it to the HCSS agency. The Member retains the right to supervise and train the personal attendant. The Member may request

a different personal attendant and the HCSS agency would be expected to honor the request. The HCSS agency establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of personal attendant services.

8.3.6 Community Based Long-term Care Service Providers

8.3.6.1 Training

The HMO must comply with Section 8.1.4.6 regarding Provider Manual and Provider training specific to the STAR+PLUS Program. The HMO must train all Community Long-term Care Service Providers regarding the requirements of the Contract and special needs of STAR+PLUS Members. The HMO must establish ongoing STAR+PLUS Provider training addressing the following issues at a minimum:

1. Covered Services and the Provider's responsibilities for providing such services to STAR+PLUS Members and billing the HMO for such services. The HMO must place special emphasis on Community Long-term Care Services and STAR+PLUS requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules, including payment policies and procedures.
2. Inpatient Stay hospital services and the authorization and billing of such services for STAR+PLUS Members.
3. Relevant requirements of the STAR+PLUS Contract, including the role of the Service Coordinator;
4. Processes for making referrals and coordinating Non-capitated Services;
5. The HMO's quality assurance and performance improvement program and the Provider's role in such programs; and
6. The HMO's STAR+PLUS policies and procedures, including those relating to Network and Out-of-Network referrals.

8.3.7.2 LTC Provider Billing

Long-term care providers are not required to utilize the billing systems that most medical facilities use on a regular basis. For this reason, the HMO must make accommodations to the claims processing system for such providers to allow for a smooth transition from traditional Medicaid to Managed Care Medicaid.

HHSC will meet with HMOs to develop a standardized method long-term care billing. All STAR+PLUS HMOs will be required to utilize the standardized method, which will be incorporated into the **HHSC Uniform Managed Care Manual**.

8.3.7.3 Rate Enhancement Payments for Agencies Providing Attendant Care

Section 8.3.7.3 modified by Version 1.5
All HMOs participating in the STAR+PLUS program must allow their Long-term Support Services (LTSS) Providers to participate in the STAR+PLUS Attendant Care Enhancement Program if the providers are currently participating in the enhanced payment program with the Department of Aging and Disability Services (DADS). HMOs may choose not to offer

participation to DADS-contracted providers who do not currently participate in the enhancement program. Additionally, HMOs may choose to include Providers in the network who do not participate in the enhanced payment program.

Attachment B-7, STAR+PLUS Attendant Care Enhanced Payment Methodology explains the methodology that the STAR+PLUS HMO will use to implement and pay the enhanced payments, including a description of the timing of the payments, in accordance with the requirements in the **Uniform Managed Care Manual** and the intent of the 2000-01 General Appropriations Act (Rider 27, House Bill 1, 76th Legislature, Regular Session, 1999) and T.A.C. Title 1, Part 15, Chapter 355.

8.3.7.4 Payment for 1915(c) Nursing Facility Waiver Services for Non-Members

Disenrolled Members: Occasionally, the Social Security Administration will place SSI recipients on hold for a short period of time, usually due failure to provide timely updates required for the continuation of SSI benefits. During this period, the recipients will not appear to be eligible for Medicaid or 1915(c) Nursing Facility Waiver services. Often the Social Security Administration reinstates these Medicaid Eligibles retroactively without a break in Medicaid coverage. To deal with this situation, for at least thirty (30) days after disenrollment, the HMO will continue to authorize and pay for 1915(c) Nursing Facility Waiver services for disenrolled STAR+PLUS Members who appear to lose eligibility due to an administrative problem related to SSI. If at the end of the thirty (30) days, the Medicaid Eligible's 1915(c) Nursing Facility Waiver eligibility is reinstated, the Medicaid Eligible will be manually enrolled into the STAR+PLUS HMO back to the date of disenrollment and the retroactive adjustment system will properly reimburse the HMO. If after thirty (30) days, the former STAR+PLUS Member continues to be ineligible for Medicaid, the individual will not be retroactively enrolled, and the HMO will bill HHSC for 1915(c) Nursing Facility Waiver services rendered during this time.

8.4 Additional CHIP Scope of Work

The following provisions only apply to HMOs participating in CHIP.

8.4.1 CHIP Provider Network

In each Service Area, the HMO must seek to obtain the participation in its Provider Network of CHIP Significant Traditional Providers (STPs), defined by HHSC as PCP Providers currently serving the CHIP population and DSH hospitals. The Procurement Library includes CHIP STPs by Service Area.

The HMO must give STPs the opportunity to participate in its Network if the STPs:

1. Agree to accept the HMO's Provider reimbursement rate for the provider type; and
2. Meet the standard credentialing requirements of the HMO, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is not the sole grounds for exclusion from the Provider Network.

8.4.2 CHIP Provider Complaint and Appeals

Section 8.4.2 modified by Version 1.2
CHIP Provider Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The HMO must resolve Provider Complaints within 30 days from the date the Complaint is received.

8.4.3 CHIP Member Complaint and Appeal Process

CHIP Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the HMO to resolve Complaints and Appeals (that are not elevated to TDI) within 30 days from the date the Complaint or Appeal is received. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints or Member Appeals are not resolved within 30 days of receipt of the Complaint or Appeal by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.** Any person, including those dissatisfied with a HMO's resolution of a Complaint or Appeal, may report an alleged violation to TDI.

8.4.4 Dental Coverage for CHIP Members

The HMO is not responsible for reimbursing dental providers for preventive and therapeutic dental services obtained by CHIP Members. However, medical and/or hospital charges, such as anesthesia, that are necessary in order for CHIP Members to access standard therapeutic dental services, are Covered Services for CHIP Members. The HMO must provide access to facilities and physician services that are necessary to support the dentist who is providing dental services to a CHIP Member under general anesthesia or intravenous (IV) sedation.

The HMO must inform Network facilities, anesthesiologists, and PCPs what authorization procedures are required, and how Providers are to be reimbursed for the preoperative evaluations by the PCP and/or anesthesiologist and for the facility services. For dental-related medical Emergency Services, the HMO must reimburse in-network and Out-of-Network providers in accordance with federal and state laws, rules, and regulations.

8.5 Additional CHIP Perinatal Scope of Work

Section 8.5 added by Version 1.3
The following provisions only apply to HMOs participating in CHIP Perinatal Program.

8.5.1 CHIP Perinatal Provider Network

In each Service Area, the CHIP Perinatal HMO must seek to obtain the participation of Providers for CHIP Perinate Members. CHIP Perinatal HMOs are encouraged to obtain the participation of Obstetricians/Gynecologists (OB/GYNs), Family Practice Physicians with experience in prenatal care, or other qualified health care Providers as CHIP Perinate Providers.

See Sections 8.1.3.2, Access to Network Providers, and 8.1.4.2, Primary Care Providers, regarding distinctions in the provider networks for CHIP Perinates and CHIP Perinate Newborns.

8.5.2 CHIP Perinatal Program Provider Complaint and Appeals

CHIP Perinatal Program Provider Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The HMO must resolve Provider Complaints within 30 days from the date the Complaint is received.

8.5.3 CHIP Perinatal Program Member Complaint and Appeal Process

CHIP Perinatal Program Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the HMO to resolve Complaints and Appeals (that are not elevated to TDI) within 30 days from the date the Complaint or Appeal is received. Any person, including those dissatisfied with a HMO's resolution of a Complaint or Appeal, may report an alleged violation to TDI.

9. Turnover Requirements

9.1 Introduction

This section presents the Turnover Requirements to which the HMO must agree. Turnover is defined as those activities that are required for the HMO to perform upon termination of the Contract in situations in which the HMO must transition Contract operations to HHSC or a subsequent Contractor.

9.2 Transfer of Data

The HMO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new HMO, at the sole discretion of HHSC and as directed by HHSC. All transferred data must be compliant with HIPAA.

All relevant data must be received and verified by HHSC or the subsequent Contractor. If HHSC determines that not all of the data regarding the provision of Covered Services to Members was transferred to HHSC or the subsequent Contractor, as required, or the data is not HIPAA compliant, HHSC reserves the right to hire an independent contractor to assist HHSC in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the HMO.

9.3 Turnover Services

Six months prior to the end of the Contract Period, including any extensions to such Period, the HMO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State or a successor HMO. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by HHSC.

As part of the Turnover Plan, the HMO must provide HHSC with copies of all relevant Member and service data, documentation, or other pertinent information necessary, as determined by the HHSC, for HHSC or a subsequent Contractor to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The plan will describe the HMO’s approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by the State and according to the schedule approved by the State.

HHSC is not limited or restricted in the ability to require additional information from the HMO or modify the turnover schedule as necessary.

9.4 Post-Turnover Services

Thirty (30) days following turnover of operations, the HMO must provide HHSC with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by HHSC.

If the HMO does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for HHSC or the subsequent Contractor to assume the operational activities successfully, the HMO agrees to reimburse the State for all reasonable costs, including, but not

limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

The HMO also agrees to pay any and all additional costs incurred by the State that are the result of the HMO's failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

The HMO must maintain all files and records related to Members and Providers for five years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. The HMO agrees to repay any valid, undisputed audit exceptions taken by HHSC in any audit of the Contract.

STAR+PLUS Covered Services

Acute Care Services

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the STAR+PLUS Medicaid managed care program.

Medicaid HMO Contractors are responsible for providing a benefit package to Members that includes all medically necessary services covered under the traditional, fee-for-service Medicaid programs except for Non-capitated Services provided to Medicaid Members outside of the HMO capitation and listed in Attachment B-1, Section 8.2.2.8. In addition to the non-capitated services listed in Attachment B-1, Section 8.2.2.8, Hospital Inpatient Stays are excluded from the capitation payment to STAR+PLUS HMOs and are paid through HHSC's Administrative Contractor responsible for payment of Traditional Medicaid fee-for-service claims. Medicaid HMO Contractors must coordinate care for Members for these Non-capitated Services so that Members have access to a full range of medically necessary Medicaid services, both capitated and non-capitated. A Contractor may elect to offer additional acute care Value-added Services.

The STAR+PLUS Members are provided with two enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1) waiver of the three-prescription per month limit, for members not covered by Medicare;
2) inclusion of an annual adult well check for patients 21 years of age and over.

Medicaid HMO Contractors are responsible for providing a benefit package to Members that includes an annual adult well check for patients 21 years of age and over. Prescription drug benefits to HMO Members are provided outside of the HMO capitation.

STAR+PLUS HMO Contractors should refer to the current ***Texas Medicaid Provider Procedures Manual*** and the bi-monthly ***Texas Medicaid Bulletin*** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. (These documents can be accessed online at: http://www.tmhp.com.)

The services listed in this Attachment are subject to modification based on Federal and State laws and regulations and Programs policy updates.

Services included under the HMO capitation payment

Modified by Version 1.5 and 1.6

- Ambulance services
- Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health Services, including:
  - Outpatient mental health services for Adults and Children
  - Outpatient chemical dependency services for children (under age 21)
  - Detoxification services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
- Birthing center services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies

- Emergency Services
- Family planning services
- Home health care services
- Hospital services, outpatient
- Laboratory
- Medical check-ups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

Community Based Long Term Care Services

The following is a non-exhaustive, high-level listing of Community Based Long Term Care Covered Services included under the STAR+PLUS Medicaid managed care program.

- Community Based Long Term Care Services for all Members
  - Personal Attendant Services – All Members of a STAR+PLUS HMO may receive medically and functionally necessary personal attendant services (PAS).
  - Day Activity and Health Services – All Members of a STAR+PLUS HMO may receive medically and functionally necessary Day Activity and Health Care Services (DAHS).
- 1915 (c) Nursing Facility Waiver Services for those Members who qualify for such services

  The state provides an enriched array of services to clients who would otherwise qualify for nursing facility care through a Home and Community Based Medicaid Waiver. In traditional Medicaid, this is known as the Community Based Alternatives (CBA) waiver. The STAR+PLUS HMO must also provide the services that are available to clients through the CBA waiver in traditional Medicaid to those clients that meet the functional and financial eligibility for the 1915 Modified by (c) Nursing Facility Waiver Services.

Modified by Version 1.5and 1.6

- Personal Attendant Services (including the three service delivery options: Self-Directed; Agency Model, Self-Directed; and Agency Model)
- Nursing Services (in home)
- Emergency Response Services (Emergency call button)
- Home Delivered Meals
- Minor Home Modifications
- Adaptive Aids and Medical Equipment
- Medical Supplies
- Physical Therapy, Occupational Therapy, Speech Therapy
- Adult Foster Care
- Assisted Living
- Transition Assistance Services (These services are limited to a maximum of $2,500.00. If the HMO determines that no other resources are available to pay for the basic services/items needed to assist a Member, who is leaving a nursing facility, with

setting up a household, the HMO may authorize up to $2,500.00 for Transition Assistance Services (TAS). The $2,500.00 TAS benefit is part of the expense ceiling when determining the Total Annual Individual Service Plan (ISP) Cost.)

CHIP Perinatal Program Covered Services

Covered CHIP Perinatal Program services must meet the definition of Medically Necessary Covered Services as defined in this **Contract**. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Program Members. CHIP Perinatal Program Members are eligible for 12-months continuous coverage following enrollment in the program.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit for the initial Perinate Newborn admission; however, facility charges are a covered benefit after the initial Perinate Newborn admission. “Initial Perinate Newborn admission” means the hospitalization associated with the birth. For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, professional service charges are a covered benefit for the initial Perinate Newborn admission and subsequent admissions. “Initial Perinate Newborn admission” means the hospitalization associated with the birth. Services include, but are not limited to, the following: • Hospital-provided Physician or Provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component)	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes between 186% and 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery. Covered medically necessary Hospital-provided services are limited to labor with delivery until birth. Services include: • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component • Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	• Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalentlevels of care • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Surgical implants • Other artificial aids including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12- month period limit	
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants • Other artificial aids including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12- month period limit.	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests • Drugs, medications and biologicals that are medically necessary prescription and injection drugs. (1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. (2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. (4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32- 36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.

Physician/ Physician Extender Professional Services	Services include, but are not limited to, the following:
	• American Academy of Pediatrics recommended well- child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations)
	• Physician office visits, in- patient and out-patient services
	• Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation
	• Medications, biologicals and materials administered in Physician's office
	• Allergy testing, serum and injections
	• Professional component (in/outpatient) of surgical services, including:
	  • Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care
	  • Administration of anesthesia by Physician (other than surgeon) or CRNA
	  • Second surgical opinions
	  • Same-day surgery performed in a Hospital without an over-night stay
		Services include, but are not limited to the following:
		• Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth
		• Physician office visits, in- patient and out-patient services
		• Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation
		• Medically necessary medications, biologicals and materials administered in Physician's office
		• Professional component (in/outpatient) of surgical services, including:
		  • Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until birth.
		  • Administration of anesthesia by Physician (other than surgeon) or CRNA
		  • Invasive diagnostic procedures directly related to the labor with delivery of the unborn child.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	• Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician- performed technical and interpretive components) • In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.	• Hospital-based Physician services (including Physician performed technical and interpretive components) • Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. • Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT.
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Not a covered benefit.	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One visit every four weeks for the first 28 weeks or pregnancy; (2) one visit every two to three weeks from 28 to 36 weeks of pregnancy; and (3) one visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician’s files and is subject to retrospective review.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
		Visits after the initial visit must include: • interim history (problems, marital status, fetal status); • physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and • laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics • Prosthetic devices such as artificial eyes, limbs, and braces • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease • Hearing aids • Diagnosis-specific disposable	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)	
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical and occupational therapies. • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24- hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing. • Inpatient mental health services are limited to: • 45 days 12-month inpatient limit • Includes inpatient psychiatric services, up to 12-month period limit, ordered by a court of	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost • 20 of the inpatient days must be held in reserve for inpatient use only • Does not require PCP referral	
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • Medication management visits do not count against the outpatient visit limit. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state- operated facility • Up to 60 days 12-month period limit for rehabilitative day treatment • 60 outpatient visits 12-month period limit • 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	• 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost • Includes outpatient psychiatric services, up to 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • Inpatient days converted to sub- acute outpatient services are in addition to the outpatient limits and do not count towards those limits • A Qualified Mental Health Professional (QMHP), as defined by and credentialed through Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of an DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. Those services include individual and group skills training (which can be components of interventions such as day treatment and in- home services), patient and family education, and crisis services	

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	• Does not require PCP referral	
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require PCP referral • Medically necessary detoxification/stabilization services, limited to 14 days per 12-month period. • 24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period • 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost • 30 days must be held in reserve for inpatient use only.	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	• Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services is defined as an organized non- residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	providing structured group and individual therapy, educational services, and life skills training • Outpatient treatment services up to a maximum of: • Intensive outpatient program (up to 12 weeks per 12-month period) • Outpatient services (up to six- months per 12-month period) • Does not require PCP referral	
Rehabilitation Services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational and speech therapy • Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment for unrelated conditions is unaffected • Up to a maximum of 120 days with a 6 month life expectancy • Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime • Services apply to the hospice diagnosis	Not a covered benefit.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions labor and delivery.	HMO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
	Covered services include, but are not limited to, the following: • Emergency services based on prudent lay person definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in- network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.	Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. • Emergency services based on prudent lay person definition of emergency health condition • Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. • Stabilization services related to the labor with delivery of the covered unborn child. • Emergency ground, air and water transportation for labor and threatened labor is a covered benefit Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Not a covered benefit.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period	Not a covered benefit.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Chiropractic Services	• Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	• Covered up to $100 for a 12- month period limit for a plan- approved program • Health Plan defines plan- approved program. • May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Value-added services	*See Attachment B-3.2*	

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

- For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinatal Newborn admission. ”Initial Perinatal Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to the covered unborn child until birth.
- Inpatient mental health services.
- Outpatient mental health services.
- Durable medical equipment or other medically related remedial devices.
- Disposable medical supplies.
- Home and community-based health care services.
- Nursing care services.
- Dental services.
- Inpatient substance abuse treatment services and residential substance abuse treatment services.
- Outpatient substance abuse treatment services.
- Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
- Hospice care.
- Skilled nursing facility and rehabilitation hospital services.
- Emergency services other than those directly related to the labor with delivery of the covered unborn child.
- Transplant services.
- Tobacco Cessation Programs.
- Chiropractic Services.
- Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery

- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child.
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity ?
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training, vision therapy, or vision services
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
- Donor non-medical expenses
- Charges incurred as a donor of an organ

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATE NEWBORNS

With the exception of the first bullet, all the following exclusions match those found in the CHIP Program.

- For CHIP Perinate Newborns in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit for the initial Perinate Newborn admission. “Initial Perinate Newborn admission” means the hospitalization associated with the birth.
- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor

- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping
- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

CHIP & CHIP PERINATAL PROGRAM DME/SUPPLIES
Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members but are a benefit for CHIP Perinate Newborns.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are not medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

STAR Covered Services

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the STAR Medicaid managed care program.

Medicaid HMO Contractors are responsible for providing a benefit package to Members that includes all medically necessary services covered under the traditional, fee-for-service Medicaid programs except for Non-capitated Services provided to STAR Members outside of the HMO capitation and listed in Attachment B-1, **Section 8.2.2.8**. Medicaid HMO Contractors must coordinate care for Members for these Non-capitated Services so that Members have access to a full range of medically necessary Medicaid services, both capitated and non-capitated. A Contractor may elect to offer additional acute care Value-added Services.

The STAR Members are provided with three enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1) waiver of the three-prescription per month limit;

2) waiver of the 30-day spell-of-illness limitation under fee-for-services; and

3) inclusion of an annual adult well check for patients 21 years of age and over.

Medicaid HMO Contractors are responsible for providing a benefit package to Members that includes the waiver of the 30-day spell-of-illness limitation under fee-for-service and the inclusion of an annual adult well check for patients 21 years of age and over. Prescription drug benefits to Medicaid HMO Members are provided outside of the HMO capitation.

Bidders and Contractors should refer to the current ***Texas Medicaid Provider Procedures Manual*** and the bi-monthly ***Texas Medicaid Bulletin*** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. (These documents can be accessed online at: http://www.tmhp.com.)

The services listed in this Attachment are subject to modification based on Federal and State laws and regulations and Programs policy updates.

Services included under the HMO capitation payment

- Ambulance services
- Audiology services, including hearing aids for adults (hearing aids for children are provided through the PACT program and are a non-capitated service)
- Behavioral Health Services, including:
  - Inpatient and outpatient mental health services for children (under age 21)
  - Outpatient chemical dependency services for children (under age 21)
  - Detoxification services
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
- Birthing center services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services

- Hospital services, including inpatient and outpatient
- Laboratory
- Medical check-ups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Podiatry
- Prenatal care
- Primary care services
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech

[Modified by Version 1.2]

- Transplantation of organs and tissues
- Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction, which can not be accomplished by glasses.)

CHIP Covered Services

Covered CHIP services must meet the CHIP definition of Medically Necessary Covered Services as defined in this **Contract**. There is no lifetime maximum on benefits; however, 12-month period, enrollment period (a 6-month period), or lifetime limitations do apply to certain services, as specified in the following chart. Please note that if services with a 12-month annual limit are all used within one 6-month enrollment period, these particular services are not available during the second 6-month enrollment period within that annual period. Co-pays apply until a family reaches its specific cost-sharing maximum.

Covered Benefit	Description
Inpatient General Acute and Inpatient Rehabilitation Hospital Services [Modified by Version 1.2]	Services include, but are not limited to, the following: • Hospital-provided Physician or Provider services • Semi-private room and board (or private if medically necessary as certified by attending) • General nursing care • Special duty nursing when medically necessary • ICU and services • Patient meals and special diets • Operating, recovery and other treatment rooms • Anesthesia and administration (facility technical component) • Surgical dressings, trays, casts, splints • Drugs, medications and biologicals • Blood or blood products that are not provided free-of-charge to the patient and their administration • X-rays, imaging and other radiological tests (facility technical component) • Laboratory and pathology services (facility technical component) • Machine diagnostic tests (EEGs, EKGs, etc.) • Oxygen services and inhalation therapy • Radiation and chemotherapy • Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care • In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Hospital, physician and related medical services, such as anesthesia, associated with dental care • Surgical implants • Other artificial aids including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: • Semi-private room and board • Regular nursing services • Rehabilitation services • Medical supplies and use of appliances and equipment furnished by the facility
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: • X-ray, imaging, and radiological tests (technical component) • Laboratory and pathology services (technical component) • Machine diagnostic tests

Covered Benefit	Description
	• Ambulatory surgical facility services • Drugs, medications and biologicals • Casts, splints, dressings • Preventive health services • Physical, occupational and speech therapy • Renal dialysis • Respiratory services • Radiation and chemotherapy • Blood or blood products that are not provided free-of-charge to the patient and the administration of these products • Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. • Surgical implants • Other artificial aids including surgical implants • Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit [Modified by Version 1.2]
Physician/Physician Extender Professional Services	Services include, but are not limited to, the following: • American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) • Physician office visits, in-patient and out-patient services • Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation • Medications, biologicals and materials administered in Physician's office • Allergy testing, serum and injections • Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations • Hospital-based Physician services (including Physician-performed technical and interpretive components) • In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. • Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this ccap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: • Orthotic braces and orthotics • Prosthetic devices such as artificial eyes, limbs, and braces • Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease

Modified by Version 1.2

Covered Benefit	Description
	• Hearing aids • Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: • Home infusion • Respiratory therapy • Visits for private duty nursing (R.N., L.V.N.) • Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). • Home health aide when included as part of a plan of care during a period that skilled visits have been approved. • Speech, physical and occupational therapies. • Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker • Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services • Services are not intended to replace 24-hour inpatient or skilled nursing facility services
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: • Neuropsychological and psychological testing. • Inpatient mental health services are limited to: • 45 days 12-month inpatient limit • Includes inpatient psychiatric services, up to 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • 25 days of the inpatient benefit can be converted to residential treatment, therapeutic foster care or other 24-hour therapeutically planned and structured services or sub-acute outpatient (partial hospitalization or rehabilitative day treatment) mental health services on the basis of financial equivalence against the inpatient per diem cost • 20 of the inpatient days must be held in reserve for inpatient use only • Does not require PCP referral
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • Medication management visits do not count against the outpatient visit limit. • The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility • Up to 60 days 12-month period limit for rehabilitative day treatment • 60 outpatient visits 12-month period limit • 60 rehabilitative day treatment days can be converted to outpatient visits on the basis of financial equivalence against the day treatment per diem cost • 60 outpatient visits can be converted to skills training (psycho educational skills development) or rehabilitative day treatment on the basis of financial equivalence against the outpatient visit cost

Covered Benefit	Description
	• Includes outpatient psychiatric services, up to 12-month period limit, ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities. Court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination • Inpatient days converted to sub-acute outpatient services are in addition to the outpatient limits and do not count towards those limits • A Qualified Mental Health Professional (QMHP), as defined by and credentialed through Texas Department of State Health Services (DSHS) standards (TAC Title 25, Part II, Chapter 412), is a Local Mental Health Authorities provider. A QMHP must be working under the authority of an DSHS entity and be supervised by a licensed mental health professional or physician. QMHPs are acceptable providers as long as the services would be within the scope of the services that are typically provided by QMHPs. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services • Does not require PCP referral
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: • Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Does not require PCP referral • Medically necessary detoxification/stabilization services, limited to 14 days per 12-month period. • 24-hour residential rehabilitation programs, or the equivalent, up to 60 days per 12-month period • 30 days may be converted to partial hospitalization or intensive outpatient rehabilitation, on the basis of financial equivalence against the inpatient per diem cost • 30 days must be held in reserve for inpatient use only.
Outpatient Substance Abuse Treatment Services	• Services include, but are not limited to, the following: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day • Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training • Outpatient treatment services up to a maximum of: • Intensive outpatient program (up to 12 weeks per 12-month period) • Outpatient services (up to six-months per 12-month period) • Does not require PCP referral

Covered Benefit	Description
Rehabilitation Services	Services include, but are not limited to, the following: • Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: • Physical, occupational and speech therapy • Developmental assessment
Hospice Care Services	Services include, but are not limited to: • Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death • Treatment for unrelated conditions is unaffected • Up to a maximum of 120 days with a 6 month life expectancy • Patients electing hospice services waive their rights to treatment related to their terminal illnesses; however, they may cancel this election at anytime • Services apply to the hospice diagnosis
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: • Emergency services based on prudent lay person definition of emergency health condition • Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers • Medical screening examination • Stabilization services • Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services • Emergency ground, air and water transportation • Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.
Transplants	Services include, but are not limited to, the following: • Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: • One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization • One pair of non-prosthetic eyewear per 12-month period
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan- approved program • Health Plan defines plan-approved program. • May be subject to formulary requirements.
[Value-added services]	*See Attachment B-3*

CHIP EXCLUSIONS FROM COVERED SERVICES

- Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
- Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
- Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
- Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
- Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
- Mechanical organ replacement devices including, but not limited to artificial heart
- Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
- Prostate and mammography screening
- Elective surgery to correct vision
- Gastric procedures for weight loss
- Cosmetic surgery/services solely for cosmetic purposes
- Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
- Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
- Acupuncture services, naturopathy and hypnotherapy
- Immunizations solely for foreign travel
- Routine foot care such as hygienic care
- Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
- Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
- Corrective orthopedic shoes
- Convenience items
- Orthotics primarily used for athletic or recreational purposes
- Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
- Housekeeping

- Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
- Services or supplies received from a nurse, which do not require the skill and training of a nurse
- Vision training and vision therapy
- Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
- Donor non-medical expenses
- Charges incurred as a donor of an organ when the recipient is not covered under this health plan

CHIP DME/SUPPLIES

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Supplies			eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are not medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and			See Diabetic Supplies

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Syringes/Diabetic			
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

Modified by Version 1.6

ATTACHMENT B-3.1: STAR+PLUS VALUE-ADDED SERVICES
February 1, 2007 through August 31, 2007

HMO: MOLINA HEALTHCARE OF TEXAS, INC. (MHT)

HMO PROGRAM: STAR PLUS Program

SERVICE AREA(S): HARRIS and BEXAR

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Nurse advice line	MHT will make available to all its members a toll-free multi-lingual nurse advice line on a 24-hour, 7 days per week basis. Staff on this line will take calls from members and perform triage services to help them determine the appropriate setting from which to obtain necessary care. Physicians will be on call to support staff for situations not covered by established protocols. After normal business hours, the staff will also take calls from providers and perform eligibility and authorization services. In all instances, staff on the advice line will coordinate medical care with the member's primary care physician. Information regarding availability and how to access this service will be provided to members in handbooks and other written material.	None	Registered Nurses and on-call PCPs

Physical Health Value-added Services

Eyeglasses-Lens and Frames	MHT will furnish eyeglasses (Frame and Lens) to Medicaid only members in addition to the vision benefits under the STAR PLUS program. Information regarding the availability of this service will be provided to members in handbooks and other written educational material. Eligible members will be able to access this service from network providers.	Limited to $200 every other year	Network vision providers, e.g., ophthalmologists, optometrists and optical companies, will render these services
Adult Dental	Members age 21 and over will have access to basic dental coverage for: Preventive, X-rays, Extractions, and Fillings. Procedures Codes include: 00120/periodic oral evaluation; 00140/limited oral evaluation; 00150 new established (comprehensive oral evaluation); 00210 intraoral complete series (including bitewings); 00220 intraoral periapical 1st film; 00230 intraoral periapical ea. Additional; 00240 intraoral occlusal film; 00270 bitewings-single film; 00272 bitewings-two films; 00274 bitewings-four films; 01110 prophylaxis- adult (cleaning - once every 6 months);01240 topical application of fluoride (excluding prophlaxis)-adult; 02140 amalgum - 1 surface, primary or permanent; 02150 amalgum-2 surface,primary or permanent; 02330 resin-1 surface, anterior; 02331 resin-2 surface, anterior; 07140 extraction	Limit of $500 per year. All procedures not listed, including specialty services, Members will be subject to a co-payment of 75% of the dentists' usual and customary charges for those services.	Dental services to be subcontracted to OraQuest Dental Plans/StarDent Their provider network will be responsible for service provision. Contract in negotiation.

Community Based Long Term Care Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Behavioral Health	Intensive Outpatient Treatment (IOP)- To be used as a diversion to inpatient and as a step down from more restrictive levels of care.	Services must be authorized based on medical necessity. Services will be authorized for greater than one and one half hours, but less than five hours per day.	Behavioral health is subcontracted to CompCare. Their provider network will be responsible for service provision.
Behavioral Health	Partial Hospitalization Program (PHP) will be used as a diversion from inpatient and also as a step down from more restrictive level of care.	Services must be authorized based on medical necessity. Services will be authorized for a minimum of 4.5 hours to a maximum of 6 hours per 24-hours per day.	Behavioral health is subcontracted to CompCare. Their provider network will be responsible for service provision.

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) Responsible for providing this service
Behavioral Health	Off-site services such as intensive case management. This program is designed to offer services to members in a location other than the provider's normal location. Services could be offered in the member's home or other location, except the member's school. These services are provided to Members to help reduce or avoid inpatient admissions by a community based mobile, multi-disciplinary team of licensed clinicians and trained, unlicensed workers working under the direction of a licensed professional of the healing arts (LPHA).	Services must be authorized and is based on medical necessity. And limited to 96 units per calendar day.	Behavioral health is subcontracted to CompCare. Their provider network will be responsible for service provision

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

   Information regarding availability and how to access this service will be provided to:

   1. Members in Member handbooks (included in new membership packet) and other written material;
   2. Providers in provider manuals and other written material.

2. Describe how a Member may obtain or access the value-added services to be provided.

   Members may find the information on how to obtain the value-added services located in their Member Handbooks or other printed materials which will describe how a member may call a toll-free number to be connected to the Member Services Department or the Nurse Advice Line, to access the value added services. Members will have access also through their Service Coordinator.

3. Describe how the HMO will identify the Value-added Service in administrative (encounter) data.

   Molina maintains a health information system that will track information on value-added services to members. This system will allow for the collection, analysis and integration of value added services that ensures the data has internal consistency and integrity. This data will be submitted to the state for reporting purposes including encounter data.

   Data reports include:

   1. Encounters on 837 files from vision, dental and behavioral health (providers and/or subcontractors)
   2. Contact lists

   The QXNT system is the core health management system. Data in this system are analyzed and reports generated for management reporting and program monitoring.

   The following are data collection sources and/or data sources:

   Membership demographics
   Claims payment
   Informacare (clinical programs system, service coordination and case management)

4. By signing the Contract and/or Contract Amendment HMO certifies that it will provide the approved Value-added Services described herein from February 1, 2007 through August 31, 2007.

   [Modified by Version 1.6]

Texas Health and Human Services Commission
HMO Performance Improvement Goal Template
for State Fiscal Year 2008
(September 1, 2007 – August 31, 2008)

A. Health Plan Information

Plan Name:
HMO Program:
HMO Service Delivery Area:

B. Overarching Goal	C. Sub Goals:
Goal 1-5: Three to five Goals for all applicable HMO Programs to be determined and negotiated prior to FY2008.	To be determined for FY2008.
Goal 6: **(STAR+PLUS HMOs)** Increase the use of the Consumer Directed Services (CDS) Program	Increase the percentage of enrollees receiving Personal Assistance Services (PAS) through the Consumer Directed Services (CDS) Program by 15% as compared to the baseline rate of __

Specific percentages for Sub-Goals will be negotiated by HHSC and the HMO before the beginning of FY2008.

Additional information related to the Performance Improvement Goals can be found in **Attachment B-1, Section 8.1.1.1,** to the Contract.

Deliverables/Liquidated Damages Matrix

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Contract Attachment B-1, RFP §7.3 — Transition Phase Schedule	The HMO must be operational no later than the agreed upon Operations Start Date. HHSC, or its agent, will determine when the HMO is considered to be operational based on the requirements in Section 7 and 8 of Attachment B-1.	Operations Start Date	Each calendar day of non-compliance, per HMO Program, per Service Area (SA).	HHSC may assess up to $10,000 per calendar day for each day beyond the Operations Start date that the HMO is not operational until the day that the HMO is operational, including all systems.
Contract Attachment B-1, RFP §7.3.1 — Transition Phase Tasks Contract Attachment B-1, RFP §8.1 — General Scope				Modified by Version 1.1
Contract Attachment B-1 RFP §7.3.1.5 — Systems Readiness Review	The HMO must submit to HHSC or to the designated Readiness Review Contractor the following plans for review, by December 14, 2005 for STAR and CHIP, and by July 31, 2006 for STAR+PLUS: • Joint Interface Plan; • Disaster Recovery Plan;	Transition Period	Each calendar day of non-compliance, per report, per HMO Program, and per SA.	HHSC may assess up to $1,000 per calendar day for each day a deliverable is late, inaccurate or incomplete.

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
	• Business Continuity Plan; • Risk Management Plan; and • Systems Quality Assurance Plan.			
Contract Attachment B-1 RFP §7.3.1.7 – Operations Readiness	Final versions of the Provider Directory must be submitted to the Administrative Services Contractor no later than 95 days prior to the Operational Start Date for the CHIP, STAR, and STAR+PLUS HMOs, and no later than 30 days prior to the Operational Start Date for the CHIP Perinatal HMOs.	Transition Period	Each calendar day of non compliance, per directory, per HMO Program and per SA.	HHSC may assess up to $1,000 per calendar day for each 3day the directory is late, inaccurate or incomplete.
Contract Attachment B-1 RFP §§ 6, 7, 8 and 9 Uniform Managed Care Manual	All reports and deliverables as specified in Sections 6, 7, 8 and 9 of Attachment B-1 must be submitted according to the timeframes and requirements stated in the Contract (including all attachments) and HHSC's Uniform Managed Care Manual. (Specific Reports or deliverables listed separately in this matrix are subject to the specified liquidated damages.)	Transition Period, Quarterly during Operations Period	Each calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $250 per calendar day if the report/deliverable is late, inaccurate, or incomplete.

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Contract Attachment B-1 RFP §8.1.6 — Marketing & Prohibited Practices Uniform Managed Care Manual	The HMO may not engage in prohibited marketing practices.	Transition, Measured Quarterly during the Operations Period	Per incident of non-compliance.	HHSC may assess up to $1,000 per incident of non-compliance.
Contract Attachment B-1 RFP §8.1.17.2 — Financial Reporting Requirements Uniform Managed Care Manual – Chapter 5	Financial Statistical Reports (FSR): For each SA, the HMO must file quarterly and annual FSRs. Quarterly reports are due no later than 30 days after the conclusion of each State Fiscal Quarter (SFQ). The first annual report is due no later than 120 days after the end of each Contract Year and the second annual report is due no later than 365 days after the end of each Contract Year.	Quarterly during the Operations Period	Per calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $1,000 per calendar day a quarterly or annual report is late, inaccurate or incomplete.
Contract Attachment B-1 RFP §8.1.17.2 — Financial Reporting Requirements:	Medicaid Disproportionate Share Hospital (DSH) Reports: The Medicaid HMO must submit, on an annual basis, preliminary and final DSH Reports. The Preliminary report is due no later than June 1st after each reporting year, and the	Measured during 4th Quarter of the Operations Period (6/1–8/31)	Per calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $1,000 per calendar day, per program, per service area, for each day the report is late, incorrect, inaccurate or incomplete.

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Uniform Managed Care Manual – Chapter 5	final report is due no later than July 15th after each reporting year. This standard does not apply to CHIP HMOs.			
Contract Attachment B-1 RFP §8.1.18 – Management Information System (MIS) Requirements	The HMO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Measured Quarterly during the Operations Period	Per calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $5,000 per calendar day of non-compliance
Contract Attachment B-1 RFP §8.1.18.3 – Management Information System (MIS) Requirements: System-Wide Functions	The HMO's MIS system must meet all requirements in Section 8.1.18.3 of Attachment B-1.	Measured Quarterly during the Operations Period	Per calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $5,000 per calendar day of non-compliance.
Contract Attachment B-1 RFP §8.1.18.5 – Claims Processing Requirements	The HMO must adjudicate all provider Clean Claims within 30 days of receipt by the HMO. The HMO must pay providers interest at an 18% per annum, calculated daily for the full period in which the Clean	Measured Quarterly during the Operations Period	Per incident of non-compliance.	HHSC may assess up to $1,000 per claim if the HMO fails to timely pay interest. [Modified by Version 1.2]

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Uniform Managed Care Manual Chapter 2	Claim remains unadjudicated beyond the 30-day claims processing deadline.			
Contract Attachment B-1 RFP §8.1.18.5 – Claims Processing Requirements Uniform Managed Care Manual – Chapter 2	The HMO must comply with the claims processing requirements and standards as described in Section 8.1.18.5 of Attachment B-1 and in Chapter 2 of the Uniform Managed Care Manual.	Measured Quarterly during the Operations Period	Per quarterly reporting period, per HMO Program, per SA.	HHSC may assess liquidated damages of up to $5,000 for the first quarter that an HMO's Claims Performance percentages by type and by Program fall below the performance standards. HHSC may assess up to $25,000 per quarter for each additional quarter that the Claims Performance percentages by type and by Program fall below the performance standards. [Modified by Version 1.2]
Contract Attachment B-1 RFP §8.1.20.2 – Reporting Requirements Uniform Managed Care Manual Chapters 2 and 5	Claims Summary Report: The HMO must submit quarterly, Claims Summary Reports to HHSC by HMO Program and each SA and claims processing subcontractor by the 30th day following the reporting period unless otherwise specified.	Measured Quarterly during the Operations Period	Per calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $1,000 per calendar day the report is late, inaccurate, or incomplete. [Modified by Version 1.2]

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Contract Attachment B-1 RFP §8.1.5.9 – Member Complaint and Appeal Process Contract Attachment B-1 RFP §8.2.7.1 – Member Complaint Process Contract Attachment B-1 RFP §8.4.3 – CHIP Member Complaint and Appeal Process	The HMO must resolve at least 98% of Member Complaints within 30 calendar days from the date the Complaint is received by the HMO.	Measured Quarterly during the Operations Period	Per reporting period, per HMO Program, per SA.	HHSC may assess up to $250 per reporting period if the HMO fails to meet the performance standard.
Contract Attachment B-1 RFP §8.3.3 – STAR+PLUS Assessment Instruments Uniform Managed Care Manual	The MDS-HC instrument must be completed and electronically submitted to HHSC in the specified format within 30 days of enrollment for every Member receiving Community-based Long-term Care Services, and then each year by the anniversary of the Member's date of enrollment.	Operations, Turnover	Per calendar day of non-compliance, per Service Area.	HHSC may assess up to $500 per calendar day per Service Area, for each day a report is late, inaccurate or incomplete. [Added by Version 1.1]
Contract	The HMO must resolve at least	Measured	Per reporting period,	HHSC may assess up to $500 per

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
Attachment B-1 RFP §8.1.5.9– Member Complaint and Appeal Process Contract Attachment B-1 RFP §8.2.7.2 – Medicaid Standard Member Appeal Process Contract Attachment B-1 RFP § 8.4.3 CHIP Member Complaint and Appeal Process	98% of Member Appeals within 30 calendar days from the date the Appeal is filed with the HMO.	Quarterly during the Operations Period	per HMO Program, per SA.	reporting period if the HMO fails to meet the performance standard.
Contract Attachment B-1 RFP §9.2 – Transfer of Data	The HMO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new HMO, at the sole discretion of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.	Measured at Time of Transfer of Data and ongoing after the Transfer of Data until satisfactorily completed	Per incident of non-compliance (failure to provide data and/or failure to provide data in required format), per HMO Program, per SA.	HHSC may assess up to $10,000 per calendar day the data is late, inaccurate or incomplete.
Contract Attachment B-1	Six months prior to the end of the contract period or any extension	Measured at Six Months prior to the	Each calendar day of non-compliance, per	HHSC may assess up to $1,000 per calendar day the Plan is late,

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
RFP §9.3 – Turnover Services	thereof, the HMO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State (HHSC) or a successor HMO.	end of the contract period or any extension thereof and ongoing until satisfactorily completed	HMO Program, per SA.	inaccurate, or incomplete.
Contract Attachment B-1 RFP §9.4 – Post-Turnover Services	The HMO must provide the State (HHSC) with a Turnover Results report documenting the completion and results of each step of the Turnover Plan 30 days after the Turnover of Operations.	Measured 30 days after the Turnover of Operations	Each calendar day of non-compliance, per HMO program, per SA.	HHSC may assess up to $250 per calendar day the report is late, inaccurate or incomplete.
Contract Attachment A HHSC Uniform Managed Care Contract Terms and Conditions, Section 4.08 Subcontractors	The HMO must notify HHSC in writing immediately upon making a decision to terminate a subcontract with a Material Subcontractor or upon receiving notification from the Material Subcontractor of its intent to terminate such subcontract.	Transition, Measured Quarterly during the Operations Period	Each calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $5,000 per calendar day of non-compliance.

1 Derived from the Contract or HHSC's Uniform Managed Care Manual.

[Modified by Version 1.2]

2 Standard specified in the Contract. Note: Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

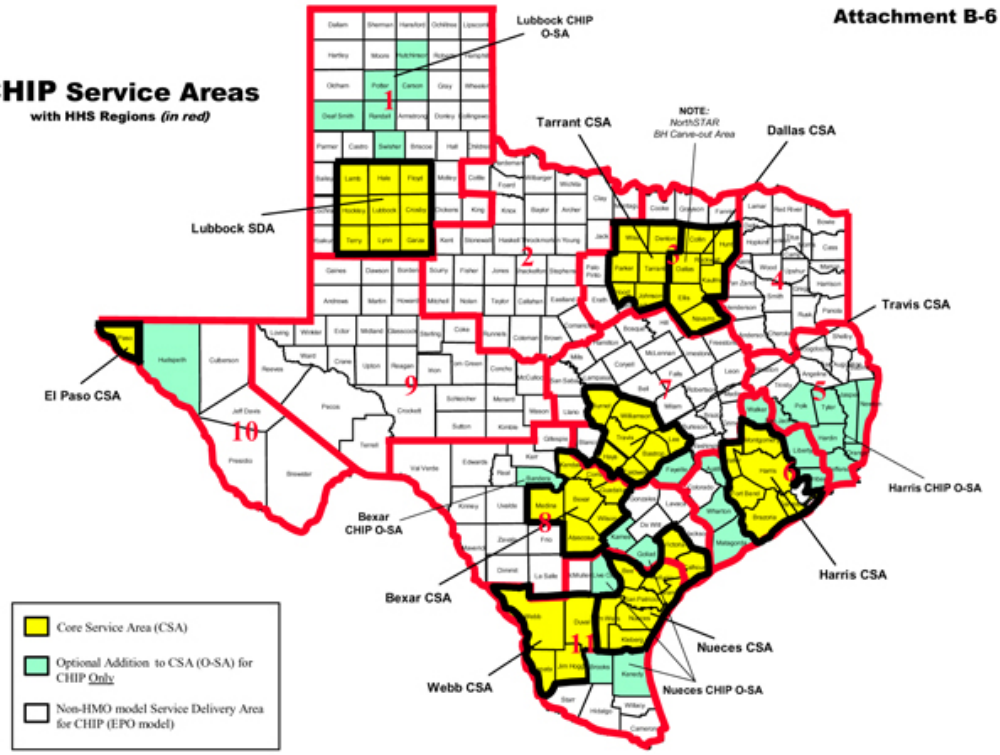
3 Period during which HHSC will evaluate service for purposes of tailored remedies.

4 Measure against which HHSC will apply remedies.

Attachment B-6

CHIP Service Areas

with HHS Regions *(in red)*



HSIC, Health Plan Operations
July 2005

CHIP HMO Service Areas

Bexar	Bexar
	Atoscosa
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson
Optional Addition to Bexar CSA (O-SA)	Bandera

Dallas	Dallas
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro
	Rockwall

Nueces	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Nueces
	Refugio
	San Patricio
	Victoria
Optional Addition to Nueces CSA (O-SA)	Brooks
	Goliad
	Karnes
	Kennedy
	Live Oak

El Paso	El Paso
	Hudspeth

Tarrant	Tarrant
	Denton
	Hood
	Johnson
	Parker
	Wise

Harris	Harris
	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller
Optional Addition to Harris CSA (O-SA)	Austin
	Chambers
	Hardin
	Jasper
	Jefferson
	Liberty
	Matagorda
	Newton
	Orange
	Polk
	San Jacinto
	Tyler
	Walker
	Wharton

Lubbock	Lubbock
	Crosby
	Floyd
	Garza
	Hale
	Hockley
	Lamb
	Lynn
	Terry
Optional Addition to Lubbock CSA (O-SA)	Carson
	Deaf Smith
	Hutchinson
	Potter
	Randall
	Swisher

Travis	Travis
	Bastrop
	Burnet
	Caldwell
	Hays
	Lee
	Williamson
O-SA	Fayette

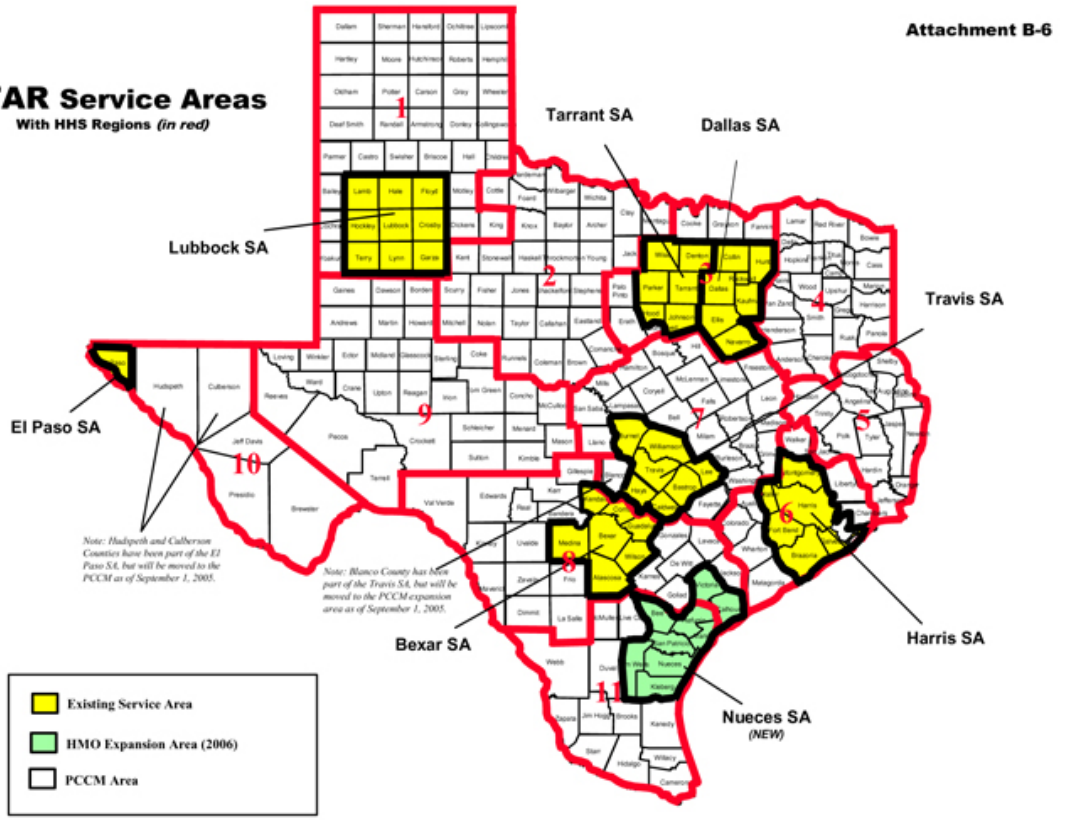
Webb *(CHIP Only SA)*	Webb
	Duval
	Jim Hogg
	Zapata

HSIC, Health Plan Operations
July 2005

Attachment B-6

STAR Service Areas

With HHS Regions *(in red)*



HHSC, Health Plan Operations
July 2005

STAR HMO Service Areas

Bexar	Bexar
	Atascosa
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson

Dallas	Dallas
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro
	Rockwall

El Paso	El Paso

Travis	Travis
	Bastrop
	Burnet
	Caldwell
	Hays
	Lee
	Williamson

Tarrant	Tarrant
	Denton
	Hood
	Johnson
	Parker
	Wise

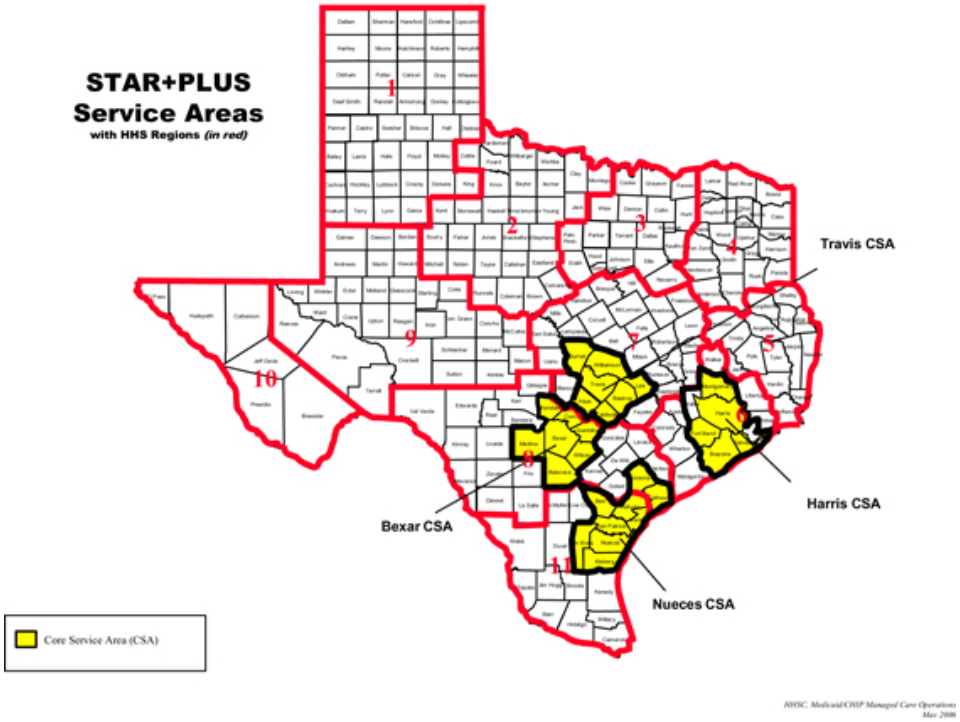
Harris	Harris
	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller

Lubbock	Lubbock
	Crosby
	Floyd
	Garza
	Hale
	Hockley
	Lamb
	Lynn
	Terry

New STAR Service Area

Nueces	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Nueces
	Refugio
	San Patricio
	Victoria

HHSC, Health Plan Operations
July 2005



STAR+PLUS HMO Service Areas

Bexar	Bexar
	Atoscosa
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson

Nueces	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Nueces
	Refugio
	San Patricio
	Victoria

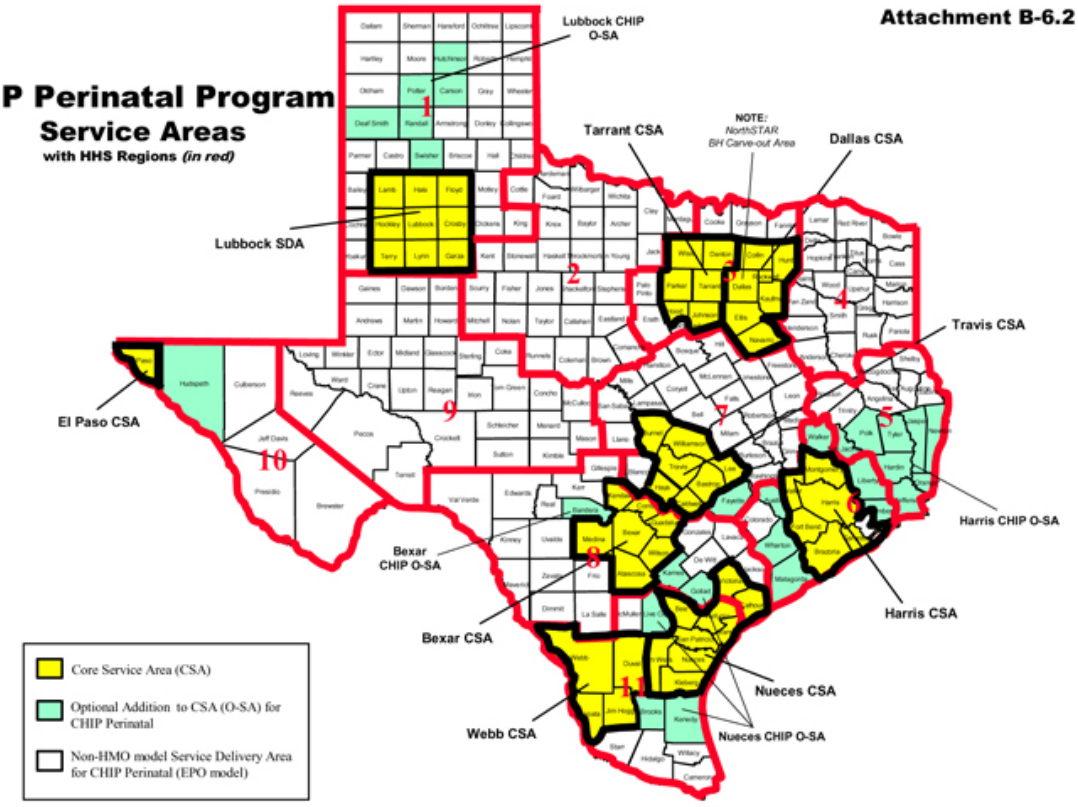
Harris	Harris
	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller

Travis	Travis
	Bastrop
	Burnet
	Caldwell
	Hays
	Lee
	Williamson

Attachment B-6.2

CHIP Perinatal Program Service Areas

with HHS Regions *(in red)*



HHSC, Health Plan Operations
July 2005

CHIP Perinatal HMO Service Areas

Bexar	Bexar
	Atoscosa
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson
Optional Addition to Bexar CSA (O-SA)	Bandera

Dallas	Dallas
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro
	Rockwall

Nueces	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Nueces
	Refugio
	San Patricio
	Victoria
Optional Addition to Nueces CSA (O-SA)	Brooks
	Goliad
	Karnes
	Kennedy
	Live Oak

El Paso	El Paso
	Hudspeth

Tarrant	Tarrant
	Denton
	Hood
	Johnson
	Parker
	Wise

Harris	Harris
	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller
Optional Addition to Harris CSA (O-SA)	Austin
	Chambers
	Hardin
	Jasper
	Jefferson
	Liberty
	Matagorda
	Newton
	Orange
	Polk
	San Jacinto
	Tyler
	Walker
	Wharton

Lubbock	Lubbock
	Crosby
	Floyd
	Garza
	Hale
	Hockley
	Lamb
	Lynn
	Terry
Optional Addition to Lubbock CSA (O-SA)	Carson
	Deaf Smith
	Hutchinson
	Potter
	Randall
	Swisher

Travis	Travis
	Bastrop
	Burnet
	Caldwell
	Hays
	Lee
	Williamson
O-SA	Fayette

Webb *(CHIP Only SA)*	Webb
	Duval
	Jim Hogg
	Zapata

HHSC, Health Plan Operations
July 2005

ATTACHMENT B-7: STAR+PLUS ATTENDANT CARE ENHANCED PAYMENTS METHODOLOGY

HMO: Molina Healthcare of Texas, Inc.

SERVICE AREA(S): Harris and Bexar

I. Provider Contracting

(a) Description of criteria the HMO will use to allow participation in the STAR+PLUS Attendant Care Enhanced Payments. Will the HMO have a enrollment period that corresponds to the DADS enrollment period to allow new providers to participate in the HMO's Attendant Care Enhanced Payments, or will the HMO have it's own enrollment period that is separate and not tied to the DADS enrollment?

(b) Description of any limitations or restrictions.

Molina Healthcare of Texas, Inc. (MHT) will offer all providers participating in the DADS Attendant Compensation Rate Enhancement the opportunity to participate in the MHT STAR+PLUS Attendant Care Enhanced Payments.

MHT does not have a designated enrollment period for providers to submit applications. In the process of building our network we will have ongoing enrollment activities until the network is complete and we have met the 7.3% figure HHSC as given to us as the target for enhancements payments. Participation for new providers to receive the enhanced payments will depend on future funding or upon current providers dropping out of the program that will need to be replaced.

II. Payment for STAR+PLUS Attendant Care Enhanced Payments	**Description of methodology the HMO will use to pay for the Attendant Care Enhanced Payments. Provide sufficient detail to fully explain the planned methodology.**
	The methodology that MHT will use to pay the STAR+PLUS Attendant Care Enhanced Payments will be to add the enhancement payment to the Personal Assistance Services (PAS), DAHS and Assisted Living participant provider rates. Based on the participant level that is contracted with each provider, the enhancement rate in effect, once supported by sufficient proof, will be added to the negotiated rate of service unit price. For example, if a provider is at a level where the unit rate is $10.00 with an enhancement payment of an additional $1.00 then the total payment made to the provider would be $ 11.00 ($10.00+$1.00). The additional STAR+PLUS Attendant Care Enhancement Payment of $ 1.00 will be tracked from encounter data for a report to break this payment out of the total expense for tracking on the quarterly FSR reports. This will also allow MHT the ability to attest to the total payouts related to long term care and the percentage of those dollars paid for the STAR+PLUS Attendant Care Enhancement Payment. The additional enhancement payments will be tied to the unique provider.
III. Timing of the Attendant Care Enhanced Payments	**Description of when the payments will be made to the Providers and the frequency of payments. Also include timeframes for Providers complaints and appeals regarding enhanced payments.**

The Attendant Care Enhanced Payment will be made as claims are being processed. MHT creates check writes for claims adjudicated twice weekly. Therefore, the receipt of the STAR+PLUS Attendant Care Enhanced Payment will be immediate as the claims are processed and will not require a separate process after the fact. Providers who submit clean claims will receive their STAR+PLUS Attendant Care Enhanced Payment in a timely manner.

MHT will develop additional provider complaint and appeal policies for the STAR+ PLUS program that are similar to those in place for the STAR and CHIP products that include enhanced payments. These policies were previously submitted to HHSC (MST-CA 01.003 and MST-CA 01.004). These policies are designed to ensure that provider complaints and appeals are resolved in a timely manner in accordance with federal and Texas regulations. MHT will advise the provider of the final resolution regarding the complaint within 30 days from the date the initial complaint was received. The provider must file a request for appeal within 30 days from the receipt of the notice of the action. The Appeal And Complaint Coordinator will send a letter to the provider within 5 business days acknowledging receipt of the appeal. MHT will advise the provider of the final decision for a standard Medicaid appeal within 30 calendar days after receipt of the initial written or oral request for an appeal.

IV. Assurances from Participating Providers

Description of how the HMO will ensure that the participating Providers are using the enhancement funds to compensate direct care workers as intended by the 2000-01 General Appropriations Act (Rider 27, House Bill 1, 76th Legislature, Regular Session, 1999) and by T.A.C. Title 1, Part 15, Chapter 355.

The STAR+ PLUS Attendant Enhanced Payment program was introduced as an incentive to increase wages and benefits for community care attendants. Participating providers in the STAR+ PLUS Attendant Enhanced Payment program must file an attestation report, on at least an annual basis, that will affirm that the enhancement dollars received and the specific allotment of those dollars. Providers failing to meet their spending requirement for the reporting period will have their STAR+ PLUS Attendant Care Enhanced Payment add-on revenues associated with the unmet spending requirements recouped. At no time will a participating provider's attendant care rate after their spending recoupment be less than the rate paid to providers not participating in the enhanced add-on rates.

In the event that MHT believes that a claim has been overpaid or paid in duplicate, or that funds were paid beyond or outside of what is provided for under the provider agreement, provider agrees to make repayment to plan or payer within thirty (30) days of written notification by MHT of the overpayment, duplicate payment, or other excess payment. Should provider discover excess money of any kind prior to being notified, provider shall contact MHT and hold the money until it is determined to whom the money belongs. In the event it is determined that MHT has underpaid provider for covered services under the provider agreement, MHT will pay provider the amount of the underpayment within thirty (30) days after agreement has been reached as to the amount of the underpayment.

In addition to any other contractual or legal remedy, MHT may recover the amounts owed by way of offset or recoupment from current or future amounts due provider following provider's exercise of provider appeal rights under this agreement. Prior to any offset or recoupment, MHT shall give provider at least thirty (30) days written notice. Any disputes concerning of overpayment or underpayment not resolved within such thirty (30) day period shall be resolved in accordance with the dispute resolution procedures outlined in the MHT Provider Manual.

V. Monitoring of Attendant Care Enhanced Payments	**Explanation of the Monitoring Process that the HMO will use to monitor whether the Attendant Care Enhanced Payments are used for the purposes intended by the Texas Legislature.**
	As mentioned above, MHT will collect an attestation report (at least annually) from each provider to ensure the enhanced payments received were used for the proper purpose. The audit of the attestation report will in the form of a desk audit. Depending on the findings, there may be an on site review. Depending on the filings, the providers may face correction actions or recoupment of their enhancement payments. All findings and information will be discussed and shared with the provider. The attestation report will be similar to those currently being used by HHSC. These desk reviews and potential audits will adhere to any HHSC requirements.

By signing the Contract and/or Contract Amendment, HMO certifies that the approved STAR+PLUS Attendant Care Enhanced Payments Methodology described herein is the methodology the HMO will use to make the legislatively mandated payments to its Long Term Services and Support (LTSS) Providers participating in the Attendant Care Enhanced Payments.

Additional information related to the Attendant Care Enhanced Payments can be found in Attachment B-1, Section 8.3.7.3 of the Contract.

ATTACHMENT B-3: VALUE-ADDED SERVICES
September 1, 2006 – August 31, 2007

HMO: **Molina Healthcare of Texas, Inc. (MHT)**
HMO PROGRAM: **STAR and CHIP programs**
SERVICE AREA(S): **HARRIS**

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Nurse Advice Line	MHT will make available to all its members a toll-free multi- lingual nurse advice line on a 24-hour, 7 days per week basis. Staff on this line will take calls from members and perform triage services to help them determine the appropriate setting from which to obtain necessary care. Physicians will be on-call to support staff for situations not covered by established criteria/protocols. After normal business hours the staff will also take calls from providers and perform eligibility and authorization services. In all instances, staff on the advice line will coordinate medical care with the member's primary care physician. Available to both STAR and CHIP members. Information regarding availability and how to access this service will be provided to members in handbooks and other written material. MHT will provide this service for at least 12 months from the operational start date of the contract.		Registered Nurses and on-call PCPs

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Weight Reduction through Participation in a Weight Watchers® program	1. MHT will enroll interested and eligible members in a local Weight Watchers® program and provide vouchers for five consecutive weeks of program attendance. The initial mailing to the member, with the vouchers, will include fact sheets about the program and suggestions for getting started with an exercise regimen; these materials are in addition to those that will be provided at the Weight Watchers ® program meetings. Within two months of issuing the initial vouchers a MHT health educator will contact the member to assess their success and commitment to the program. If the member is fully participating in the program, the educator will issue vouchers for an additional five weeks of program attendance. Eligible members will be allowed a maximum of ten vouchers. 2. MHT will provide this service to members aged 15 and older in STAR and CHIP in every contracted service area who have a BMI of 30 or above. 3. The service will be limited to members aged 15 and older. A member's body mass index (level of obesity), readiness to make behavior changes important to weight control and willingness to attend group classes for five consecutive weeks will be assessed by MHT health education staff before program participation is approved. The second set of five vouchers will only be issued to members who show commitment to and active participation in the program. 4. Local Weight Watchers® programs will provide their established package of educational services for MHT members, with supplemental information and assessments provided by MHT health education staff.	Limited to members in STAR and CHIP, aged 15 or older with a BMI of 30 or above.	Certified Health Education Staff

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Weight Reduction through Participation in a Weight Watchers® program	5. Information regarding the availability of this service will be provided to members in handbooks and other written educational material. In addition, primary care physicians and other network providers will be informed of the availability of this service and encouraged to recommend program participation to members who could benefit. (continued) 6. Members will be able to call MHT health education staff directly, during regular business hours, to request participation in a local Weight Watchers® program. Physicians may also make referrals on behalf of their member patients to MHT for program participation. 7. MHT will provide this service for at least 12 months from the operational start date of the contract.	Limited to members in STAR and CHIP, aged 15 or older with a BMI of 30 or above.	Certified Health Education Staff
Smoking Cessation	1. MHT will utilize a nationally recognized telephonic smoking cessation program, called Free and Clear®, that also includes written informational and support material. Participating members will be mailed a smoking cessation "kit" including a workbook, smoking diary and handbooks and other written material. Telephone support is a major factor of the program. A smoking cessation specialist will telephone the member within two weeks of program registration to answer any questions and on three subsequent occasions in the months following the member's "quit date" to provide support and relapse prevention information. Program participants will have toll free telephone access to smoking cessation specialists for support and counseling.	STAR: Limited to members in STAR who are aged 18 or older or pregnant women of any age. Limited to $185.00 per eligible member.	Certified Health Education Staff and PCPs

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Smoking Cessation (continued)	2. MHT will provide this service to members in STAR who are aged 18 or older and all pregnant women in the Star program of any age, with a tobacco addiction and who desire to end the addiction. 3. Group Health Cooperative, a company based in Seattle, Washington, will provide the Free and Clear® telephonic smoking cessation program for MHT members, with administrative support provided by MHT. 4. Primary care physicians and other network providers will be informed of the availability of this service and encouraged to recommend program participation to members who could benefit. 5. Members will be able to call MHT health education staff directly, during regular business hours, to request participation in the Free and Clear ® smoking cessation program. Physicians may also make referrals on behalf of their member patients to MHT for program participation. 6. MHT will provide this service for at least 12 months from the operational start date of the contract.		

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Disease Management Program – Congestive Heart Failure	1. MHI is finalizing a new disease management program for congestive heart failure, which will be complete at the end of 2004. It will operate on the *InformaCare* platform, enabling integration of all disease management components. Program components will resemble those utilized for MHT's diabetes and asthma disease management programs, and will include: • Strategies and methodologies to identify members eligible for the program, • Clinical indicators for participation and stratification to risk levels, • Member outreach methodologies, • Development and dissemination of clinical practice guidelines, • Provider education, • Member interventions specific to each risk level, and • Evaluation indicators for clinical and financial outcomes. 2. MHT will make the program available to all STAR members diagnosed with congestive heart failure in every contracted service area. 3. All members with diagnosed congestive heart failure will be enrolled in Disease Management services. 4. MHT health professional staff will render these disease management services in conjunction with the member's providers.		PCPs

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Disease Management Program – Congestive Heart Failure (continued)	5. Information regarding the availability of this service will be provided to members in handbooks and other written educational material. In addition, primary care and specialty physicians will be informed of the availability of this service and encouraged to recommend program participation to and for members who could benefit. 6. Physicians may make referrals to MHT for disease management services for their member patients. MHT health professional staff may also contact a member's primary care or specialty physician to initiate such services based on a review of paid claims. 7. MHT will provide this service for at least 12 months from the operational start date of the contract.		PCPs
Vision Services	1. MHT will provide to STAR and CHIP members a larger choice of available frames, lens types, and materials. Subject to medical necessity for a new prescription for glasses. 2. Information regarding the availability of this service will be provided to members in handbooks and other written educational material. 3. Eligible members will be able to access this service from network providers. 4. MHT will provide this service for at least 12 months from the operational start date of the contract.	Increase of benefit limited to $50.00 above the basic benefit per eligible member.	Network vision providers, e.g., optometrists and optical companies, will render these services.

Behavioral Health Value-added Services for Members Under 21

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
None			

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
None			

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

   Information regarding availability and how to access this service will be provided to:

   1. Members in Member handbooks (included in new membership packet) and other written material;
   2. Providers in provider manuals and other written material.

2. Describe how a Member may obtain or access the value-added services to be provided.

Members may find the information on how to obtain the value-added services located in their Member Handbooks or other printed materials which will describe how a member may call a toll-free number to be connected to the Member Services Department or the Nurse Advice Line, to access the value added services. Member Services staff will be able to assist the members with accessing the value-added service(s) in question.

3. Describe how the HMO will identify the Value-added Service in administrative (encounter) data.

Molina maintains a health information system that collects, analyzes, and integrates the data necessary to implement its Value-added Services; ensures the information received from providers of services is reliable and complete; and makes available to the State the collected information, including encounter data.

Multiple sources of identification are used to identify the members in the eligible population. These include the following:

- Pharmacy claims data for all classifications of diabetic medications
- Encounter data or paid claim with an CPT or ICD-9 code indicating a diagnosis of diabetes
- Member Services – incoming calls have the potential to identify eligible members. Eligible members are referred to the program registry.
- Practitioner referral
- Case Management or Utilization Management review for an eligible member
- Member self-referral – general plan promotion of program through member newsletter and other member communications

CollectingData

a. QNXT is the core system used by Molina. The data are analyzed for the development of ongoing programs and the monitoring of healthcare outcomes. All systems are constantly evaluated for performance, reliability, and usefulness.

b. The following are the systems and their data source: Membership (age/sex, language, ethnicity demographics): QNXT (core enrollment, utilization and claims payment system) membership data; and InformaCare (clinical programs system – disease management, care coordination, and medical case management); and Language Line (outside vendor).

4. By signing the Contract and/or Contract Amendment HMO certifies that it will provide the approved Value-added Services described herein from September 1, 2006 through August 31, 2007.

ATTACHMENT B-3.2: CHIP PERINATAL PROGRAM VALUE-ADDED SERVICES
January 1, 2007 through August 31, 2007

HMO: _____

SERVICE AREA(S): _____

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

Behavioral Health Value-added Services for Members Under 21

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

2. Describe how a Member may obtain or access the value-added services to be provided.

3. Describe how the HMO will identify the Value-added Service in administrative (encounter) data.

4. By signing the Contract and/or Contract Amendment HMO certifies that it will provide the approved Value-added Services described herein from January 1, 2007 through August 31, 2007.

Texas Health and Human Services Commission
STAR and CHIP HMO
Performance Improvement Goals
SFY 2007
(September 1, 2006 – August 31, 2007)

Modified by Version 1.2 and 1.4

A. Health Plan Information

Plan Name: Molina Healthcare of Texas, Inc.

HMO Program: CHIP

HMO Service Delivery Area: Harris/ Harris Expansion SDA

B. Overarching Goal	C. Sub Goals:
Goal 1: **Improve Access to Primary Care Services for Members**	• **90% of new members will be contacted and reminded/assisted with making a PCP appointment within 90 days of entering the health plan** • **90% of new members with default assigned PCP will be contacted to assist with re-assignment within 30 days of default PCP assignment**
Goal 2: **Improve Access to Behavioral Health Services for Members**	• **Contact 90% of members discharged from a behavioral health inpatient stay to remind them of the 7-day follow-up appointment needed** • **Identify and survey 90% of members who do not keep their 7-day follow-up appointment to determine why appointments were not made/kept**
Goal 3: **Improve Current Member Understanding About the CHIP Benefit Renewal Processes**	• **87% of current members are (successfully*) mailed renewal reminders by the 10th day of their 4th month of enrollment** • **90% of members who are in months 4-6 of their renewal period and who call Members Services Helpline will get a reminder about renewing CHIP enrollment packet and submitting on time** *** a successful mailing is one that is not returned as undeliverable**

Additional information related to the Performance Improvement Goals can be found in **Attachment B-1, Section 8.1.1.1,** to the Contract.

Texas Health and Human Services Commission
STAR and CHIP HMO
Performance Improvement Goals
SFY 2007
(September 1, 2006 – August 31, 2007)

Modified by Versions 1.2 and 1.4

A. Health Plan Information

Plan Name: Molina Healthcare of Texas, Inc.

HMO Program: STAR

HMO Service Delivery Area: Harris/ Harris Expansion SDA

B. Overarching Goal	C. Sub Goals:
Goal 1: **Improve Access to Primary Care Services for Members**	• **90% of new members will be contacted and reminded/assisted with making a PCP appointment within 90 days of entering the health plan** • **90% of new members with default assigned PCP will be contacted to assist with re-assignment within 30 days of default PCP assignment**
Goal 2: **Improve Access to Behavioral Health Services for Members**	• **Contact 90% of members discharged from a behavioral health inpatient stay to remind them of the 7-day follow-up appointment needed** • **Identify and survey 90% of members who do not keep their 7-day follow-up appointment to determine why appointments were not made/kept**
Goal 3: **Improve Access to Clinically Appropriate Alternatives to Emergency Room Services Outside of Regular Office Hours**	• **100% of member newsletters will contain appropriate reminders and information about alternatives to inappropriate ER utilization** • **Increase number of contracted urgent care clinics to 2 by the end of the fiscal year**

Additional information related to the Performance Improvement Goals can be found in **Attachment B-1, Section 8.1.1.1,** to the Contract.

Exhibit 10.27

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 *(#* H5628)

Between

Centers for Medicare & Medicaid Services (hereinafter referred to as CMS)

and

Molina Healthcare of , Inc.

(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
☒ Part D Addendum	/s/ GKO
_____ Employer-Only MA-PD Addendum (800 Series)	_____
_____ Employer-Only MA Only Addendum (800 Series)	_____
_____ Variances/Waivers (Provided directly to Demonstration Organizations by CMS)	_____
_____ 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, 2006, 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)(l)(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(l)]**

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(l)]**

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. **[422.502(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. **[422.502(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. **[422.502(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. **[422.502(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, Medicare 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 (l)(b)(ii) and (l)(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)(l)(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)]**

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)(l)]**

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 contact 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

	Chief Executive Officer
Printed Name	Title
/s/	September 8, 2005
Signature	

Molina Healthcare of , Inc.

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

/s/ Patricia P. Smith	10/17/05
Patricia P. Smith	Date
Director	
Medicare Advantage Group	
Center for Beneficiary Choices	

Contract #H5628

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 Molina Healthcare of , Inc., a Medicare managed care organization (hereinafter referred to as the MA-PD Sponsor) agree to amend the contract (H5628) 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 from Prescription Drug Plans released on January 21, 2005 (as revised on March 9, 2005) [applicable to Medicare Part C contractors] or the Solicitation for Applications from Cost Plan Sponsors released on January 21, 2005 as revised on March 9. 2005) [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 contact 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, 2006. 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, 2005 and shall not process enrollment applications prior to November 15, 2005. MA-PD Sponsor shall begin delivering Part D benefit services on January 1, 2006.

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 non-renewal 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 0 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.

In witness whereof, the parties hereby execute this addendum.

FOR THE MA-PD SPONSOR

Printed Name	Chief Executive Officer Title
/s/ Signature Molina Healthcare of , Inc.	September 8, 2005

FOR THE CENTERS FOR MEDICARE & MEDICAID SERVICES

/s/ Patricia Smith Patricia Smith Director Medicare Advantage Group Center for Beneficiary Choices	Date
/s/ Robert Donnelly Robert Donnelly Director Medicare Drug Benefit Group Center for Beneficiary Choices	Date

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 (Molina Healthcare of , Inc.), 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.

_____
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 (Molina Healthcare of , Inc.), 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.

Chief Executive Officer

on behalf of

(INDICATE MA ORGANIZATION)

DATE

Medicare Advantage Attestation of Benefit Plan and Price
MOLINA HEALTHCARE OF , INC.
H5628
Date: 09/07/2005

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 2006.

Plan ID	Segment ID	Version	Plan Name	Plan Type	Transaction Type	MA Premium	Part D Premium	CMS Approval Date	Effective Date
001	0	6	Molina Advantage	HMO	Initial	0.00	32.34	09/07/2005	01/01/2006

/s/ 8 September 2005
CEO: **Date:**

/s/ 9/8/05
CFO: **Date:**

EXHIBIT 21.1

LIST OF SUBSIDIARIES

Name	Jurisdiction of Incorporation
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 Indiana, Inc.	Indiana
Molina Healthcare of Texas, Inc.	Texas
Molina Healthcare of Ohio, Inc.	Ohio
Molina Healthcare of Georgia, Inc.	Georgia
Molina Healthcare of Nevada, Inc.	Nevada
Molina Healthcare Insurance Company, Inc.	Ohio
HCLB, Inc.	Michigan

EXHIBIT 23.1

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 9, 2007, with respect to the consolidated financial statements of Molina Healthcare, Inc., Molina Healthcare Inc.'s management assessment of the effectiveness of internal control over financial reporting, and the effectiveness of internal control over financial reporting of Molina Healthcare, Inc., included in its Annual Report (Form 10-K) for the year ended December 31, 2006, filed with the Securities and Exchange Commission.

/S/ ERNST & YOUNG LLP

Los Angeles, California
March 9, 2007

EXHIBIT 31.1

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, 2006 of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

March 14, 2007
Date

/s/ JOSEPH M. MOLINA
Joseph M. Molina
Chief Executive Officer and President

EXHIBIT 31.2

SECTION 302 CERTIFICATION

I, John C. Molina, certify that:

1. I have reviewed this annual report on Form 10-K for the fiscal year ended December 31, 2006, of Molina Healthcare, Inc.;

2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary in order to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;

3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;

4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   (a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period for which this report is being prepared;

   (b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   (c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   (d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and

5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):

   (a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report information; and

   (b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

March 14, 2007
Date

/s/ JOHN C. MOLINA
John C. Molina, J.D.
Chief Financial Officer and Treasurer

EXHIBIT 32.1

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2006 as filed with the Securities and Exchange Commission (the "Report"), I, J. Mario Molina, M.D., Chief Executive Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

March 14, 2007

/s/ JOSEPH M. MOLINA

Joseph M. Molina, M.D.
Chief Executive Officer and President

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.

EXHIBIT 32.2

CERTIFICATE PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report of Molina Healthcare, Inc. (the "Company") on Form 10-K for the period ending December 31, 2006 as filed with the Securities and Exchange Commission (the "Report"), I, John C. Molina, J.D., Chief Financial Officer of the Company, certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

(1) The Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934, as amended; and

(2) The information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

March 14, 2007

/s/ JOHN C. MOLINA

John C. Molina, J.D.
Chief Financial Officer and Treasurer

This certification accompanies this report pursuant to Section 906 of the Sarbanes-Oxley Act of 2002 and shall not, except to the extent required by the Sarbanes-Oxley Act of 2002, be deemed filed by the Company for purposes of Section 18 of the Securities Exchange Act of 1934, as amended. A signed original of this written statement required by Section 906 has been provided to Molina Healthcare, Inc. and will be retained by Molina Healthcare, Inc. and furnished to the Securities and Exchange Commission or its staff upon request.