UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

[X] **QUARTERLY REPORT PURSUANT TO SECTION 13 OR 15(d) OF THE SECURITIES EXCHANGE ACT OF 1934**

For the quarterly period ended June 30, 2011

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: 001-31826

CENTENE CORPORATION

(Exact name of registrant as specified in its charter)

Delaware	**42-1406317**
(State or other jurisdiction of incorporation or organization)	*(I.R.S. Employer Identification Number)*
7700 Forsyth Boulevard **St. Louis, Missouri**	**63105**
(Address of principal executive offices)	*(Zip Code)*

Registrant's telephone number, including area code:

(314) 725-4477

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 whether the registrant has submitted electronically and posted on its corporate Web site, if any, every Interactive Data File required to be submitted and posted pursuant to Rule 405 of Regulation S-T (232.405 of this chapter) during the preceding 12 months (or for such shorter period that the registrant was required to submit and post such files). ☒ Yes ☐ No

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer, or a smaller reporting company. See the definitions of "large accelerated filer", "accelerated filer" and "small reporting company" in Rule 12b-2 of the Exchange Act. Large accelerated filer ☒ Accelerated filer ☐ Non-accelerated filer ☐ (do not check if a smaller reporting company) Smaller reporting company ☐

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

As of July 15, 2011, the registrant had 50,312,876 shares of common stock outstanding.

CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including "believe," "anticipate," "plan," "expect," "estimate," "intend," "seek," "target," "goal," "may," "will," "should," "can," "continue" and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled "Management's Discussion and Analysis of Financial Condition and Results of Operations," and Part II, Item 1A. "Risk Factors." Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry's actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing and we undertake no obligation to update or revise the forward-looking statements included in this filing, whether as a result of new information, future events or otherwise, after the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including:

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- membership and revenue projections;
- timing of regulatory contract approval;
- changes in healthcare practices;
- changes in federal or state laws or regulations, including the Patient Protection and Affordable Care Act and the Health Care and Education Affordability Reconciliation Act and any regulations enacted thereunder;
- inflation;
- provider contract changes;
- new technologies;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicaid managed care contracts by state governments;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

PART I
FINANCIAL INFORMATION

ITEM 1. ***Financial Statements.***

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)
(Unaudited)

	June 30, 2011	December 31, 2010
ASSETS		
Current assets:		
Cash and cash equivalents of continuing operations	$ 474,450	$ 433,914
Cash and cash equivalents of discontinued operations	—	252
Total cash and cash equivalents	474,450	434,166
Premium and related receivables, net of allowance for uncollectible accounts of $574 and $17, respectively	152,135	136,243
Short-term investments, at fair value (amortized cost $77,560 and $21,141, respectively)	78,808	21,346
Other current assets	69,143	64,154
Current assets of discontinued operations other than cash	—	912
Total current assets	774,536	656,821
Long-term investments, at fair value (amortized cost $508,299 and $585,862, respectively)	518,490	595,879
Restricted deposits, at fair value (amortized cost $26,615 and $22,755, respectively)	26,662	22,758
Property, software and equipment, net of accumulated depreciation of $157,706 and $138,629, respectively	340,392	326,341
Goodwill	281,981	278,051
Intangible assets, net	30,342	29,109
Other long-term assets	38,041	30,057
Long-term assets of discontinued operations	—	4,866
Total assets	$ 2,010,444	$ 1,943,882
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 482,913	$ 456,765
Accounts payable and accrued expenses	152,578	185,218
Unearned revenue	111,110	117,344
Current portion of long-term debt	3,172	2,817
Current liabilities of discontinued operations	—	3,102
Total current liabilities	749,773	765,246
Long-term debt	336,468	327,824
Other long-term liabilities	53,899	53,378
Long-term liabilities of discontinued operations	—	379
Total liabilities	1,140,140	1,146,827
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 52,831,462 issued and 50,295,329 outstanding at June 30, 2011, and 52,172,037 issued and 49,616,824 outstanding at December 31, 2010	53	52
Additional paid-in capital	405,711	384,206
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	7,183	6,424
Retained earnings	505,862	453,743
Treasury stock, at cost (2,536,133 and 2,555,213 shares, respectively)	(50,343)	(50,486)
Total Centene stockholders' equity	868,466	793,939
Noncontrolling interest	1,838	3,116
Total stockholders' equity	870,304	797,055
Total liabilities and stockholders' equity	$ 2,010,444	$ 1,943,882

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF OPERATIONS
(In thousands, except share data)
(Unaudited)

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Revenues:				
Premium	$ 1,248,588	$ 1,025,928	$ 2,401,365	$ 2,025,243
Service	29,428	24,682	55,812	47,589
Premium and service revenues	1,278,016	1,050,610	2,457,177	2,072,832
Premium tax	36,998	26,162	74,194	72,661
Total revenues	1,315,014	1,076,772	2,531,371	2,145,493
Expenses:				
Medical costs	1,035,740	859,335	1,992,814	1,699,043
Cost of services	20,312	15,707	40,488	32,859
General and administrative expenses	166,425	133,470	329,006	268,977
Premium tax	37,234	26,551	74,663	73,294
Total operating expenses	1,259,711	1,035,063	2,436,971	2,074,173
Earnings from operations	55,303	41,709	94,400	71,320
Other income (expense):				
Investment and other income	2,933	4,142	6,682	11,199
Debt extinguishment costs	(8,488)	—	(8,488)	—
Interest expense	(5,256)	(3,869)	(10,951)	(7,682)
Earnings from continuing operations, before income tax expense	44,492	41,982	81,643	74,837
Income tax expense	16,429	17,254	30,757	29,779
Earnings from continuing operations, net of income tax expense	28,063	24,728	50,886	45,058
Discontinued operations, net of income tax expense (benefit) of $0, $(90), $0 and $4,350, respectively	—	(226)	—	3,694
Net earnings	28,063	24,502	50,886	48,752
Noncontrolling interest (loss)	(311)	1,729	(1,233)	1,977
Net earnings attributable to Centene Corporation	$ 28,374	$ 22,773	$ 52,119	$ 46,775
Amounts attributable to Centene Corporation common stockholders:				
Earnings from continuing operations, net of income tax expense	$ 28,374	$ 22,999	$ 52,119	$ 43,081
Discontinued operations, net of income tax (benefit) expense	—	(226)	—	3,694
Net earnings	$ 28,374	$ 22,773	$ 52,119	$ 46,775
Net earnings (loss) per common share attributable to Centene Corporation:				
Basic:				
Continuing operations	$ 0.57	$ 0.46	$ 1.04	$ 0.89
Discontinued operations	—	—	—	0.08
Earnings per common share	$ 0.57	$ 0.46	$ 1.04	$ 0.97
Diluted:				
Continuing operations	$ 0.54	$ 0.45	$ 1.00	$ 0.86
Discontinued operations	—	—	—	0.08
Earnings per common share	$ 0.54	$ 0.45	$ 1.00	$ 0.94
Weighted average number of shares outstanding:				
Basic	50,167,052	49,135,552	49,959,892	48,203,312
Diluted	52,489,414	50,866,318	52,171,213	49,807,084

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENT OF STOCKHOLDERS' EQUITY
(In thousands, except share data)
(Unaudited)
Six Months Ended June 30, 2011

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2010	52,172,037	$ 52	$ 384,206	$ 6,424	$ 453,743	2,555,213	$ (50,486)	$ 3,116	$ 797,055
Comprehensive Earnings:									
Net earnings	—	—	—	—	52,119	—	—	(1,233)	50,886
Change in unrealized investment gain, net of $450 tax	—	—	—	759	—	—	—	—	759
Total comprehensive earnings									51,645
Common stock issued for employee benefit plans	659,425	1	11,488	—	—	—	—	—	11,489
Issuance of stock warrants	—	—	—	—	—	(50,000)	1,172	—	1,172
Common stock repurchases	—	—	—	—	—	30,920	(1,029)	—	(1,029)
Stock compensation expense	—	—	8,839	—	—	—	—	—	8,839
Excess tax benefits from stock compensation	—	—	1,178	—	—	—	—	—	1,178
Contribution from Noncontrolling interest	—	—	—	—	—	—	—	244	244
Deconsolidation of Noncontrolling interest	—	—	—	—	—	—	—	(289)	(289)
Balance, June 30, 2011	52,831,462	$ 53	$ 405,711	$ 7,183	$ 505,862	2,536,133	$ (50,343)	$ 1,838	$ 870,304

The accompanying notes to the consolidated financial statements are an integral part of this statement.

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)
(Unaudited)

	Six Months Ended June 30,	
	2011	**2010**
Cash flows from operating activities:		
Net earnings	$ 50,886	$ 48,752
Adjustments to reconcile net earnings to net cash provided by operating activities		
Depreciation and amortization	28,567	24,918
Stock compensation expense	8,839	6,888
Gain on sale of investments, net	(107)	(3,987)
Debt extinguishment costs	8,488	—
Gain on sale of UHP	—	(8,201)
Deferred income taxes	(3,529)	4,928
Changes in assets and liabilities		
Premium and related receivables	(16,146)	(57,718)
Other current assets	(4,001)	948
Other assets	(878)	1,719
Medical claims liabilities	24,684	(28,868)
Unearned revenue	(12,465)	(85,950)
Accounts payable and accrued expenses	(34,739)	(3,536)
Other operating activities	3,555	1,851
Net cash provided by (used in) operating activities	53,154	(98,256)
Cash flows from investing activities:		
Capital expenditures	(31,744)	(31,177)
Capital expenditures of Centene Center LLC	(3,384)	(32,425)
Purchases of investments	(103,239)	(306,124)
Proceeds from asset sales	—	13,420
Sales and maturities of investments	120,448	291,735
Investments in acquisitions, net of cash acquired	(3,192)	(21,473)
Net cash used in investing activities	(21,111)	(86,044)
Cash flows from financing activities:		
Proceeds from exercise of stock options	12,264	1,759
Proceeds from borrowings	419,183	42,161
Proceeds from stock offering	—	104,534
Payment of long-term debt	(414,695)	(97,193)
Contributions from (distributions to) noncontrolling interest	244	(4,840)
Excess tax benefits from stock compensation	1,369	295
Common stock repurchases	(1,029)	(568)
Debt issue costs	(9,095)	—
Net cash provided by financing activities	8,241	46,148
Net increase (decrease) in cash and cash equivalents	40,284	(138,152)
Cash and cash equivalents, beginning of period	434,166	403,752
Cash and cash equivalents, end of period	$ 474,450	$ 265,600
Supplemental disclosures of cash flow information:		
Interest paid	$ 11,822	$ 7,320
Income taxes paid	$ 40,111	$ 27,940
Supplemental disclosure of non-cash investing and financing activities:		
Contribution from noncontrolling interest	$ —	$ 306
Capital expenditures	$ 1,381	$ 36,280

The accompanying notes to the consolidated financial statements are an integral part of these statements.

CENTENE CORPORATION AND SUBSIDIARIES

NOTES TO THE CONSOLIDATED FINANCIAL STATEMENTS
(Dollars in thousands, except share data)
(Unaudited)

1. Basis of Presentation

The accompanying interim financial statements have been prepared under the presumption that users of the interim financial information have either read or have access to the audited financial statements included in the Form 10-K for the fiscal year ended December 31, 2010. The unaudited interim financial statements herein have been prepared pursuant to the rules and regulations of the Securities and Exchange Commission. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2010 audited financial statements, have been omitted from these interim financial statements where appropriate. In the opinion of management, these financial statements reflect all adjustments, consisting only of normal recurring adjustments, which are necessary for a fair presentation of the results of the interim periods presented.

Certain 2010 amounts in the consolidated financial statements have been reclassified to conform to the 2011 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

2. Acquisitions

- *Casenet, LLC.* In December 2010, the Company acquired an additional ownership interest in Casenet, LLC for total consideration of $6,619, bringing its ownership interest to 68%. The initial allocation resulted in goodwill of $1,752 and other identifiable intangible assets of $4,500 that were recorded in the Specialty Services segment. During the second quarter of 2011, the Company finalized the allocation of the fair value that resulted in goodwill of $8,975, other identifiable intangible assets of $3,561 and an increase in unearned revenue of $6,284. The goodwill is not deductible for income tax purposes. During the second quarter of 2011, the Company increased its ownership interest in Casenet to 73%.

- *Citrus Health Care, Inc.* In December 2010, the Company acquired certain assets in non-reform counties of Citrus Health Care, Inc., a Florida Medicaid and long term care health plan for $28,689. During 2010, the Company performed a preliminary allocation of fair value that resulted in goodwill of $22,951 and other identifiable intangible assets of $5,738 that were recorded in the Medicaid Managed Care segment. During the second quarter of 2011, the Company finalized the allocation of the fair value that resulted in goodwill of $19,069 and other identifiable intangible assets of $9,620. All of the goodwill is deductible for income tax purposes.

3. Investments and Restricted Deposits

Short-term and long-term investments and restricted deposits by investment type consist of the following:

	June 30, 2011				December 31, 2010			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 28,254	$ 548	$ (34)	$ 28,768	$ 28,665	$ 510	$ (140)	$ 29,035
Corporate securities	190,542	3,746	(73)	194,215	197,577	3,124	(586)	200,115
Restricted certificates of deposit	5,888	—	—	5,888	6,814	—	—	6,814
Restricted cash equivalents	13,400	—	—	13,400	8,814	—	—	8,814
Municipal securities:								
General obligation	113,851	3,466	—	117,317	109,866	3,601	(6)	113,461
Pre-refunded	32,072	689	—	32,761	32,442	756	—	33,198
Revenue	102,027	2,845	(2)	104,870	100,198	2,781	(15)	102,964
Variable rate demand notes	91,160	—	—	91,160	106,540	—	—	106,540
Asset backed securities	13,387	301	—	13,688	17,391	243	(43)	17,591
Cost method investments and equity method securities	7,347	—	—	7,347	7,060	—	—	7,060
Life insurance contracts	14,546	—	—	14,546	14,391	—	—	14,391
Total	$ 612,474	$ 11,595	$ (109)	$ 623,960	$ 629,758	$ 11,015	$ (790)	$ 639,983

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost method and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government coporations and agencies. As of June 30, 2011, the Company had no single issue with a par value greater than $5,000. As of June 30, 2011, 36% of the Company's investments in securities recorded at fair value that carry a rating by Moody's or S&P were rated AAA, 76% were rated AA- or higher, and 99% were rated A- or higher. At June 30, 2011, the Company held certificates of deposit, life insurance contracts and cost and equity method invesments which did not carry a credit rating.

The fair value of available-for-sale investments with gross unrealized losses by investment type and length of time that individual securities have been in a continuous unrealized loss position were as follows:

	June 30, 2011				December 31, 2010			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ (34)	$ 7,371	$ —	$ —	$ (140)	$ 9,246	$ —	$ —
Corporate securities	(73)	21,733	—	—	(586)	40,341	—	—
Municipal securities:								
General obligation	—	—	—	—	(6)	1,131	—	—
Revenue	(2)	838	—	—	(15)	2,419	—	—
Asset backed securities	—	—	—	—	(43)	5,276	—	—
Total	$ (109)	$ 29,942	$ —	$ —	$ (790)	$ 58,413	$ —	$ —

As of June 30, 2011, the gross unrealized losses were generated from 34 positions out of a total of 401 positions. The decline in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

For each security in an unrealized loss position, the Company assesses whether it intends to sell the security or if it is more likely than not the Company will be required to sell the security before recovery of the amortized cost basis for reasons such as liquidity, contractual or regulatory purposes. If the security meets this criterion, the decline in fair value is other-than-temporary and is recorded in earnings. The Company does not intend to sell these securities prior to maturity and it is not likely that the Company will be required to sell these securities prior to maturity; therefore, there is no indication of other than temporary impairment for these securities.

The contractual maturities of short-term and long-term investments and restricted deposits are as follows:

	June 30, 2011				December 31, 2010			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 77,560	$ 78,808	$ 19,516	$ 19,516	$ 21,141	$ 21,346	$ 17,387	$ 17,392
One year through five years	396,676	406,770	7,099	7,146	464,270	474,255	5,368	5,366
Five years through ten years	37,983	37,990	—	—	39,732	39,731	—	—
Greater than ten years	73,640	73,730	—	—	81,860	81,893	—	—
Total	$ 585,859	$ 597,298	$ 26,615	$ 26,662	$ 607,003	$ 617,225	$ 22,755	$ 22,758

Actual maturities may differ from contractual maturities due to call or prepayment options. Asset backed securities are included in the one year through five years category, while equity securities and life insurance contracts are included in the five years through ten years category. The Company has an option to redeem at amortized cost substantially all of the securities included in the Greater than ten years category listed above.

Realized gains and losses are determined on the basis of specific identification or a first-in, first-out methodology, if specific identification is not practicable. The Company's gross recorded realized gains and losses on investments were as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Gains	$ —	$ 683	$ 133	$ 3,717
Losses	(11)	(245)	(26)	(245)
Net realized (losses) gains	$ (11)	$ 438	$ 107	$ 3,472

Realized gains in six months ended June 30, 2010 included a gain of $2,961 representing a gain from a distribution from the Reserve Primary fund in excess of our adjusted basis.

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other than temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment.

Investment amortization of $5,009 and $5,716 was recorded in the six months ended June 30, 2011 and 2010, respectively.

4. Fair Value Measurements

Assets and liabilities recorded at fair value in the consolidated balance sheets are categorized based upon the extent to which the fair value estimates are based upon observable or unobservable inputs. Level inputs are as follows:

Level Input:	Input Definition:
Level I	Inputs are unadjusted, quoted prices for identical assets or liabilities in active markets at the measurement date.
Level II	Inputs other than quoted prices included in Level I that are observable for the asset or liability through corroboration with market data at the measurement date.
Level III	Unobservable inputs that reflect management's best estimate of what market participants would use in pricing the asset or liability at the measurement date.

The following table summarizes fair value measurements by level at June 30, 2011, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 474,450	$ —	$ —	$ 474,450
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 19,117	$ 2,277	$ —	$ 21,394
Corporate securities	—	194,215	—	194,215
Municipal securities:				
General obligation	—	117,317	—	117,317
Pre-refunded	—	32,761	—	32,761
Revenue	—	104,870	—	104,870
Variable rate demand notes	—	91,160	—	91,160
Asset backed securities	—	13,688	—	13,688
Total investments	$ 19,117	$ 556,288	$ —	$ 575,405
Restricted deposits available for sale:				
Cash and cash equivalents	$ 13,400	$ —	$ —	$ 13,400
Certificates of deposit	5,888	—	—	5,888

U.S. Treasury securities and obligations of U.S. government corporations and agencies	6,844	530	—	7,374
Total restricted deposits	$ 26,132	$ 530	$ —	$ 26,662
Total assets at fair value	$ 519,699	$ 556,818	$ —	$ 1,076,517
Liabilities				
Interest rate swap contract	$ —	$ 1,819	$ —	$ 1,819

The following table summarizes fair value measurements by level at December 31, 2010, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 433,914	$ —	$ —	$ 433,914
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 14,809	$ 7,096	$ —	$ 21,905
Corporate securities	—	200,115	—	200,115
Municipal securities:				
General obligation	—	113,461	—	113,461
Pre-refunded	—	33,198	—	33,198
Revenue	—	102,964	—	102,964
Variable rate demand notes	—	106,540	—	106,540
Asset backed securities	—	17,591	—	17,591
Total investments	$ 14,809	$ 580,965	$ —	$ 595,774
Restricted deposits available for sale:				
Cash and cash equivalents	$ 8,814	$ —	$ —	$ 8,814
Certificates of deposit	6,814	—	—	6,814
U.S. Treasury securities and obligations of U.S. government corporations and agencies	7,130	—	—	7,130
Total restricted deposits	$ 22,758	$ —	$ —	$ 22,758
Total assets at fair value	$ 471,481	$ 580,965	$ —	$ 1,052,446

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and cost-method investments, which approximates fair value, was $21,893 and $21,451 as of June 30, 2011 and December 31, 2010, respectively.

5. Debt

Debt consists of the following:

	June 30, 2011	December 31, 2010
Senior notes, at par	$ 250,000	$ 175,000
Unamortized discount on Senior notes	(3,074)	—
Interest rate swap fair value	(1,819)	—
Senior notes, net	245,107	175,000
Revolving credit agreement	—	60,000
Mortgage notes payable	88,335	89,500
Capital leases and other	6,198	6,141
Total debt	339,640	330,641
Less current portion	(3,172)	(2,817)
Long-term debt	$ 336,468	$ 327,824

Senior Notes

In May 2011, the Company exercised its option to redeem its $175,000 7.25% Senior Notes due April 1, 2014 ($175,000 Notes). The Company redeemed the $175,000 Notes at 103.625% and wrote off unamortized debt issuance costs, resulting in a pre-tax expense of $8,488.

In May 2011, pursuant to a shelf registration statement, the Company issued non-callable $250,000 5.75% Senior Notes due June 1, 2017 ($250,000 Notes) at a discount to yield 6%. At June 30, 2011, the unamortized debt discount was $3,074. The indenture governing the $250,000 Notes contains non-financial and financial covenants. Interest is paid semi-annually in June and December. In connection with the issuance, the Company entered into an interest rate swap as discussed below. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $250,000 Notes. At June 30, 2011, the fair value of the interest rate swap decreased the principal amount of the notes by $1,819.

Revolving Credit Agreement

In January 2011, the Company replaced its $300,000 revolving credit agreement with a new $350,000 revolving credit facility, or the revolver. The revolver is unsecured and has a five-year maturity with non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver bear interest based upon LIBOR rates, the Federal funds rate, or the prime rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.25% to 0.50% depending on the total debt to EBITDA ratio, as defined. As of June 30, 2011, the Company had no borrowings outstanding under the agreement, leaving availability of $350,000.

The Company has outstanding letters of credit of $43.3 million as of June 30, 2011, which are not part of the revolver. The letters of credit bore interest at 1.75% on June 30, 2011.

6. Interest Rate Swap

In May 2011, the Company entered into $250,000 notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, the Company receives a fixed rate of 5.75% and pays a variable rate of LIBOR plus 3.5% adjusted quarterly, which allows the Company to adjust the $250,000 Notes to a floating rate. The Company does not hold or issue any derivative instrument for trading or speculative purposes.

The interest rate swaps are formally designated and qualify as fair value hedges. The interest rate swaps are recorded at fair value in the Consolidated Balance Sheet in other assets or other liabilities. Gains and losses due to changes in fair value of the interest rate swaps completely offset changes in the fair value of the hedged portion of the underlying debt. Therefore, no gain or loss has been recognized due to hedge ineffectiveness. Offsetting changes in fair value of both the interest rate swaps and the hedged portion of the underlying debt both were recognized in interest expense in the Consolidated Statement of Operations.

The fair value of the Swap Agreements as of June 30, 2011 was a liability of approximately $1,819, and is included in other long term liabilities in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

7. Contingencies

In May 2008, the Internal Revenue Service (IRS) began an audit of the Company's 2006 and 2007 tax returns. In connection with the IRS examination, the field agent initially denied the $34,856 tax benefit related to the abandonment of the FirstGuard stock in 2007 based on certain assumptions of fact by the IRS. In June 2011, the Company met with the IRS appeals officer and agreed to a tentative settlement for the open tax years of 2006 and 2007. The tentative settlement is not expected to have a material impact on the consolidated financial statements.

The Company is routinely subjected to legal proceedings in the normal course of business. While the ultimate resolution of such matters is uncertain, the Company does not expect the results of any of these matters individually, or in the aggregate, to have a material effect on its financial position or results of operations.

8. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per common share:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Net earnings attributable to Centene Corporation common stockholders:				
Earnings from continuing operations, net of tax	$ 28,374	$ 22,999	$ 52,119	$ 43,081
Discontinued operations, net of tax	—	(226)	—	3,694
Net earnings	$ 28,374	$ 22,773	$ 52,119	$ 46,775
Shares used in computing per share amounts:				
Weighted average number of common shares outstanding	50,167,052	49,135,552	49,959,892	48,203,312
Common stock equivalents (as determined by applying the treasury stock method)	2,322,362	1,730,766	2,211,321	1,603,772
Weighted average number of common shares and potential dilutive common shares outstanding	52,489,414	50,866,318	52,171,213	49,807,084
Net earnings per share attributable to Centene Corporation common stockholders:				
Basic:				
Continuing operations	$ 0.57	$ 0.46	$ 1.04	$ 0.89
Discontinued operations	—	—	—	0.08
Earnings per common share	$ 0.57	$ 0.46	$ 1.04	$ 0.97
Diluted:				
Continuing operations	$ 0.54	$ 0.45	$ 1.00	$ 0.86
Discontinued operations	—	—	—	0.08
Earnings per common share	$ 0.54	$ 0.45	$ 1.00	$ 0.94

The calculation of diluted earnings per common share for the three and six months ended June 30, 2011 excludes the impact of 30,586 and 113,244 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units. The calculation of diluted earnings per common share for the three and six months ended June 30, 2010 excludes the impact of 1,913,073 and 1,864,028 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

9. Segment Information

Centene operates in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment consists of Centene's health plans including all of the functions needed to operate them. The Specialty Services segment consists of Centene's specialty companies offering products for behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, long-term care programs, managed vision, telehealth services, and pharmacy benefits management. The health plans in Arizona, operated by our long-term care company, and Massachusetts, operated by our individual health insurance provider, are included in the Specialty Services segment.

Segment information for the three months ended June 30, 2011 follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 1,098,924	$ 179,092	$ —	$ 1,278,016
Premium and service revenues from internal customers	17,297	177,351	(194,648)	—
Total premium and service revenues	$ 1,116,221	$ 356,443	$ (194,648)	$ 1,278,016
Earnings from operations	$ 42,551	$ 12,752	$ —	$ 55,303

Segment information for the three months ended June 30, 2010 follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 900,463	$ 150,147	$ —	$ 1,050,610
Premium and service revenues from internal customers	15,101	122,963	(138,064)	—
Total premium and service revenues	$ 915,564	$ 273,110	$ (138,064)	$ 1,050,610
Earnings from operations	$ 28,043	$ 13,666	$ —	$ 41,709

Segment information for the six months ended June 30, 2011 follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 2,099,563	$ 357,614	$ —	$ 2,457,177
Premium and service revenues from internal customers	33,044	324,471	(357,515)	—
Total premium and service revenues	$ 2,132,607	$ 682,085	$ (357,515)	$ 2,457,177
Earnings from operations	$ 70,617	$ 23,783	$ —	$ 94,400

Segment information for the six months ended June 30, 2010 follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 1,780,442	$ 292,390	$ —	$ 2,072,832
Premium and service revenues from internal customers	30,227	247,949	(278,176)	—
Total premium and service revenues	$ 1,810,669	$ 540,339	$ (278,176)	$ 2,072,832
Earnings from operations	$ 46,743	$ 24,577	$ —	$ 71,320

10. Comprehensive Earnings

Differences between net earnings and total comprehensive earnings resulted from changes in unrealized gains on investments available for sale, as follows:

	Three Months Ended June 30,		Six Months Ended June 30,	
	2011	2010	2011	2010
Net earnings	$ 28,063	$ 24,502	$ 50,886	$ 48,752
Reclassification adjustment, net of tax	10	323	192	135
Change in unrealized gains on investments, net of tax	1,204	1,874	567	1,917
Total change	1,214	2,197	759	2,052
Comprehensive earnings	29,277	26,699	51,645	50,804
Comprehensive (losses) earnings attributable to the noncontrolling interests	(311)	1,729	(1,233)	1,977
Comprehensive earnings attributable to Centene Corporation	$ 29,588	$ 24,970	$ 52,878	$ 48,827

ITEM 2. Management's Discussion and Analysis of Financial Condition and Results of Operations.

The following discussion of our financial condition and results of operations should be read in conjunction with our consolidated financial statements and the related notes included elsewhere in this filing. The discussion contains forward-looking statements that involve both known and unknown risks and uncertainties, including those set forth under Part II, Item 1A. "Risk Factors" of this Form 10-Q.

OVERVIEW

Our financial performance for the second quarter of 2011 is summarized as follows:

- Quarter-end at-risk managed care membership of 1,580,500, an increase of 45,900 members.
- Premium and service revenues from continuing operations of $1.3 billion, representing 21.6% growth year over year.
- Health Benefits Ratio from continuing operations of 83.0%, compared to 83.8% in 2010.
- General and Administrative expense ratio from continuing operations of 13.0%, compared to 12.7% in 2010.
- Diluted net earnings per share from continuing operations of $0.54, including $(0.10) of debt extinguishment costs, compared to $0.45 in the prior year.
- Total operating cash flows of $(40.8) million.

The following items contributed to our revenue and membership growth over the last year:

- *Arizona.* In December 2010, Cenpatico Behavioral Health of Arizona began operating under an expanded contract to manage behavioral healthcare services for an additional four counties. In February 2011, Bridgeway Health Solutions, LLC began operating under an agreement with Pima Health Systems of Arizona to administer their long-term care program on a non-risk basis.

- *Celtic Insurance Company, Inc.* In July 2010, we closed on the acquisition of certain assets and liabilities of NovaSys Health, LLC, a third party administrator in Arkansas that complements our existing Celtic business. In November 2010, Celtic began operating under a new contract with the Texas Department of Insurance to provide affordable health insurance plans for small businesses under the new Healthy Texas initiative.

- *Florida*. During 2010, we completed the conversion of members from Access Health Solutions LLC, or Access, to our subsidiary, Sunshine State Health Plan, on an at-risk basis. Additionally, in December 2010, we completed the acquisition of Citrus Health Care, Inc., a Medicaid and long-term care health plan.

- *Illinois*. In May 2011, our new subsidiary, IlliniCare Health Plan, began providing managed care services for older adults and adults with disabilities under the Integrated Care Program in six counties.

- *Massachusetts.* In April 2010, we began offering an individual insurance product, under the names of Commonwealth Choice and CeltiCare Direct, for residents who do not qualify for other state funded insurance programs.

- *Mississippi.* In January 2011, we began operating through the Mississippi Coordinated Access Network (MississippiCan) program. During the second quarter of 2011, the contract effectiveness provision was amended, and accordingly, revenue, medical costs and related earnings for January 1, 2011 through June 30, 2011 were recorded during the second quarter of 2011. As a result, the recognition of earnings of approximately $0.07 per diluted share related to the Mississippi operations from the first quarter were recorded in the second quarter of 2011. General and administrative expenses related to the Mississippi operations were recognized in our consolidated statement of operations during the first quarter of 2011.

- *South Carolina.* In June 2010, we completed the acquisition of Carolina Crescent Health Plan.

- *Texas.* In February 2011, we began operating under an additional STAR+PLUS ABD contract in the Dallas service area.

We expect the following item to contribute to our future growth potential:

- In May 2011, Bridgeway Health Solutions announced it was awarded a contract to deliver Long-term Care services in three geographic service areas of Arizona, effective October 1, 2011.

- In July 2011, our subsidiary, Kentucky Spirit Health Plan, announced it was awarded a three-year contract with the Kentucky Finance and Administration Cabinet to serve Medicaid beneficiaries. Kentucky Spirit Health Plan will provide integrated healthcare which includes behavioral health, pharmacy, vision and dental services to Medicaid recipients. Operations are expected to commence in the fourth quarter of 2011.

- In July 2011, Louisiana Healthcare Connections, our joint venture subsidiary, wasselected to contract with the Louisiana Department of Health and Hospitals to provide healthcare services to Medicaid enrollees participating in the Medicaid Coordinated Care Network project in all three of the state's geographical services areas for a three year term. Services for these members are expected to begin in the first quarter of 2012, with a three-phased membership roll-out ending in the second quarter of 2012.

In April 2010, we were notified by the Wisconsin Department of Health Services that our Wisconsin subsidiary, Managed Health Services (MHS), was not awarded the Southeast Wisconsin BadgerCare Plus Managed Care contract. The change was effective November 1, 2010; after a two-month transition period (September through October), MHS no longer served BadgerCare Plus Standard and Benchmark members in Milwaukee, Washington, Ozaukee, Waukesha and Kenosha counties. MHS continues to serve more than 7,800 Wisconsin Core Plan and SSI members in this region and more than 72,000 members in other regions of the state. In 2010, we filed a legal challenge to the State of Wisconsin's decision on the southeast region reprocurement. The lawsuit is currently pending before the Wisconsin court of appeals. The timing and outcome of any decision from the appellate court is unknown at this time.

MEMBERSHIP

From June 30, 2010 to June 30, 2011, we increased our at-risk managed care membership by 45,900. The following table sets forth our membership by state for our managed care organizations:

	June 30,		December 31,
	2011	2010	2010
Arizona	22,800	22,100	22,400
Florida	190,600	113,100	194,900
Georgia	303,100	295,600	305,800
Illinois	700	—	—
Indiana	206,700	212,700	215,800
Massachusetts	32,900	30,100	36,200
Mississippi	30,800	—	—
Ohio	159,900	159,300	160,100
South Carolina	82,800	92,600	90,300

Texas	470,400	475,500	433,100
Wisconsin	79,800	133,600	74,900
Total at-risk membership	1,580,500	1,534,600	1,533,500
Non-risk membership	10,400	50,900	4,200
Total	1,590,900	1,585,500	1,537,700

The following table sets forth our membership by line of business:

	June 30,		December 31,
	2011	2010	2010
Medicaid	1,172,400	1,135,500	1,177,100
CHIP & Foster Care	211,400	272,400	210,500
ABD & Medicare	156,300	93,800	104,600
Hybrid Programs	35,500	30,100	36,200
Long-term Care	4,900	2,800	5,100
Total at-risk membership	1,580,500	1,534,600	1,533,500
Non-risk membership	10,400	50,900	4,200
Total	1,590,900	1,585,500	1,537,700

The following table provides supplemental information of other membership categories:

	June 30,		December 31,
	2011	2010	2010
Cenpatico Behavioral Health:			
Arizona	173,200	119,700	174,600
Kansas	45,000	39,100	39,200

RESULTS OF CONTINUING OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the three and six months ended June 30, 2011 and 2010, prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for the three and six months ended June 30 is as follows ($ in millions):

	Three Months Ended June 30,			Six months Ended June 30,		
	2011	2010	% Change 2010-2011	2011	2010	% Change 2010-2011
Premium	$ 1,248.6	$ 1,025.9	21.7%	$ 2,401.4	$ 2,025.2	18.6%
Service	29.4	24.7	19.2%	55.8	47.6	17.3%
Total premium and service revenues	1,278.0	1,050.6	21.6%	2,457.2	2,072.8	18.5%
Premium tax	37.0	26.2	41.4%	74.2	72.7	2.1%
Total revenues	1,315.0	1,076.8	22.1%	2,531.4	2,145.5	18.0%
Medical costs	1,035.7	859.3	20.5%	1,992.8	1,699.0	17.3%
Cost of services	20.3	15.7	29.3%	40.5	32.9	23.2%
General and administrative expenses	166.4	133.5	24.7%	329.0	269.0	22.3%
Premium tax expense	37.2	26.6	40.2%	74.7	73.3	1.9%
Earnings from operations	55.4	41.7	32.6%	94.4	71.3	32.4%
Investment and other income, net	(10.9)	0.3	— %	(12.8)	3.5	(462.7)%
Earnings from continuing operations, before income tax expense	44.5	42.0	6.0%	81.6	74.8	9.1%
Income tax expense	16.4	17.3	(4.8)%	30.7	29.7	3.3%
Earnings from continuing operations, net of income tax expense	28.1	24.7	13.5%	50.9	45.1	12.9%
Discontinued operations, net of income tax expense (benefit) of $0, $(0.1), $0 and $4.4 respectively	—	(0.2)	(100.0)%	—	3.7	(100.0)%
Net earnings	28.1	24.5	14.5%	50.9	48.8	4.4%
Noncontrolling interest	(0.3)	1.7	(118.0)%	(1.2)	2.0	(162.4)%
Net earnings attributable to Centene Corporation	$ 28.4	$ 22.8	24.6%	$ 52.1	$ 46.8	11.4%
Amounts attributable to Centene Corporation common stockholders:						
Earnings from continuing operations, net of income tax expense	$ 28.4	$ 23.0	23.4%	$ 52.1	$ 43.1	21.0%
Discontinued operations, net of income tax expense (benefit)	—	(0.2)	(100.0)%	—	3.7	(100.0)%
Net earnings	$ 28.4	$ 22.8	24.6%	$ 52.1	$ 46.8	11.4%
Diluted earnings per common share attributable to Centene Corporation:						
Continuing operations	$ 0.54	$ 0.45	20.0%	$ 1.00	$ 0.86	16.3%
Discontinued operations	—	—	— %	—	0.08	(100.0)%
Total diluted earnings per common share	$ 0.54	$ 0.45	20.0%	$ 1.00	$ 0.94	6.4%

Three Months Ended June 30, 2011 Compared to Three Months Ended June 30, 2010

Revenues and Revenue Recognition

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are not significant in relation to total revenue recorded and are reflected in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Premium and service revenues increased 21.6% in the three months ended June 30, 2011 over the corresponding period in 2010 as a result of the addition of our Mississippi contract, membership growth and premium rate increases during the second half of 2010. During the second quarter of 2011, revenue from our Mississippi contract of $100.4 million was recognized for the period January 1, 2011 through June 30, 2011, of which $52.8 million related to the first quarter of 2011.

During the second quarter of 2011, one of our states performed a special review and identified additional membership deletions for previous periods. The amount of any reduction to revenue related to this review is subject to consideration of rate adequacy calculations, as part of actuarially soundness standards, for the appropriate periods. We have estimated the revenue impact related to retroactive eligibility reductions due to the state and have increased our accrual for those adjustments in our consolidated financial statements. There can be no assurance that future adjustment of amounts related to membership reconciliations will not have a material adverse effect on the Company.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the three months ended June 30:

	2011	2010
Medicaid and CHIP	80.1%	83.4%
ABD and Medicare	88.0	86.5
Specialty Services	85.8	81.7
Total	83.0	83.8

The consolidated HBR for the three months ended June 30, 2011 of 83.0% was a decrease of 0.8% over the comparable period in 2010 primarily as a result of lower utilization and contract enhancements.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $33.0 million in the three months ended June 30, 2011 compared to the corresponding period in 2010. This was primarily due to expenses for additional staff and facilities to support our membership growth.

The consolidated G&A expense ratio for the three months ended June 30, 2011 and 2010 was 13.0%, and 12.7%, respectively. The consolidated G&A expense ratio was reduced by 0.6% for the recognition of revenue in the second quarter from our Mississippi contract for the period January 1, 2011 through March 31, 2011. The resulting year over year increase in the G&A expense ratio was driven by increased business expansion costs.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the three months ended June 30, ($ in millions):

	2011	2010
Investment income	$ 3.0	$ 4.2
Debt extinguishment costs	(8.5)	—
Interest expense	(5.3)	(3.9)
Other income (expense), net	$ (10.8)	$ 0.3

The decrease in investment income in 2011 reflects the continued low market interest rates.

In May 2011, the Company redeemed its $175.0 million 7.25% Senior Notes due April 1, 2014 at 103.625% and wrote off unamortized debt issuance costs. Debt extinguishment costs totaled $8.5 million, or $0.10 per diluted share.

Interest expense increased during the quarter by $1.4 million primarily reflecting increased borrowings on the revolving credit agreements as well as borrowings on the mortgage loan associated with the real estate development including our corporate headquarters. The real estate development was placed in service in the third quarter of 2010 and accordingly we ceased capitalizing interest on the project.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for the three months ended June 30, 2011 was 36.7% compared to 42.9% in the corresponding period in 2010. The decrease in the effective tax rate was driven by a higher rate in 2010 resulting from the write off of a deferred tax asset of $1.7 million during the second quarter of 2010 as a result of certain enacted legislation. The year over year decrease in the effective tax rate was also associated with the tax benefits in 2011 from disqualifying dispositions of incentive stock options as well as the recognition of state net operating losses in Wisconsin as a result of a change in tax law during the quarter.

In May 2008, the Internal Revenue Service (IRS) began an audit of the 2006 and 2007 tax returns. In connection with the IRS examination, the field agent initially denied the $34.9 million tax benefit related to the abandonment of the FirstGuard stock in 2007 based on certain assumptions of fact by the IRS. In June 2011, we met with the IRS appeals officer and agreed to a tentative settlement for the open tax years of 2006 and 2007. The tentative settlement is not expected to have a material impact on the consolidated financial statements.

Segment Results

The following table summarizes our operating results by segment for the three months ended June 30, (in millions):

	2011	2010	% Change 2010-2011
Premium and Service Revenues			
Medicaid Managed Care	$ 1,116.2	$ 915.6	21.9%
Specialty Services	356.4	273.1	30.5%
Eliminations	(194.6)	(138.1)	41.0%
Consolidated Total	$ 1,278.0	$ 1,050.6	21.6%
Earnings from Operations			
Medicaid Managed Care	$ 42.5	$ 28.0	51.7%
Specialty Services	12.8	13.7	(6.7)%
Consolidated Total	$ 55.3	$ 41.7	32.6%

Medicaid Managed Care

Premium and service revenues increased 21.9% in the three months ended June 30, 2011 over the comparable period due to the addition of the Mississippi contract, membership growth and premium rate increases in the second half of 2010. During the second quarter of 2011, revenue from our Mississippi contract of $100.4 million was recognized for the period January 1, 2011 through June 30, 2011, of which $52.8 million related to the first quarter of 2011. Earnings from operations increased 51.7% in the three months ended June 30, 2011 reflecting overall growth in our membership, reduced HBR and leveraging of our general and administrative expenses.

Specialty Services

Premium and service revenues increased 30.5% in the three months ended June 30, 2011 primarily due to growth of our operations in Arizona and Massachusetts, as well as membership growth in our Medicaid segment and the associated specialty services provided to this increased membership. Earnings from operations decreased 6.7% in the three months ended June 30, 2011 reflecting a higher HBR in 2011 and increased general and administrative expenses resulting from business expansion costs for new specialty services.

Six Months Ended June 30, 2011 Compared to Six Months Ended June 30, 2010

Premium and Service Revenues

Premium and service revenues increased 18.5% in the six months ended June 30, 2011 over the corresponding period in 2010 as a result of the addition of our Mississippi contract, membership growth and net premium rate increases during the second half of 2010. The premium rates specified in our state contracts are generally updated on an annual basis through contract amendments. In the six months ended June 30, 2011, we received premium rate adjustments in certain markets which yielded a net 0% composite change across all of our markets.

Operating Expenses

Medical Costs

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. The Health Benefits Ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided. The table below depicts the HBR for our membership by member category for the six months ended June 30:

	2011	2010
Medicaid and CHIP	81.3%	84.5%

ABD and Medicare	86.8%	83.4%
Specialty Services	84.2%	81.2%
Total	83.0%	83.9%

The consolidated HBR for the six months ended June 30, 2011 of 83.0% was a decrease of 0.9% over the comparable period in 2010 primarily as a result of utilization and contract enhancements.

General and Administrative Expenses

General and administrative expenses, or G&A, increased by $60.0 million in the six months ended June 30, 2011 compared to the corresponding period in 2010. This was primarily due to expenses for additional staff and facilities to support our membership growth.

The consolidated G&A expense ratio for the six months ended June 30, 2011 and 2010 was 13.4%, and 13.0%, respectively. The increase in the G&A expense ratio reflects an increase of 0.4% as a result of increased business expansion costs.

Other Income (Expense)

The following table summarizes the components of other income (expense) for the six months ended June 30, ($ in millions):

	2011	2010
Investment income	$ 6.7	$ 8.2
Debt extinguishment costs	(8.5)	—
Gain on Reserve Primary Fund distributions	—	3.0
Interest expense	(11.0)	(7.7)
Other income (expense), net	$ (12.8)	$ 3.5

The decrease in investment income in 2011 reflects the continued low market interest rates.

In May 2011, the Company redeemed its $175.0 million 7.25% Senior Notes due April 1, 2014 at 103.625% and wrote off unamortized debt issuance costs. Debt extinguishment costs totaled $8.5 million, or $0.10 per diluted share.

Interest expense for the six months ended June 30, 2011 increased by $3.3 million from the comparable period in 2010 primarily due to borrowings on the mortgage loan associated with the real estate development including our corporate headquarters. The real estate development was placed in service in the third quarter of 2010 and accordingly we ceased capitalizing interest on the project.

Income Tax Expense

Excluding the effects of noncontrolling interests, our effective tax rate for the six months ended June 30, 2011 was 37.1% compared to 40.9% in the corresponding period in 2010. The decrease in the effective tax rate was driven by a higher rate in 2010 resulting from the write off of a deferred tax asset of $1.7 million during the second quarter of 2010 as a result of certain enacted legislation.

In May 2008, the Internal Revenue Service (IRS) began an audit of the 2006 and 2007 tax returns. In connection with the IRS examination, the field agent initially denied the $34.9 million tax benefit related to the abandonment of the FirstGuard stock in 2007 based on certain assumptions of fact by the IRS. In June 2011, we met with the IRS appeals officer and agreed to a tentative settlement for the open tax years of 2006 and 2007. The tentative settlement is not expected to have a material impact to the consolidated financial statements.

Segment Results

The following table summarizes our operating results by segment for the six months ended June 30, (in millions):

	2011	2010	% Change 2010-2011
Premium and Service Revenues			
Medicaid Managed Care	$ 2,132.6	$ 1,810.7	17.8%
Specialty Services	682.1	540.3	26.2%
Eliminations	(357.5)	(278.2)	28.5%
Consolidated Total	$ 2,457.2	$ 2,072.8	18.5%
Earnings from Operations			
Medicaid Managed Care	$ 70.6	$ 46.7	51.1%
Specialty Services	23.8	24.6	(3.2)%
Consolidated Total	$ 94.4	$ 71.3	32.4%

Medicaid Managed Care

Premium and service revenues increased 17.8% in the six months ended June 30, 2011 due to the addition of the Mississippi contract, membership growth and net premium rate increases in the second half of 2010. Earnings from operations increased 51.1% in the six months ended June 30, 2011 reflecting overall growth in our membership, reduced HBR and leveraging of our general and administrative expenses.

Specialty Services

Premium and service revenues increased 26.2% in the six months ended June 30, 2011 primarily due to growth of our operations in Arizona and Massachusetts, as well as membership growth in our Medicaid segment and the associated specialty services provided to this increased membership. Earnings from operations decreased 3.2% in the six months ended June 30, 2011 reflecting a loss from our care management software business, which decreased earnings from operations by 20.0%.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the six months ended June 30, 2011 and 2010, used in the discussion of liquidity and capital resources ($ in millions).

	Six Months Ended June 30,	
	2011	2010
Net cash provided by (used in) operating activities	$ 53.2	$ (98.3)
Net cash used in investing activities	(21.1)	(86.0)
Net cash provided by financing activities	8.2	46.1
Net increase (decrease) in cash and cash equivalents	$ 40.3	$ (138.2)

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $53.2 million in the six months ended June 30, 2011, compared to using cash of $98.3 million in the comparable period in 2010. We record prepayments from our states as unearned revenue. As of June 30, 2011, we had unearned revenues of $111.1 million, representing advance payments from four of our state customers. In comparison, at June 30, 2010, we received no advance payments. Additionally, as of June 30, 2011, we had capitation receivable from one state, compared to capitation receivable from two states at June 30, 2010.

The table below details the impact to cash flows from operations from the timing of payments from our states ($ in millions).

	Six Months Ended June 30,	
	2011	2010
Premium and related receivables	$ (16.1)	$ (57.7)
Unearned revenue	(12.5)	(86.0)
Net decrease in operating cash flow	$ (28.6)	$ (143.7)

We expect our cash flow provided by operating activities to moderate during the remainder of 2011; however the states in which we operate may decide to adjust their payment schedules which could positively or negatively impact our reported cash flows from operating activities in any given period.

Investing activities used cash of $21.1 million in the six months ended June 30, 2011 and $86.0 million in the comparable period in 2010. Cash flows from investing activities in 2011 and 2010 primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of June 30, 2011, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.0 years. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity, recent trading activity in similar securities and other observable inputs. Our investment guidelines are compliant with the regulatory restrictions enacted in each state.

The following table summarizes our cash and investment balances ($ in millions):

	June 30, 2011	December 31, 2010
Cash, cash equivalents and short-term investments	$ 553.2	$ 455.2
Long-term investments	518.5	595.9
Restricted deposits	26.7	22.8
Total cash, investments and restricted deposits	$ 1,098.4	$ 1,073.9
Unregulated cash and investments	$ 36.5	$ 30.9
Regulated cash, investments and restricted deposits	1,061.9	1,043.0
Consolidated Total	$ 1,098.4	$ 1,073.9

We spent $28.9 million and $16.8 million in the six months ended June 30, 2011 and 2010, respectively, on capital expenditures for system enhancements and market expansions. We also spent $2.8 million and $14.4 million in 2011 and 2010, respectively, for costs associated with our headquarters development including land, tenant improvements and furniture. We anticipate spending approximately $30 million additional on capital expenditures in 2011 primarily associated with our new data center, system enhancements and market expansions.

During 2009, we began construction of a real estate development that includes the Company's corporate headquarters. For the six months ended June 30, 2011 and 2010, Centene Center LLC had capital expenditures of $3.4 million and $32.4 million, respectively, for costs associated with the real estate development. The development was placed into service in the third quarter of 2010. We anticipate spending approximately $6 million additional on capital expenditures in 2011 associated with the real estate development.

Our financing activities provided cash of $8.2 million in the six months ended June 30, 2011 compared to $46.1 million in the comparable period in 2010. During 2011, our financing activities primarily related to repayments and proceeds of long term debt as discussed below.

In January 2011, we replaced our $300 million revolving credit agreement with a new $350 million revolving credit facility, or the revolver. The revolver is unsecured and has a five-year maturity with non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver will bear interest based upon LIBOR rates, the Federal funds rate, or the prime rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.25% to 0.50% depending on the total debt to EBITDA ratio. As of June 30, 2011, we had no borrowings outstanding under the agreement, leaving availability of $350.0 million. As of June 30, 2011, we were in compliance with all covenants.

In May 2011, we exercised our option to redeem the $175 million 7.25% Senior Notes due April 1, 2014 ($175 million Notes). We redeemed the $175 million Notes at 103.625% and wrote off unamortized debt issuance costs, resulting in a pre-tax expense of $8.5 million.

In May 2011, pursuant to a shelf registration statement, we issued non-callable $250 million of 5.75% Senior Notes due June 1, 2017 ($250 million Notes) at a discount to yield 6%. The indenture governing the $250 million Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used a portion of the net proceeds from the offering to repay the $175 million Notes and call premium and to repay approximately $50 million outstanding on our revolving credit facility. The additional proceeds will be used for general corporate purposes.

At June 30, 2011, we had working capital, defined as current assets less current liabilities, of $24.8 million, as compared to $(108.4) million at December 31, 2010. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed. Our working capital is negative from time to time due to our efforts to increase investment returns through purchases of investments that have maturities

of greater than one year and, therefore, are classified as long-term.

At June 30, 2011, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 28.1%, compared to 29.3% at December 31, 2010. Excluding the $79.0 million non-recourse mortgage note, our debt to capital ratio is 23.0%, compared to 23.9% at December 31, 2010. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

Based on our operating plan, we expect that our available cash, cash equivalents and investments, cash from our operations and cash available under our credit facility will be sufficient to finance our general operations and capital expenditures for at least 12 months from the date of this filing.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries 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. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of June 30, 2011, our subsidiaries had aggregate statutory capital and surplus of $569.9 million, compared with the required minimum aggregate statutory capital and surplus requirements of $324.0 million and we estimate our Risk Based Capital, or RBC, percentage to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of June 30, 2011, each of our health plans was in compliance with the risk-based capital requirements enacted in those states.

ITEM 3. ***Quantitative and Qualitative Disclosures About Market Risk.***

INVESTMENTS AND DEBT

As of June 30, 2011, we had short-term investments of $78.8 million and long-term investments of $545.2 million, including restricted deposits of $26.7 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Agency bonds, life insurance contracts, U.S. Treasury investments, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2011, the fair value of our fixed income investments would decrease by approximately $9.8 million. Declines in interest rates over time will reduce our investment income.

We entered into interest rate swap agreements with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of our $250 million Senior Note debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at June 30, 2011, the fair value of our debt would decrease by approximately $13.8 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

For a discussion of the interest rate risk that our investments are subject to, see "Risk Factors–Risks Related to Our Business–Our investment portfolio may suffer losses from reductions in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity."

INFLATION

While the inflation rate in 2010 for medical care costs was slightly less than that for all items, historically inflation for medical care costs has generally exceeded that for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include health care cost trend.

While we currently believe our strategies to mitigate healthcare cost inflation will continue to be successful, competitive pressures, new healthcare and pharmaceutical product introductions, demands from healthcare providers and customers, applicable regulations or other factors may affect our ability to control the impact of healthcare cost increases.

ITEM 4. ***Controls and Procedures.***

Evaluation of Disclosure Controls and Procedures - We maintain disclosure controls and procedures as defined in Rules 13a-15(e) and 15d-15(e) under the Securities Exchange Act of 1934 (Exchange Act) that are designed to provide reasonable assurance that information required to be disclosed by us in reports that we file or submit under the Exchange Act is (i) recorded, processed, summarized and reported within the time periods specified in SEC rules and forms; and (ii) accumulated and communicated to our management, including our principal executive officer and principal financial officer, as appropriate to allow timely decisions regarding required disclosure.

In connection with the filing of this Form 10-Q, management evaluated, under the supervision and with the participation of our Chief Executive Officer and Chief Financial Officer, the effectiveness of the design and operation of our disclosure controls and procedures as of June 30, 2011. Based upon that evaluation, our Chief Executive Officer and Chief Financial Officer concluded that our disclosure controls and procedures were effective at the reasonable assurance level as of June 30, 2011.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended June 30, 2011 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

PART II
OTHER INFORMATION

ITEM 1. ***Legal Proceedings.***

In May 2008, the Internal Revenue Service (IRS) began an audit of the 2006 and 2007 tax returns. In connection with the IRS examination, the field agent initially denied the $34.9 million tax benefit related to the abandonment of the FirstGuard stock in 2007 based on certain assumptions of fact by the IRS. In June 2011, we met with the IRS appeals officer and agreed to a tentative settlement for the open tax years of 2006 and 2007. The tentative settlement is not expected to have a material impact to the consolidated financial statements.

ITEM 1A. ***Risk Factors.***

FACTORS THAT MAY AFFECT FUTURE RESULTS AND THE TRADING PRICE OF OUR COMMON STOCK

You should carefully consider the risks described below before making an investment decision. The trading price of our common stock could decline due to any of these risks, in which case you could lose all or part of your investment. You should also refer to the other information in this filing, including our consolidated financial statements and related notes. The risks and uncertainties described below are those that we currently believe may materially affect our Company. Additional risks and uncertainties that we are unaware of or that we currently deem immaterial also may become important factors that affect our Company.

Risks Related to Being a Regulated Entity

Reduction in Medicaid, CHIP and ABD funding could substantially reduce our profitability.

Most of our revenues come from Medicaid, CHIP and ABD premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, CHIP and ABD funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Recent budget proposals for 2012 have suggested federal cuts to Medicaid funding (ie. through block grants and other means) by as much as $1 trillion over 10 years.

States periodically consider reducing or reallocating the amount of money they spend for Medicaid, CHIP, Foster Care and ABD. The current adverse economic conditions have, and are expected to continue to, put pressures on state budgets as tax and other state revenues decrease while the Medicaid eligible population increases, creating more need for funding. We anticipate this will require government agencies with whom we contract to find funding alternatives, which may result in reductions in funding for current programs and program expansions, contraction of covered benefits, limited or no premium rate increases or premium decreases. In recent years, the majority of states have implemented measures to restrict Medicaid, CHIP, Foster Care and ABD costs and eligibility. If any state in which we operate were to decrease premiums paid to us, or pay us less than the amount necessary to keep pace with our cost trends, it could have a material adverse effect on our revenues and operating results.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act were enacted. The Acts permit states to expand Medicaid to all individuals under age 65 with incomes up to 133% of the federal poverty level beginning April 1, 2010 and requires this expansion by January 1, 2014. Additional federal funds will be provided to states in 2014, but the amount of the federal support decreases each year. We cannot predict when the states will make these expansions. Further, because the states have to pay for a portion of the care, states may reduce our rates in order to afford the additional beneficiaries.

The American Reinvestment and Recovery Act of 2009 and subsequent legislation provided additional federal Medicaid funding for states' Medicaid expenditures between October 1, 2008 and June 30, 2011. During this time period, the share of Medicaid costs that were paid for by the federal government went up, and each state's share went down. Now that this additional funding has expired, we cannot predict whether the states will have sufficient funds for their Medicaid programs.

Changes to Medicaid, CHIP, Foster Care and ABD programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under these programs, all of which could have a negative impact on our business. Recent legislation generally requires that eligibility levels be maintained, but this could cause states to reduce reimbursement or reduce benefits in order to afford to maintain eligibility levels. A number of states have requested waivers to the requirements to maintain eligibility levels and legislation has been introduced that would eliminate the requirement that eligibility levels be maintained. We believe that reductions in Medicaid, CHIP, Foster Care and ABD payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

If we are unable to participate in CHIP programs, our growth rate may be limited.

CHIP is a federal initiative designed to provide coverage for low-income children not otherwise covered by Medicaid or other insurance programs. The programs vary significantly from state to state. Participation in CHIP programs is an important part of our growth strategy. If states do not allow us to participate or if we fail to win bids to participate, our growth strategy may be materially and adversely affected.

If CHIP is not reauthorized or states face shortfalls, our business could suffer.

Federal support for CHIP has been authorized through 2019, with funding authorized through 2015. We cannot be certain that funding for CHIP will be reauthorized when current funding expires in 2015. Thus, we cannot predict the impact that reauthorization will have on our business.

States receive matching funds from the federal government to pay for their CHIP programs which have a per state annual cap. Because of funding caps, there is a risk that states could experience shortfalls in future years, which could have an impact on our ability to receive amounts owed to us from states in which we have CHIP contracts.

If any of our state contracts are terminated or are not renewed, our business will suffer.

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, CHIP and ABD. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire or renew between August 31, 2011 and December 31, 2016. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on April 12, 2010, the Wisconsin Department of Health Services notified us that our Wisconsin subsidiary was not awarded a Southeast Wisconsin BadgerCare Plus Managed Care contract. While we will continue to serve other regions of the state, we transitioned the affected members to other plans by November 1, 2010. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

Changes in government regulations designed to protect the financial interests of providers and members rather than our investors could force us to change how we operate and could harm our business.

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and

generally are intended to benefit and protect the financial interests of health plan providers and members rather than investors. The enactment of new laws and rules or changes to existing laws and rules or the interpretation of such laws and rules could, among other things:

- force us to restructure our relationships with providers within our network;
- require us to implement additional or different programs and systems;
- mandate minimum medical expense levels as a percentage of premium revenues;
- restrict revenue and enrollment growth;
- require us to develop plans to guard against the financial insolvency of our providers;
- increase our healthcare and administrative costs;
- impose additional capital and reserve requirements; and
- increase or change our liability to members in the event of malpractice by our providers.

Regulations may decrease the profitability of our health plans.

Certain states have enacted regulations which require us to maintain a minimum health benefits ratio, or establish limits on our profitability. Other states require us to meet certain performance and quality metrics in order to receive our full contractual revenue. In certain circumstances, our plans may be required to pay a rebate to the state in the event profits exceed established levels. These regulatory requirements, changes in these requirements or the adoption of similar requirements by other regulators may limit our ability to increase our overall profits as a percentage of revenues. Most states, including but not limited to Georgia, Indiana, Texas and Wisconsin have implemented prompt-payment laws and many states are enforcing penalty provisions for failure to pay claims in a timely manner. Failure to meet these requirements can result in financial fines and penalties. In addition, states may attempt to reduce their contract premium rates if regulators perceive our health benefits ratio as too low. Any of these regulatory actions could harm our financial position, results of operations or cash flows. Certain states also impose marketing restrictions on us which may constrain our membership growth and our ability to increase our revenues.

We face periodic reviews, audits and investigations under our contracts with state government agencies, and these audits could have adverse findings, which may negatively impact our business.

We contract with various state governmental agencies to provide managed healthcare services. Pursuant to these contracts, we are subject to various reviews, audits and investigations to verify our compliance with the contracts and applicable laws and regulations. Any adverse review, audit or investigation could result in:

- cancellation of our contracts;
- refunding of amounts we have been paid pursuant to our contracts;
- imposition of fines, penalties and other sanctions on us;
- loss of our right to participate in various markets;
- increased difficulty in selling our products and services; and
- loss of one or more of our licenses.

Failure to comply with government regulations could subject us to civil and criminal penalties.

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of our contracts to provide services, the suspension or revocation of our licenses or our exclusion from participating in the Medicaid, CHIP, Foster Care and ABD programs. If we were to become subject to these penalties or exclusions as the result of our actions or omissions or our inability to monitor the compliance of our providers, it would negatively affect our ability to operate our business.

HIPAA broadened the scope of fraud and abuse laws applicable to healthcare companies. HIPAA created civil penalties for, among other things, billing for medically unnecessary goods or services. HIPAA established new enforcement mechanisms to combat fraud and abuse, including civil and, in some instances, criminal penalties for failure to comply with specific standards relating to the privacy, security and electronic transmission of most individually identifiable health information. The HITECH Act expanded the scope of these provisions by mandating individual notification in instances of data breach, providing enhanced penalties for HIPAA violations, and granting enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights. It is possible that Congress may enact additional legislation in the future to increase penalties and to create a private right of action under HIPAA, which could entitle patients to seek monetary damages for violations of the privacy rules.

We may incur significant costs as a result of compliance with government regulations, and our management will be required to devote time to compliance.

Many aspects of our business are affected by government laws and regulations. The issuance of new regulations, or judicial or regulatory guidance regarding existing regulations, could require changes to many of the procedures we currently use to conduct our business, which may lead to additional costs that we have not yet identified. We do not know whether, or the extent to which, we will be able to recover from the states our costs of complying with these new regulations. The costs of any such future compliance efforts could have a material adverse effect on our business. We have already expended significant time, effort and financial resources to comply with the privacy and security requirements of HIPAA and will have to expend additional time and financial resources to comply with the HIPAA provisions contained in the American Recovery and Reinvestment Act of 2009 and the Patient Protection and Affordable Care Act and Health Care and Education Affordability Reconciliation Act. We cannot predict whether states will enact stricter laws governing the privacy and security of electronic health information. If any new requirements are enacted at the state or federal level, compliance would likely require additional expenditures and management time.

Changes in healthcare law and benefits may reduce our profitability.

Changes in applicable laws and regulations are continually being considered, and interpretations of existing laws and rules may also change from time to time. We are unable to predict what regulatory changes may occur or what effect any particular change may have on our business. For example, these changes could reduce the number of persons enrolled or eligible to enroll in Medicaid, reduce the reimbursement or payment levels for medical services or reduce benefits included in Medicaid coverage. For example, some states, including Indiana and Ohio have removed, and others could consider removing, pharmacy coverage from the services covered by managed care entities. We are also unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare in general.

The recently enacted health care reform law and the implementation of that law could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act were enacted. This legislation provides comprehensive changes to the U.S. health care system, which will be phased in at various stages through 2018. Among other things, by January 1, 2014, states will be required to expand their Medicaid programs to provide eligibility to nearly all people under age 65 with income below 133 percent of the federal poverty line. As a result, millions of low-income adults without children who currently cannot qualify for coverage, as well as many low-income parents and, in some instances, children now covered through CHIP, will be made eligible for Medicaid. States were permitted to begin such expansions on April 1, 2010.

The legislation also imposes an annual insurance industry assessment of $8 billion starting in 2014, with increasing annual amounts thereafter. Such assessment may not be deductible for income tax purposes. If this federal premium tax is imposed as enacted, and if the cost of the federal premium tax is not included in the calculation of our rates, or if we are unable to otherwise adjust our business model to address this new tax, our results of operations, financial position and liquidity may be materially adversely affected.

There are numerous outstanding steps required to implement the legislation, including the promulgation of a substantial number of new and potentially more onerous federal regulations. Further, various health insurance reform proposals are also emerging at the state level. Federal legislation has been introduced to permit states as early as 2014 (as opposed to 2017 as is in the current health care reform law) to opt out of the health care reform law and provide their own model in certain circumstances. Because of the unsettled nature of these reforms and numerous steps required to implement them, we cannot predict what additional health insurance requirements will be implemented at the federal or state level, or the effect that any future legislation or regulation will have on our business or our growth opportunities.

In addition, there have been a number of lawsuits filed that challenge all or part of the health care reform law. On January 31, 2011, a Florida District Court ruled that the entire health care reform law is unconstitutional. This judgment has been stayed pending appeal. Other courts have ruled in favor of the law or have only struck down certain provisions of the law. These cases are under appeal and others are in process. We cannot predict the ultimate outcome of any of the litigation. Various Congressional leaders have indicated a desire to revisit some or all of the health care reform law during 2011. While the U.S House of Representatives voted to repeal the whole health care reform law, the U.S. Senate voted against such a repeal, and there have separately been a number of bills introduced that would repeal, change or defund certain provisions of the law. The 2011 budget eliminates two programs funded under the health care reform law – the Consumer Operated and Oriented Plan (CO-OP) and the Free Choice Voucher programs). Further,

a number of states have passed legislation intended to block various requirements of the health care reform law. Because of these challenges, we cannot predict whether any or all of the legislation will be implemented as enacted, overturned, repealed or modified.

Although we believe the legislation may provide us with significant opportunities to grow our business, the enacted reforms, as well as future regulations and legislative changes, may in fact have a material adverse affect on our results of operations, financial position or liquidity. If we fail to effectively implement our operational and strategic initiatives with respect to the implementation of health care reform, or do not do so as effectively as our competitors, our business may be materially adversely affected.

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

States may administer Medicaid managed care programs pursuant to demonstration programs or required waivers of federal Medicaid standards. Waivers and demonstration programs are generally approved for two year periods and can be renewed on an ongoing basis if the state applies. We have no control over this renewal process. If a state does not renew such a waiver or demonstration program or the Federal government denies a state's application for renewal, membership in our health plan in the state could decrease and our business could suffer.

Changes in federal funding mechanisms may reduce our profitability.

Changes in funding for Medicaid may affect our business. For example, on May 29, 2007, CMS issued a final rule that would reduce states' use of intergovernmental transfers for the states' share of Medicaid program funding. By restricting the use of intergovernmental transfers, this rule may restrict some states' funding for Medicaid, which could adversely affect our growth, operations and financial performance. On May 23, 2008, the United States District Court for the District of Columbia vacated the final rule as improperly promulgated. On November 30, 2010, CMS issued final regulations that remove these provisions and restore the regulatory language that was in place before the 2007 regulations were issued. While this rule has been removed, we cannot predict whether another similar rule or any other rule that changes funding mechanisms will be promulgated, and if any are, what impact they will have on our business.

Legislative changes in the Medicare program may also affect our business. For example, the Medicare Prescription Drug, Improvement and Modernization Act of 2003 revised cost-sharing requirements for some beneficiaries and required states to reimburse the federal Medicare program for costs of prescription drug coverage provided to beneficiaries who are enrolled simultaneously in both the Medicaid and Medicare programs.

The failure of the federal government to raise the federal debt ceiling could affect funding for Medicaid and our cash flow.

As has been widely reported, the United States Treasury Secretary has stated that the federal government may not be able to meet its debt payments in the relatively near future unless the federal debt ceiling is raised. If legislation increasing the debt ceiling is not enacted and the debt ceiling is reached, the federal government may stop or delay making payments on its obligations, including funding for Medicaid. A failure by the federal government to fund or a material delay in the funding for Medicaid could have a material adverse effect on our cash flows.

If state regulatory agencies require a statutory capital level higher than the state regulations, we may be required to make additional capital contributions.

Our operations are conducted through our wholly owned subsidiaries, which include health maintenance organizations, or HMOs, and managed care organizations, or MCOs. HMOs and MCOs are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state. Additionally, state regulatory agencies may require, at their discretion, individual HMOs to maintain statutory capital levels higher than the state regulations. If this were to occur to one of our subsidiaries, we may be required to make additional capital contributions to the affected subsidiary. Any additional capital contribution made to one of the affected subsidiaries could have a material adverse effect on our liquidity and our ability to grow.

If state regulators do not approve payments of dividends and distributions by our subsidiaries to us, we may not have sufficient funds to implement our business strategy.

We principally operate through our health plan subsidiaries. If funds normally available to us become limited in the future, we may need to rely on dividends and distributions from our subsidiaries to fund our operations. These subsidiaries are subject to regulations that limit the amount of dividends and distributions that can be paid to us without prior approval of, or notification to, state regulators. If these regulators were to deny our subsidiaries' request to pay dividends to us, the funds available to us would be limited, which could harm our ability to implement our business strategy.

Risks Related to Our Business

Ineffectiveness of state-operated systems and subcontractors could adversely affect our business.

Our health plans rely on other state-operated systems or sub-contractors to qualify, solicit, educate and assign eligible members into the health plans. The effectiveness of these state operations and sub-contractors can have a material effect on a health plan's enrollment in a particular month or over an extended period. When a state implements new programs to determine eligibility, new processes to assign or enroll eligible members into health plans, or chooses new contractors, there is an increased potential for an unanticipated impact on the overall number of members assigned into the health plans.

Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows.

Our medical expense includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

We can not be sure that our medical claims liability estimates are adequate or that adjustments to those estimates will not unfavorably impact our results of operations. For example, in the three months ended June 30, 2006 we adjusted IBNR by $9.7 million for adverse medical costs development from the first quarter of 2006.

Additionally, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. For example, we commenced operations in South Carolina in December 2007, began our Foster Care program in Texas in April 2008, commenced operations in Florida in February 2009, in Massachusetts in July 2009, in Mississippi in January 2011, commenced operations in Illinois in 2011 and expect to commence operations in Kentucky in the fourth quarter of 2011. For a period of time after the inception of business in these states, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims. The addition of new categories of individuals who are eligible for Medicaid under new legislation may pose the same difficulty in estimating our medical claims liability and utilization patterns.

From time to time in the past, our actual results have varied from our estimates, particularly in times of significant changes in the number of our members. The accuracy of our medical claims liability estimate may also affect our ability to take timely corrective actions, further harming our results.

Receipt of inadequate or significantly delayed premiums would negatively affect our revenues, profitability or cash flows.

Our premium revenues consist of fixed monthly payments per member and supplemental payments for other services such as maternity deliveries. These premiums are fixed by contract, and we are obligated during the contract periods to provide healthcare services as established by the state governments. We use a large portion of our revenues to pay the costs of healthcare services delivered to our members. If premiums do not increase when expenses related to medical services rise, our earnings will be affected negatively. In addition, our actual medical services costs may exceed our estimates, which would cause our health benefits ratio, or our expenses related to medical services as a percentage of premium revenue, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to certain providers without granting a corresponding increase in premiums to us. If this were to occur in one or more of the states in which we operate, our profitability would be harmed. In addition, if there is a significant delay in our receipt of premiums to offset previously incurred health benefits costs, our cash flows or earnings could be negatively impacted.

In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the State

analyzing encounter submissions of processed claims data to determine the acuity of our membership relative to the entire state's Medicaid membership. The risk score is dependent on several factors including our providers' completeness and quality of claims submission, our processing of the claim, submission of the processed claims in the form of encounters to the states' encounter systems and the states' acceptance and analysis of the encounter data. If the risk scores assigned to our premiums that are risk adjusted are not adequate or do not appropriately reflect the acuity of our membership, our earnings will be affected negatively.

Failure to effectively manage our medical costs or related administrative costs or uncontrollable epidemic or pandemic costs would reduce our profitability.

Our profitability depends, to a significant degree, on our ability to predict and effectively manage expenses related to health benefits. We have less control over the costs related to medical services than we do over our general and administrative expenses. Because of the narrow margins of our health plan business, relatively small changes in our health benefits ratio can create significant changes in our financial results. Changes in healthcare regulations and practices, the level of use of healthcare services, hospital costs, pharmaceutical costs, major epidemics or pandemics, new medical technologies and other external factors, including general economic conditions such as inflation levels, are beyond our control and could reduce our ability to predict and effectively control the costs of providing health benefits. In 2009, the H1N1 influenza pandemic resulted in heightened costs due to increased physician visits and increased utilization of hospital emergency rooms and pharmaceutical costs. We cannot predict what impact an epidemic or pandemic will have on our costs in the future. Additionally, we may not be able to manage costs effectively in the future. If our costs related to health benefits increase, our profits could be reduced or we may not remain profitable.

Our investment portfolio may suffer losses from changes in market interest rates and changes in market conditions which could materially and adversely affect our results of operations or liquidity.

As of June 30, 2011, we had $553.2 million in cash, cash equivalents and short-term investments and $545.2 million of long-term investments and restricted deposits.We maintain an investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities which may include asset backed securities, bank deposits, commercial paper, certificates of deposit, money market funds, municipal bonds, corporate bonds, instruments of the U.S. Treasury and other government corporations and agencies, insurance contracts and equity securities. These investments are subject to general credit, liquidity, market and interest rate risks. Substantially all of these securities are subject to interest rate and credit risk and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition. For example, in the third quarter of 2008, we recorded a loss on investments of approximately $4.5 million due to a loss in a money market fund.

Our investments in state, municipal and corporate securities are not guaranteed by the United States government which could materially and adversely affect our results of operation, liquidity or financial condition.

As of June 30, 2011, we had $540.3 million of investments in state, municipal and corporate securities.These securities are not guaranteed by the United States government. State and municipal securities are subject to additional credit risk based upon each local municipality's tax revenues and financial stability. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

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

Historically, the acquisition of Medicaid and specialty services businesses, contract rights and related assets of other health plans both in our existing service areas and in new markets has accounted for a significant amount of our growth. Many of the other potential purchasers have greater financial resources than we have. In addition, many of the sellers are interested either in (a) selling, along with their Medicaid assets, other assets in which we do not have an interest or (b) selling their companies, including their liabilities, as opposed to the assets of their ongoing businesses.

We generally are 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 currently operate, we would be required to obtain the necessary licenses to operate in that state. In addition, even if we already operate in a state in which we acquire a new business, we would be required to obtain additional regulatory approval if the acquisition would result in our operating in an area of the state in which we did not operate previously, and we could be required to renegotiate provider contracts of the acquired business. We cannot provide any assurance that we would be able to comply with these regulatory requirements for an acquisition in a timely manner, or at all. In deciding whether to approve a proposed acquisition, state regulators may consider a number of factors outside our control, including giving preference to competing offers made by locally owned entities or by not-for-profit entities.

We also may be unable to obtain sufficient additional capital resources for future acquisitions. If we are unable to effectively execute our acquisition strategy, our future growth will suffer and our results of operations could be harmed.

Execution of our growth strategy may increase costs or liabilities, or create disruptions in our business.

We pursue acquisitions of other companies or businesses from time to time. Although we review the records of companies or businesses we plan to acquire, even an in-depth review of records may not reveal existing or potential problems or permit us to become familiar enough with a business to assess fully its capabilities and deficiencies. As a result, we may assume unanticipated liabilities or adverse operating conditions, or an acquisition may not perform as well as expected. We face the risk that the returns on acquisitions will not support the expenditures or indebtedness incurred to acquire such businesses, or the capital expenditures needed to develop such businesses. We also face the risk that we will not be able to integrate acquisitions into our existing operations effectively without substantial expense, delay or other operational or financial problems. Integration may be hindered by, among other things, differing procedures, including internal controls, business practices and technology systems. We may need to divert more management resources to integration than we planned, which may adversely affect our ability to pursue other profitable activities.

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

- additional personnel who are not familiar with our operations and corporate culture;
- provider networks that may operate on different terms than our existing networks;
- existing members, who may decide to switch to another healthcare plan; and
- disparate administrative, accounting and finance, and information systems.

Additionally, our growth strategy includes start-up operations in new markets or new products in existing markets. We may incur significant expenses prior to commencement of operations and the receipt of revenue. As a result, these start-up operations may decrease our profitability. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

Accordingly, we may be unable to identify, consummate and integrate future acquisitions or start-up operations successfully or operate acquired or new businesses profitably.

Acquisitions of unfamiliar new businesses could negatively impact our business.

We are subject to the expenditures and risks associated with entering into any new line of business. Our failure to properly manage these expenditures and risks could have a negative impact on our overall business. For example, effective July 2008, we completed the previously announced acquisition of Celtic Group, Inc., the parent company of Celtic Insurance Company, or Celtic. Celtic is a national individual health insurance provider that provides health insurance to individual customers and their families. While we believed that the addition of Celtic would be complementary to our business, we had not previously operated in the individual health care industry.

If competing managed care programs are unwilling to purchase specialty services from us, we may not be able to successfully implement our strategy of diversifying our business lines.

We are seeking to diversify our business lines into areas that complement our Medicaid business in order to grow our revenue stream and balance our dependence on Medicaid risk reimbursement. In order to diversify our business, we must succeed in selling the services of our specialty subsidiaries not only to our managed care plans, but to programs operated by third-parties. Some of these third-party programs may compete with us in some markets, and they therefore may be unwilling to purchase specialty services from us. In any event, the offering of these services will require marketing activities that differ significantly from the manner in which we seek to increase revenues from our Medicaid programs. Our inability to market specialty services to other programs may impair our ability to execute our business strategy.

Failure to achieve timely profitability in any business would negatively affect our results of operations.

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

Adverse credit market conditions may have a material adverse affect on our liquidity or our ability to obtain credit on acceptable terms.

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has been restricted. Such conditions may persist during 2011 and beyond. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

Our access to additional financing will depend on a variety of factors such as prevailing economic and credit market conditions, the general availability of credit, the overall availability of credit to our industry, our credit ratings and credit capacity, and perceptions of our financial prospects. Similarly, our access to funds may be impaired if regulatory authorities or rating agencies take negative actions against us. If a combination of these factors were to occur, our internal sources of liquidity may prove to be insufficient, and in such case, we may not be able to successfully obtain additional financing on favorable terms or at all. We believe that if credit could be obtained, the terms and costs of such credit could be significantly less favorable to us than what was obtained in our most recent financings.

We derive a majority of our premium revenues from operations in a small number of states, and our financial position, results of operations or cash flows would be materially affected by a decrease in premium revenues or profitability in any one of those states.

Operations in a few states have accounted for most of our premium revenues to date. If we were unable to continue to operate in any of our current states or if our current operations in any portion of one of those states were significantly curtailed, our revenues could decrease materially. Our Medicaid contract with Kansas, which terminated December 31, 2006, together with our Medicaid contract with Missouri, accounted for $317.0 million in revenue for the year ended December 31, 2006. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly depending on legislative or other governmental or regulatory actions and decisions, economic conditions and similar factors in those states. For example, states we currently serve may bid out their Medicaid program through a Request for Proposal, or RFP, process. Our inability to continue to operate in any of the states in which we operate would harm our business.

Competition may limit our ability to increase penetration of the markets that we serve.

We compete for members principally on the basis of size and quality of provider network, benefits provided and quality of service. We compete with numerous types of competitors, including other health plans and traditional state Medicaid programs that reimburse providers as care is provided. In addition, the impact of health care reform and potential growth in our segment may attract new competitors. Subject to limited exceptions by federally approved state applications, the federal government requires that there be choices for Medicaid recipients among managed care programs. Voluntary programs, increases in the number of competitors and mandated competition may limit our ability to increase our market share.

Some of the health plans with which we compete have greater financial and other resources and offer a broader scope of products than we do. In addition, significant merger and acquisition activity has occurred in the managed care industry, as well as in industries that act as suppliers to us, such as the hospital, physician, pharmaceutical, medical device and health information systems businesses. To the extent that competition intensifies in any market that we serve, our ability to retain or increase members and providers, or maintain or increase our revenue growth, pricing flexibility and control over medical cost trends may be adversely affected.

In addition, in order to increase our membership in the markets we currently serve, we believe that we must continue to develop and implement community-specific products, alliances with key providers and localized outreach and educational programs. If we are unable to develop and implement these initiatives, or if our competitors are more successful than we are in doing so, we may not be able to further penetrate our existing markets.

If we are unable to maintain relationships with our provider networks, our profitability may be harmed.

Our profitability depends, in large part, upon our ability to contract favorably with hospitals, physicians and other healthcare providers. Our provider arrangements with our primary care physicians, specialists and hospitals generally may be cancelled by either party without cause upon 90 to 120 days prior written notice. We cannot provide any assurance that we will be able to continue to renew our existing contracts or enter into new contracts enabling us to service our members profitably.

From time to time providers assert or threaten to assert claims seeking to terminate non-cancelable agreements due to alleged actions or inactions by us. Even if these allegations represent attempts to avoid or renegotiate contractual terms that have become economically disadvantageous to the providers, it is possible that in the future a provider may pursue such a claim successfully. In addition, we are aware that other managed care organizations have been subject to class action suits by physicians with respect to claim payment procedures, and we may be subject to similar claims. Regardless of whether any claims brought against us are successful or have merit, they will still be time-consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

We will be required to establish acceptable provider networks prior to entering new markets. We may be unable to enter into agreements with providers in new markets on a timely basis or under favorable terms. If we are unable to retain our current provider contracts or enter into new provider contracts timely or on favorable terms, our profitability will be harmed.

We may be unable to attract and retain key personnel.

We are highly dependent on our ability to attract and retain qualified personnel to operate and expand our business. If we lose one or more members of our senior management team, including our chief executive officer, Michael F. Neidorff, who has been instrumental in developing our business strategy and forging our business relationships, our business and financial position, results of operations or cash flows could be harmed. Our ability to replace any departed members of our senior management or other key employees may be difficult and may take an extended period of time because of the limited number of individuals in the Medicaid managed care and specialty services industry with the breadth of skills and experience required to operate and successfully expand a business such as ours. Competition to hire from this limited pool is intense, and we may be unable to hire, train, retain or motivate these personnel.

Negative publicity regarding the managed care industry may harm our business and financial position, results of operations or cash flows.

The managed care industry has received negative publicity. This publicity has led to increased legislation, regulation, review of industry practices and private litigation in the commercial sector. These factors may adversely affect our ability to market our services, require us to change our services, and increase the regulatory burdens under which we operate. Any of these factors may increase the costs of doing business and adversely affect our financial position, results of operations or cash flows.

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

Our providers and employees involved in medical care decisions may be subject to medical malpractice claims. In addition, some states have adopted legislation that permits managed care organizations to be held liable for negligent treatment decisions or benefits coverage determinations. Claims of this nature, if successful, could result in substantial damage awards against us and our providers that could exceed the limits of any applicable insurance coverage. Therefore, successful malpractice or tort claims asserted against us, our providers or our employees could adversely affect our financial condition and profitability. Even if any claims brought against us are unsuccessful or without merit, they would still be time consuming and costly and could distract our management's attention. As a result, we may incur significant expenses and may be unable to operate our business effectively.

Loss of providers due to increased insurance costs could adversely affect our business.

Our providers routinely purchase insurance to help protect themselves against medical malpractice claims. In recent years, the costs of maintaining commercially reasonable levels of such insurance have increased dramatically, and these costs are expected to increase to even greater levels in the future. As a result of the level of these costs, providers may decide to leave the practice of medicine or to limit their practice to certain areas, which may not address the needs of Medicaid participants. We rely on retaining a sufficient number of providers in order to maintain a certain level of service. If a significant number of our providers exit our provider networks or the practice of medicine generally, we may be unable to replace them in a timely manner, if at all, and our business could be adversely affected.

Growth in the number of Medicaid-eligible persons could cause our financial position, results of operations or cash flows to suffer if state and federal budgets decrease or do not increase.

Less favorable economic conditions may cause our membership to increase as more people become eligible to receive Medicaid benefits. During such economic downturns, however, state and federal budgets could decrease, causing states to attempt to cut healthcare programs, benefits and rates. Additionally, the number of individuals eligible for Medicaid managed care will likely increase as a result of the recent health care reform legislation. We cannot predict the impact of changes in the United States economic environment or other economic or political events, including acts of terrorism or related military action, on federal or state funding of healthcare programs or on the size of the population eligible for the programs we operate. If federal or state funding decreases or remains unchanged while our membership increases, our results of operations will suffer.

Growth in the number of Medicaid-eligible persons may be countercyclical, which could cause our financial position, results of operations or cash flows to suffer when general economic conditions are improving.

Historically, the number of persons eligible to receive Medicaid benefits has increased more rapidly during periods of rising unemployment, corresponding to less favorable general economic conditions. Conversely, this number may grow more slowly or even decline if economic conditions improve. Therefore, improvements in general economic conditions may cause our membership levels to decrease, thereby causing our financial position, results of operations or cash flows to suffer, which could lead to decreases in our stock price during periods in which stock prices in general are increasing.

If we are unable to integrate and manage our information systems effectively, our operations could be disrupted.

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, 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.

Our information systems and applications require continual maintenance, upgrading and enhancement to meet our operational needs and regulatory requirements. Moreover, our acquisition activity requires frequent 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 maintain or expand our information systems, we could suffer, among other things, from operational disruptions, loss of existing members and difficulty in attracting new members, regulatory problems and increases in administrative expenses. In addition, our ability to integrate and manage our information systems may be impaired as the result of events outside our control, including acts of nature, such as earthquakes or fires, or acts of terrorists.

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

Premium payments to us are based upon eligibility lists produced by state governments. From time to time, states require us to reimburse them for premiums paid to us based on an eligibility list that a state later discovers contains individuals who are not in fact eligible for a government sponsored program or are eligible for a different premium category or a different program. Alternatively, a state could fail to pay us for members for whom we are entitled to payment. Our results of operations would be adversely affected as a result of such reimbursement to the state if we had made related payments to providers and were unable to recoup such payments from the providers.

We may not be able to obtain or maintain adequate insurance.

We maintain liability insurance, subject to limits and deductibles, for claims that could result from providing or failing to provide managed care and related services. These claims could be substantial. We believe that our present insurance coverage and reserves are adequate to cover currently estimated exposures. We cannot provide any assurance that we will be able to obtain adequate insurance coverage in the future at acceptable costs or that we will not incur significant liabilities in excess of policy limits.

From time to time, we may become involved in costly and time-consuming litigation and other regulatory proceedings, which require significant attention from our management.

We are a defendant from time to time in lawsuits and regulatory actions relating to our business. Due to the inherent uncertainties of litigation and regulatory proceedings, we cannot accurately predict the ultimate outcome of any such proceedings. An unfavorable outcome could have a material adverse impact on our business and financial position, results of operations or cash flows. In addition, regardless of the outcome of any litigation or regulatory proceedings, such proceedings are costly and time consuming and require significant attention from our management. For example, we have in the past, or may be subject to in the future, securities class action lawsuits, IRS examinations or similar regulatory actions. Any such matters could harm our business and financial position, results of operations or cash flows.

An unauthorized disclosure of sensitive or confidential member information could have an adverse effect on our business.

As part of our normal operations, we collect, process and retain confidential member information. We are subject to various federal and state laws and rules regarding the use and disclosure of confidential member information, including HIPAA and the Gramm-Leach-Bliley Act. The American Recovery and Reinvestment Act of 2009 further expands the coverage of HIPAA by, among other things, extending the privacy and security provisions, requiring new disclosures if a data breach occurs, mandating new regulations around electronic medical records, expanding enforcement mechanisms, allowing the state Attorneys General to bring enforcement actions and increasing penalties for violations. Despite the security measures we have in place to ensure compliance with applicable laws and rules, our facilities and systems, and those of our third party service providers, may be vulnerable to security breaches, acts of vandalism, computer viruses, misplaced or lost data, programming and/or human errors or other similar events. Any security breach

involving the misappropriation, loss or other unauthorized disclosure or use of confidential member information, whether by us or a third party, could have a material adverse effect on our business, financial condition, cash flows, or results of operations.

ITEM 2. ***Unregistered Sales of Equity Securities and Use of Proceeds.***

Issuer Purchases of Equity Securities
Second Quarter 2011

Period	Total Number of Shares Purchased [1]	Average Price Paid per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs[2]
April 1 – April 30, 2011	1,391	$ 34.15	—	1,667,724
May 1 – May 31, 2011	8,604	36.62	—	1,667,724
June 1 – June 30, 2011	7,622	34.76	—	1,667,724
Total	17,617	$ 35.62	—	1,667,724

(1) Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes or option cost upon vesting of restricted stock units or option exercise.

(2) Our Board of Directors adopted a stock repurchase program of up to 4,000,000 shares. No duration has been placed on the repurchase program.

ITEM 5. ***Other Information.***

In April 2011, the Company reported that a majority of its stockholders entitled to vote at the 2011 Annual Meeting had voted to recommend, on a non-binding advisory basis, an annual frequency for future Say-on-Pay votes. In July 2011, the Company's Board of Directors determined that, consistent with the Board of Directors' recommendation for the 2011 Annual Meeting, the Company will hold future Say-on-Pay votes on an annual basis until the next frequency vote is conducted.

ITEM 6. *Exhibits.*

Exhibits.

EXHIBIT NUMBER	DESCRIPTION
4.1	Indenture, dated May 27, 2011, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 5.75% Senior Notes due 2017 (including Form of Global Note as Exhibit A thereto), incorporated by reference to Exhibit 4.1 to the Company's Current Report on Form 8-K filed May 27, 2011.
10.1[1]	Amendment #10 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State.
10.2[1]	Amendment S (Version 1.18.1) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.
12.1	Computation of ratio of earnings to fixed charges.
31.1	Certification of Chairman, President and Chief Executive Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
31.2	Certification of Executive Vice President and Chief Financial Officer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of Chairman, President and Chief Executive Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
32.2	Certification of Executive Vice President and Chief Financial Officer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.
101.1[2]	XBRL Taxonomy Instance Document.
101.2[2]	XBRL Taxonomy Extension Schema Document.
101.3[2]	XBRL Taxonomy Extension Calculation Linkbase Document.
101.4[2]	XBRL Taxonomy Extension Definition Linkbase Document.
101.5[2]	XBRL Taxonomy Extension Label Linkbase Document.
101.6[2]	XBRL Taxonomy Extension Presentation Linkbase Document.

[1] The Company has requested confidential treatment of the redacted portions of this exhibit pursuant to Rule 24b-2 under the Securities Exchange Act of 1934, as amended, and has separately filed a complete copy of this exhibit with the Securities and Exchange Commission.

[2] XBRL (Extensible Business Reporting Language) information is furnished and not filed or a part of a registration statement or prospectus for purposes of sections 11 or 12 of the Securities Act of 1933, is deemed not filed for purposes of section 18 of the Securities Exchange Act of 1934, and otherwise is not subject to liability under these sections.

SIGNATURES

Pursuant to the requirements of the Securities Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized as of July 26, 2011.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

By: /s/ WILLIAM N. SCHEFFEL
Executive Vice President and Chief Financial Officer
(principal financial officer)

By: /s/ JEFFREY A. SCHWANEKE
Vice President, Corporate Controller and Chief Accounting Officer
(principal accounting officer)

EXPLANATORY NOTE: "*" INDICATES THE PORTION OF THIS EXHIBIT THAT HAS BEEN OMITTED AND SEPARATELY FILED WITH THE SECURITIES AND EXCHANGE COMMISSION PURSUANT TO A REQUEST FOR CONFIDENTIAL TREATMENT.**

AMENDMENT #10 TO CONTRACT NO. 0653 BETWEEN GEORGIA DEPARTMENT OF COMMUNITY HEALTH AND PEACH STATE HEALTH PLAN

This Amendment is between the Georgia Department of Community Health (hereinafter referred to as "DCH" or the "Department") and Peach State Health Plan, (hereinafter referred to as "Contractor") and is made effective this 19th day of February, 2011(hereinafter referred to as the "Effective Date"). Other than the changes, modifications and additions specifically articulated in this Amendment #10 to Contract #0653, RFP #41900-001-0000000027, the original Contract, and the previous amendments thereto, shall remain in effect and binding on and against DCH and Contractor. Unless expressly modified or added in this Amendment #10, the terms and conditions of the original Contract and all previous amendments are expressly incorporated into this Amendment #10 as if completely restated herein.

WHEREAS, DCH and Contractor executed a contract for the provision of services to members of the Georgia Families Program;

WHEREAS, pursuant to **Section 32.0,** ***Amendment in Writing***, DCH and Contractor desire to amend the above-referenced Contract; and

WHEREAS, the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS) must approve this Amendment as a condition precedent to its becoming effective for any purpose.

NOW THEREFORE, in consideration of the mutual promises of the Parties, the terms, provisions and conditions of this Amendment and other good and valuable consideration, the sufficiency of which is hereby acknowledged, DCH and Contractor hereby agree as follows:

I. To amend *Section* ***1.1.3***, by deleting the term "Member" and replacing it with the phrase "Member and P4HB Participant" throughout this section of the Contract.

II. To amend *Section* ***1.2 ELIGIBILITY FOR GEORGIA FAMILIES***, by adding the following Medicaid eligibility category to subsection ***1.2.1.1***:

- *Planning for Healthy Babies 1115 Demonstration Waiver Participants* (otherwise known as P4HB Participants) – Women ages 18 through 44 who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal poverty level. This Demonstration includes two distinct groups: women eligible for Family Planning Services only and women eligible for Interpregnancy Care and Family Planning Services.

III. To further amend *Section* ***1.2 ELIGIBILITY FOR GEORGIA FAMILIES***, by adding the following provision under ***1.2.1 Medicaid***:

1.2.1.2 The following Medicaid eligibility categories are required to receive Resource Mothers Outreach through GF:

Women ages 18 through 44 who qualify under the Low Income Medicaid Class of Assistance under the Georgia Medicaid State Plan who are already enrolled in GF and who deliver a VLBW baby on or after January 1, 2011.

- Women ages 18 through 44 who qualify under the Aged Blind and Disabled Classes of Assistance under the Georgia Medicaid State Plan and who deliver a VLBW baby on or after January 1, 2011.

IV. To further amend *Section* ***1.2 ELIGIBILITY FOR GEORGIA FAMILIES***, by adding the following provision under ***1.2.3 Exclusions***:

1.2.3.2 The following recipients are excluded from the Demonstration:

- Women who become pregnant while enrolled in the Demonstration.
- Women determined to be infertile (sterile) or who are sterilized while enrolled in the Demonstration.
- Women who become eligible for any other Medicaid or commercial insurance program.
- Women who no longer meet the Demonstration's eligibility requirements
- Women who are or become incarcerated.

V. To amend *Section* ***1.3.2***, by deleting the term ***"Members"*** and replacing it with the phrase ***"Members and P4HB Participants"*** throughout this section of the Contract.

VI. To amend ***Section 1.4 DEFINITIONS***, by deleting the provision in its entirety and replacing with the revised language contained in Exhibit 1 to this Amendment.

VII. To amend *Section* ***2.1 GENERAL PROVISIONS***, by adding the following language:

2.1.2 DCH is responsible for providing training materials regarding the Demonstration including specific materials regarding the Resource Mothers Outreach component of the Demonstration.

VIII. To amend *Section* ***2.3 ELIGIBILITY AND ENROLLMENT,*** by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout the following Sections: 2.3.4; 2.3.5; 2.3.6; 2.3.7; 2.3.9; 2.3.10; 2.3.11; and 2.3.12.

IX. To amend *Section* ***2.3 ELIGIBILITY AND ENROLLMENT***, by adding the following language:

2.3.1.1 The State of Georgia has the sole authority for determining eligibility for the Demonstration and whether P4HB Participants are eligible for enrollment in GF. DCH or its Agent will determine eligibility for the Demonstration and will continue responsibility for the electronic eligibility verification system (EVS).

2.3.2.1 DCH or its Agent will review the Medicaid Management Information System (MMIS) file daily and send written notification and information within two (2) Business Days to all P4HB Participants who are determined eligible for GF. A P4HB Participant shall have thirty (30) Calendar Days to select a CMO and a Family Planning Provider. A P4HB Participant eligible for IPC services under GF will have thirty (30) Calendar Days to select a CMO plan, a Family Planning Provider and a PCP. The Family Planning Provider and the PCP may be the same provider.

2.3.3.1 If the Potential P4HB Participant does not choose a CMO Plan within thirty (30) Calendar Days of being deemed eligible for the Demonstration, DCH or its Agent will Auto-Assign the individual to a CMO plan using the algorithm described in Section 2.3.3 for Members.

2.3.3.2 Women already enrolled in GF due to pregnancy will have an expedited enrollment into the Demonstration upon termination of their pregnancy benefits. Members determined to be eligible for the Demonstration must be afforded the opportunity to choose a new CMO, if desired, for the delivery of Demonstration related Services. All P4HB Participants will have thirty (30) days from the date of eligibility notification to choose a CMO.

2.3.3.3 The Contractor will notify its current pregnant Members at least thirty (30) Calendar Days prior to the expected date of delivery and prior to the date upon which the Member will end RSM, that they may be eligible to enroll in the Demonstration and may choose to switch to a different CMO plan for receipt of Demonstration services. Members who do not make a choice will be deemed to have chosen to remain in their current CMO plan for receipt of the Demonstration services they are eligible to receive.

X. To amend *Section **2.4 DISENROLLMENT***, by deleting the terms ***"Member"*** and ***"Members"*** in the following Sections and replacing them with the phrases, "***Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout Sections 2.4.1 and 2.4.2.

XI. To amend *Section **2.4 DISENROLLMENT***, by adding the following provision:

2.4.4.1 When disenrollment is necessary because a P4HB Participant loses eligibility for the Demonstration (for example, she has died, been incarcerated, or moved out-of-state) disenrollment shall be immediate.

XII. To amend *Section **2.5 MEMBER SERVICES AND MARKETING***, by renaming it ***MEMBER AND P4HB PARTICIPANT SERVICES AND MARKETING*** and by adding the following provision:

2.5.3 DCH will provide the Contractor with the Demonstration's logo and design along with specific Demonstration language to be used in all written materials distributed to P4HB Participants and Potential P4HB Participants.

XIII. To amend *Section **2.6 COVERED SERVICES AND SPECIAL COVERAGE PROVISIONS***, by adding the following language:

2.6.1 P4HB Participants are not eligible to participate in the EPSDT program.

2.6.2 Specific services available under this Demonstration are outlined in Attachment N to this Contract.

XIV. To amend *Section **2.8 QUALITY MONITORING***, by adding the following provision:

2.8.2 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor for the Demonstration and the outcomes resulting from those services. This strategy is incorporated in Attachment O.

XV. To amend *Section **4.1 ENROLLMENT***, by adding the following provisions to the subsections listed herein:

4.1.1 Enrollment Procedures

4.1.1.2.1 DCH or its Agent will make every effort to ensure that individuals ineligible for Enrollment in the Demonstration are not enrolled in GF as P4HB Participants. However, to ensure that such individuals are not enrolled in the Demonstration, the Contractor shall assist DCH or its Agent in the identification of P4HB Participants that are ineligible for enrollment in the Demonstration, as discussed in Section 1.2.3, but have been inadvertently enrolled in GF as P4HB Participants.

4.1.2 Selection of a Primary Care Provider (PCP)

4.1.2.1.1 At the time of plan selection, Family Planning Only P4HB Participants, with counseling and assistance from DCH or its Agent, will be encouraged to choose a Primary Care Provider. Because primary care services are not covered services under the Demonstration for the Family Planning Only P4HB Participants, the Contractor is required to maintain an up-to-date list of available Providers affiliated with the Georgia Association for Primary Health Care and other primary care Providers serving the uninsured and underinsured populations who are available to provide primary care services. The Contractor must not use Demonstration funds to reimburse for primary care services delivered to Family Planning Only P4HB Participants.

4.1.2.1.2 At the time of plan selection, IPC P4HB Participants, with counseling and assistance from DCH or its Agent, will be encouraged to choose an In-Network PCP. If an IPC P4HB Participant fails to select a PCP, or if the IPC P4HB Participant has been Auto-Assigned to the CMO plan, the Contractor shall Auto-Assign the IPC P4HB Participant to a PCP based on the algorithm identified in 4.1.2.1. If there is no IPC P4HB Participant or immediate family member historical usage, IPC P4HB Participants shall be Auto-Assigned to a PCP, using an algorithm developed by the Contractor, based on geographic proximity.

4.1.2.2.1 For IPC P4HB Participants, PCP assignment shall be effective immediately. The Contractor shall notify the IPC P4HB Participant via surface mail of her Auto-Assigned PCP within ten (10) Calendar Days of Auto-Assignment.

XVI. To amend *Section **4.2 DISENROLLMENT***, by deleting the terms **"*Member"*** and ***"Members"*** and replacing them with the phrases **"*Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout the following Sections: 4.2.1; 4.2.1.1; 4.2.2; 4.2.4.

XVII. To amend *Section **4.2.1, Disenrollment Initiated by the Member***, by adding the following provision:

4.2.1.4 A P4HB Participant may request Disenrollment from a CMO plan for cause at any time during the ninety (90) Calendar Days following the date of the P4HB Participant's initial enrollment with the CMO plan or the date DCH or its Agent sends the Participant notice of the enrollment into the Demonstration, whichever is later. The following constitutes cause for Disenrollment by the P4HB Participant:

- The P4HB Participant moves out of the CMO plan's Service Region;
- The P4HB Participant requests to be assigned to the same CMO plan as family members; and
- The P4HB Participant otherwise becomes ineligible for participation in the Demonstration.
- Other reasons, per 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the Demonstration amendment, or lack of Demonstration Providers experienced in dealing with the P4HB Participant's health care needs. (DCH or its Agent shall make determination of these reasons.)

XVIII. To amend Section ***4.2.2.1***, by adding the following provision:

4.2.2.1.1 The Contractor shall complete all Disenrollment paperwork for P4HB Participants it is seeking to disenroll.

XIX. To amend *Section **4.2.2.2**,* by adding the following language:

4.2.2.2.1 The Contractor shall notify DCH or its Agent upon identification of a P4HB Participant who it knows or believes meets the following criteria for disenrollment from the Demonstration:

- The P4HB Participant no longer meets the eligibility criteria for the Demonstration.

- The IPC P4HB Participant has reached the end of the twenty-four (24) months of eligibility for the IPC component of the Demonstration.
- The P4HB Participant becomes pregnant while enrolled in the Demonstration;
- The P4HB Participant becomes infertile through a sterilization procedure;
- The P4HB Participant moves out of the CMO plan's Service Region;
- The P4HB Participant's utilization of services is fraudulent or abusive;
- The Participant's eligibility category changes to a category ineligible for participation in the P4HB program;
- The P4HB Participant has died, been incarcerated, or moved out of State, thereby making her ineligible for Medicaid.

XX. To amend *Section **4.3 MEMBER SERVICES***, by renaming it ***MEMBER AND P4HB PARTICIPANT SERVICES*** and by adding the following language to subsection ***4.3.1, General Provisions***:

The Contractor shall ensure that P4HB Participants are aware of their rights and responsibilities, the role of the Family Planning Provider and PCP (for IPC P4HB Participants only), how to obtain care, what to do in an emergency or urgent medical situation arising from the receipt of Demonstration related Services, how to submit a Grievance, request an Appeal, or Administrative Law Hearing, and how to report suspected Fraud and Abuse. The Contractor shall convey this information via written materials and via telephone, internet, and face-to-face communications that allow the P4HB Participant to submit questions and receive responses from the Contractor.

XXI. To amend *Section **4.3.2 Requirements for Written Materials***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

XXII. To amend *Section **4.3.3 Member Handbook Requirements***, by renaming it ***Member Handbook and P4HB Participant Information Requirements*** and by adding the following language:

4.3.3.1.1 The Contractor shall mail to all newly enrolled P4HB Participants an information packet including but not limited to the following:

- General information pertaining to the Demonstration (eligibility, enrollment and disenrollment criteria, and information pertaining to the Demonstration's program components – family planning only, IPC, Resource Mothers Outreach).
- A list of benefits and services available under each Demonstration component
- A list of service exclusions or limitations under each Demonstration component
- Information about the role of the Family Planning Provider
- Information about the selection of a Primary Care Provider affiliated with the Georgia Association for Primary Health Care and whose services are not covered under the Demonstration
- Information on where and how P4HB Participants may access other benefits and services not available from or not covered by the Contractor under the Demonstration
- Information about the role of the PCP for the IPC P4HB Participant only
- Information about appointment procedures
- Information on how to access Demonstration services, including non-emergency transportation (NET) available to the IPC P4HB Participants only
- A notice stating that the Contractor shall be liable only for those Demonstration services authorized by CMS under the Demonstration
- A description of all pre-certification, prior authorization or other requirements for Demonstration related Services and treatments
- The geographic boundaries of the Service Regions
- Notice of all appropriate mailing addresses and telephone numbers to be utilized by P4HB Participants seeking information or authorization, including an inclusion of the Contractor's toll-free telephone line and Web site
- A description of the P4HB Participant's rights and responsibilities as described in Section 4.3.4
- The policies and procedures for Disenrollment from the Demonstration
- Information on Advance Directives
- A statement that additional information, including information on the structure and operation of the CMO plan and physician incentive plans, shall be made available upon request
- Information on the extent to which, and how, after hours and emergency coverage are provided, including the following:
  - What constitutes an Urgent and Emergency Demonstration related Medical Condition, Demonstration related Emergency Services, and Demonstration related Post Stabilization Services;
  - The fact that Prior Authorization is not required for Demonstration related Emergency Services;
  - The process and procedures for obtaining Demonstration related Emergency Services, including the use of the 911 telephone systems or its local equivalent;
  - The location of any emergency settings and other locations at which Demonstration Providers and hospitals furnish Demonstration related Emergency and Post Stabilization Services; and
  - The fact that a P4HB Participant has a right to use any hospital or other setting for Demonstration related Emergency Services
- Information on the Grievance Systems policies and procedures, as described in Section 4.14 of the Contract. This description must include the following:
  - The right to file a Grievance and Appeal with the Contractor;
  - The requirements and timeframes for filing a Grievance or Appeal with the Contractor;
  - The availability of assistance in filing a Grievance or Appeal with the Contractor;
  - The toll-free numbers P4HB Participants can use to file a Grievance or an Appeal with the Contractor by phone;
  - The right to a State Administrative Law hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;
  - Notice that if the P4HB Participant files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the P4HB Participant may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the P4HB Participant; and
  - Any Appeal rights that the State chooses to make available to Providers to challenge the failure of the Contractor to cover the Demonstration related Service.
- The Contractor shall submit to DCH for review and approval any changes and edits to the P4HB Participant Information Packet at least thirty (30) Calendar Days before the effective date of change.

XXIII. To amend *Section **4.3.4 Member Rights,*** by renaming it ***Member and P4HB Participant Right***, and by adding the following language:

4.3.4.2 The Contractor shall have written policies and procedures regarding the rights of P4HB Participants and shall comply with any applicable federal and State laws and regulations that pertain to P4HB Participant rights. These rights shall be included in the P4HB Participant Information Packet. At a minimum, said policies and procedures shall specify the P4HB Participant's right to:

- Receive information pursuant to 42CFR 438.10;
- Be treated with respect and with due consideration for the P4HB Participant's dignity and privacy;
- Have all records and medical and personal information remain confidential;
- Receive information on available Demonstration related treatment options and alternatives, presented in a manner appropriate to the P4HB Participant's condition and ability to understand;

- Participate in decisions regarding her Demonstration services;
- Request and receive a copy of her Medical Records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;
- Be furnished Demonstration related Services in accordance with 42 CFR 438.206 through 438.210 as appropriate;
- Freely exercise her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the P4HB Participant is treated;
- Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the Demonstration related Services provided to the P4HB Participant for which DCH does not pay the Contractor; not be held liable for Demonstration related Services provided to the P4HB Participant for which neither DCH nor the CMO pays the Demonstration Provider that furnishes the Demonstration related Services; and not be held liable for payments of Demonstration related Services furnished under a contract, Referral, or other arrangement to the extent that those payments are in excess of the amount the P4HB Participant would owe if the Contractor provided the services directly; and
- Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60 and Attachment K of this Contract.

XXIV. To amend *Section **4.3.5 Provider Directory***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

XXV. To further amend *Section **4.3.5 Provider Directory***, by deleting Section 4.3.5.2 in its entirety and replacing it with the following language:

- 4.3.5.2 The Provider Directory shall include names, locations, office hours, telephone numbers of and non-English language spoken by, current contracted Providers. This includes, at a minimum, information on PCPs, specialists, Family Planning Providers, dentists, pharmacists, FQHCs and RHCs, mental health and substance abuse Providers, and hospitals. The Provider Directory shall also identify Providers that are not accepting new patients.

XXVI. To amend *Section **4.3.6 Member Identification (ID) Card***, by renaming it ***Member and P4HB Participant Identification (ID) Card*** and by adding the following provisions:

4.3.6.5 The Contractor shall mail via surface mail a P4HB Participant ID Card to all new P4HB Participants in the Demonstration within ten (10) Calendar Days of receiving the notice of enrollment from DCH or its Agent. The P4HB Participant's ID Card must meet all requirements as specified in Sections 4.3.6.2, 4.3.6.3 and 4.3.6.4. The P4HB Participant's ID Card will identify the Demonstration component in which the P4HB Participant is enrolled:

- A Pink color will signify the P4HB Participants as eligible for Family Planning Services Only.
- A Purple color will signify the P4HB Participants as eligible for Interpregnancy Care Services and Family Planning Services.
- A Yellow color will signify the P4HB Participant as eligible for Case Management - Resource Mothers Outreach Only.

4.3.6.6 At the time the P4HB Participant's ID card is supplied to a P4HB Participant, the Contractor shall provide written materials that explain the meaning of the color coding of the ID card and its relevance to Demonstration benefits.

XXVII. To amend *Section **4.3.7 Toll-free Member Services Line,*** by renaming it ***Toll-free Member and P4HB Participant Services Line,*** and by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

XXVIII. To amend *Section **4.3.8 Internet Presence/Web Site***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases *"**Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract, and by adding the following provisions:

4.3.8.7 The Contractor shall provide general and up to date information about the Demonstration on its website. This information must incorporate DCH's messaging regarding the Demonstration.

4.3.8.8 The Contractor shall provide links from its website to the DCH P4HB website.

XXIX. To amend *Section **4.3.9 Cultural Competency,*** by deleting the term ***"Members"*** and replacing it with the phrase ***"Members or P4HB Participants"*** throughout this section of the Contract.

XXX. To amend *Section **4.3.10, Translation Services***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

XXXI. To amend *Section **4.4. MARKETING,*** by deleting the term ***"Members"*** and replacing it with the phrase ***"Members or P4HB Participants"*** throughout this section of the Contract.

XXXII. To amend *Section **4.5 COVERED BENEFITS AND SERVICES***, by adding the following provision:

4.5.1.2 The Contractor shall at a minimum provide to P4HB Participants Demonstration related Services and Benefits pursuant to the **CMS SPECIAL TERMS AND CONDITIONS (STCs), NUMBER: 11-W-00249/4 Document** pertaining to the Planning for Healthy Babies 1115 Demonstration Waiver Program. These STCs have been incorporated into this Contract as Attachment Q.

XXXIII. To amend *Section **4.6.1 Emergency Services***, by adding the following provisions:

4.6.1.3.1 The Contractor shall provide payment for Demonstration related Emergency Services when furnished by a qualified Provider, regardless of whether that Provider is in the Contractor's network. These services shall not be subject to prior authorization requirements. The Contractor shall be required to pay all Demonstration related Emergency Services that are Medically Necessary until the P4HB Participant is stabilized. The Contractor shall also pay for any screening examination services conducted to determine whether a Demonstration related Emergency Medical Condition exists.

4.6.1.5.1 The attending emergency room physician, or the Provider actually treating the P4HB Participant, is responsible for determining when the P4HB Participant is sufficiently stabilized for transfer or discharge, and that determination is binding on the Contractor, who shall be responsible for coverage and payment. The Contractor, however, may establish arrangements with a hospital whereby the Contractor may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the P4HB Participant, provided that such arrangement does not delay the provision of Demonstration related Emergency Services.

4.6.1.6.1 The Contractor shall not retroactively deny a Claim for a Demonstration related emergency screening examination because the Condition, which appeared to be a Demonstration related Emergency Medical Condition under the prudent layperson standard, turned out to be non-emergency in nature. If a Demonstration related emergency screening examination leads to a clinical determination by the examining physician that an actual Demonstration related Medical Condition does not exist, then the determining factor for payment liability shall be whether the P4HB Participant had acute symptoms of sufficient severity at the time of presentation. In this case, the Contractor shall pay for all Demonstration related emergency screening and care services provided. Payment shall be at either the rate negotiated under the Provider Contract, or the rate paid by DCH under the Fee for Service Medicaid Program.

4.6.1.7.1 The Contractor may establish guidelines and timelines for submittal of notification regarding provision of Demonstration related Emergency Services, but, the Contractor shall not refuse to cover a Demonstration related Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the P4HB Participant's Family Planning Provider and/or PCP (in the case of the IPC P4HB Participant), CMO plan representative, or DCH of the P4HB Participant's Demonstration related screening and treatment within said timeframes.

4.6.1.8.1 When a representative of the Contractor instructs the P4HB Participant to seek Emergency Services, the Contractor shall be responsible for payment for the Demonstration related Medical Screening examination without regard to whether the Condition meets the prudent layperson standard.

4.6.1.9.1 The P4HB Participant who has a Demonstration related Emergency Medical Condition shall not be held liable for payment of subsequent Demonstration related screening and treatment needed to diagnose the specific Condition or stabilize the P4HB Participant.

4.6.1.10.1 Once the P4HB Participant's condition is stabilized, the Contractor may require Pre-Certification for hospital admission or prior authorization for follow up care.

XXXIV. To amend *Section **4.6.2 Post-Stabilization Services***, by adding the following provisions:

4.6.2.7 The Contractor shall be responsible for providing Demonstration related Post Stabilization care services twenty-four (24) hours a day, seven (7) days a week, both inpatient and outpatient, related to a Demonstration related Emergency Medical Condition, that are provided after a P4HB participant is stabilized in order to maintain the stabilized Condition, or, pursuant to 42 CFR 438.114(e), to improve or resolve the P4HB Participant's Condition.

4.6.2.8 The Contractor shall be responsible for payment for Demonstration related Post Stabilization Services that are Prior Authorized or Pre-Certified by an In-Network Provider or organization representative, regardless of whether they are provided within or outside the Contractor's network of Providers.

4.6.2.9 The Contractor is financially responsible for Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network that are administered to maintain the P4HB participant's stabilized Condition for one (1) hour while awaiting response on a Pre-Certification or Prior Authorization request.

4.6.2.10 The Contractor is financially responsible for Demonstration related Post Stabilization Services obtained from any Provider, regardless of whether they are within or outside the Contractor's Provider network, that are not prior authorized by a CMO plan Provider or organization representative but are administered to maintain, improve or resolve the Member's stabilized Condition if:

- The Contractor does not respond to the Provider's request for pre-certification or prior authorization within one (1) hour;
- The Contractor cannot be contacted; or
- The Contractor's Representative and the attending physician cannot reach an agreement concerning the P4HB Participant's care and a CMO plan physician is not available for consultation. In this situation the Contractor shall give the treating physician the opportunity to consult with an In-Network physician and the treating physician may continue with care of the P4HB Participant until a CMO plan physician is reached or one of the criteria in Section 4.6.2.11 is met.

4.6.2.11 The Contractor's financial responsibility for Demonstration related Post-Stabilization Services it has not approved will end when:

- An In-Network Provider with privileges at the treating hospital assumes responsibility for the P4HB Participant's care;
- An In-Network Provider assumes responsibility for the P4HB Participant's care through transfer;
- The Contractor's Representative and the treating physician reach an agreement concerning the P4HB Participant's care; or
- The P4HB Participant is discharged.

4.6.2.12 In the event the P4HB Participant received Demonstration related Post Stabilization Services from a Provider outside the Contractor's network, the Contractor is prohibited from charging the P4HB Participant more than she would be charged if she had obtained services through an In-Network Provider.

XXXV. To amend *Section **4.6.3 Urgent Care Services***, by deleting this section in its entirety and replacing it with the following language:

The Contractor shall provide Urgent Care services to Members as necessary.
Such services shall not be subject to Prior Authorization or Pre-Certification.

The Contractor shall provide Demonstration related Urgent Care services to P4HB Participants as necessary. Such services shall not be subject to Prior Authorization or Pre-Certification.

XXXVI. To amend *Section **4.6.4.1 Family Planning Services***, by deleting it in its entirety and replacing it with the following language:

4.6.4.1 The Contractor shall provide access to Family Planning Services within the network to Members and P4HB Participants. In meeting this obligation, the Contractor shall make a reasonable effort to contract with all family planning clinics, including those funded by Title X of the Public Health Services Act, for the provision of Family Planning Services. The Contractor shall verify its efforts to contract with Title X Clinics by maintaining records of communication. The Contractor shall not limit Members' or P4HB Participants' freedom of choice for Family Planning Services to In-Network Providers and the Contractor shall cover services provided by any qualified Provider regardless of whether the Provider is In-Network. The Contractor shall not require a Referral if a Member or P4HB Participant chooses to receive Family Planning Services and supplies from outside of the network.

XXXVII. To amend *Section **4.6.4.2***, by deleting the term ***"Members"*** and replacing it with

the phrase **"*Members or P4HB Participants"*** throughout this section of the Contract.

XXXVIII. To amend *Section **4.6.4.3**,* by deleting it in its entirety and replacing it with the following language:

4.6.4.3 Family Planning Services and supplies for Members and P4HB Participants include at a minimum:

- Education and counseling necessary to make informed choices and understand contraceptive methods;
- Initial and annual complete physical examinations including a pelvic examination and Pap test;
- Follow up, brief and comprehensive visits – up to four (4) such visits for P4HB Participants;
- Pregnancy testing;
- Contraceptive supplies and follow up care;
- Diagnosis of sexually transmitted infections;
- Treatment of sexually transmitted infections with the following exception - P4HB Participants are excluded from receiving drugs for the treatment of HIV/AIDS and hepatitis under the Demonstration;
- For P4HB Participants - Drugs, supplies, or devices related to the women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirement; (subject to the national drug rebate program requirements).
- Infertility assessments with the following exception – P4HB Participants are excluded from receiving this benefit.

XXXIX. To amend *Section **4.6.5 Sterilizations, Hysterectomies and Abortions***, by adding the following provision:

4.6.5.1.1 In compliance with Federal regulations, the Contractor shall cover sterilizations for P4HB Participants only if all of the following requirements are met:

- The P4HB Participant is at least twenty-one (21) years of age at the time consent is obtained;
- The P4HB Participant is mentally competent;
- The P4HB Participant voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services. This includes the completion of all applicable documentation.
- At least thirty (30) Calendar Days, but not more than one hundred and eight (180) Calendar Days, have passed between the date of informed consent and the date of sterilization.
- An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a P4HB Participant who is visually impaired, hearing impaired or otherwise disabled; and
- The P4HB Participant is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

XL. To amend *Section **4.6.5.2,*** by adding the following provision:

4.6.5.2.1 A hysterectomy shall not be considered a Covered Service for P4HB Participants.

XLI. To amend *Section **4.6.5.4,*** by adding the following provision:

4.6.5.4.1 Abortions or abortion-related services shall not be considered a Covered Service for P4HB Participants.

XLII. To amend *Section **4.6.6 Pharmacy***, by adding the following provision:

4.6.6.1.1 The Contractor shall provide covered pharmacy services either directly or through a Pharmacy Benefits Manager (PBM) to P4HB Participants.

4.6.6.1.2 The Contractor shall make available to P4HB Participants folic acid and/or a multivitamin with folic acid.

XLIII. To amend *Section **4.6.7 Immunizations***, by adding the following provision:

4.6.7.1.1 The Contractor shall provide P4HB Participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the Advisory Committee on Immunization Practices (ACIP) guidelines as needed.

4.6.7.2.1 The Contractor shall ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccines for Children (VFC) program for P4HB Participants eighteen (18) years of age.

XLIV. To amend *Section **4.6.8 Transportation***, by adding the following provision:

4.6.8.2.1 The Contractor shall coordinate with the NET vendors for services required by P4HB Participants in the IPC component of the Demonstration.

XLV. To amend *Section **4.6.11 Mental Health and Substance Abuse***, by adding the following provision:

4.6.11.4 The Contractor shall permit Participants in the IPC Component of the Demonstration to receive Detoxification and Intensive Outpatient Rehabilitation Services as specified in the Special Terms and Conditions. (See Attachment O.)

XLVI. To amend *Section **4.6.12 Advance Directives***, by deleting the term **"*Members"*** and replacing it with the phrase "***Members or P4HB Participants"*** throughout this section of the Contract.

XLVII. To amend *Section **4.8.2 Primary Care Providers (PCPs),*** by adding the following provision:

4.8.2.1.1 The Contractor shall offer its P4HB Participants in the IPC component of the Demonstration freedom of choice in

selecting a PCP. The Contractor shall have written PCP selection policies and procedures describing how IPC P4HB Participants select their PCPs.

XLVIII. To further amend *Section **4.8.2 Primary Care Providers (PCPs)***, by deleting subsection ***4.8.2.4*** in its entirety and replacing it with the following language:

4.8.2.4 The Contractor may require that Members and IPC P4HB Participants are assigned to the same PCP for a period of up to six (6) months. In the event the Contractor requires that Members and IPC P4HB Participants are assigned to the same PCP for a period of six (6) months or less, the following exceptions shall be made:

4.8.2.4.1 Members and IPC P4HB Participants shall be allowed to change PCPs without cause during the first ninety (90) Calendar Days following PCP selection;

4.8.2.4.2 Members and IPC P4HB Participants shall be allowed to change PCPs with cause at any time. The following constitute cause for change:

- The PCP no longer meets the geographic access standards as defined in Section 4.8.14;
- The PCP does not, because of moral or religious objections, provide the Covered Service(s) the Member seeks; and
- The Member or IPC Participant requests to be assigned to the same PCP as other family members.

4.8.2.4.3 Members and IPC P4HB Participants shall be allowed to change PCPs every six (6) months.

XLIX. To further amend *Section **4.8.2 Primary Care Providers (PCPs)***, by adding the following provision:

4.8.2.5.1 The PCP is responsible for supervising, coordinating, and providing all Primary Care to each assigned IPC P4HB Participant. In addition, the PCP is responsible for coordinating and/or initiating Referrals for non-CMO paid or provided specialty care, maintaining continuity of each IPC P4HB Participant's Health Care and maintaining the IPC P4HB Participant's Medical Record, which includes documentation of all services provided by the PCP as well as any specialty services. The Contractor shall require that PCPs fulfill these responsibilities for all IPC P4HB Participants.

L. To amend *Section **4.8.4 Pharmacies***, by deleting the term ***"Members"*** and replacing it with the phrase *"**Members or P4HB Participants"*** throughout this section of the Contract.

LI. To amend *Section **4.8.5 Hospitals***, by adding the following provision:

4.8.5.1.1 The Contractor shall maintain a comprehensive Provider network of hospitals such that they are available and accessible for Demonstration related Service and Benefit delivery to all P4HB Participants.

LII. To amend *Section **4.8.6 Laboratories***, by adding the following provision:

4.8.6.1 The Contractor shall maintain a comprehensive Provider network of laboratories that ensures laboratories are accessible to all P4HB Participants for Demonstration related Services. The Contractor shall ensure that all laboratory testing sites providing services under this Contract have either a clinical laboratory (CLIA) certificate or a waiver of a certificate of registration, along with a CLIA number, pursuant to 42 CFR 493.3.

LIII. To amend *Section **4.8.12.2 Dental Practitioners***, by adding the following provision:

4.8.12.2.1 The Contractor must establish a sufficient number of general dentists as specified by 4.8.13 – Geographic Access Requirements to provide covered dental services to IPC P4HB Participants in the Contractor's Service Region.

LIV. To amend *Section **4.8.13 Geographic Access Requirements***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

LV. To amend *Section **4.8.16 Mainstreaming***, by deleting the term ***"Members"*** and replacing it with the phrase ***"Members or P4HB Participants"*** throughout this section of the Contract.

LVI. To amend *Section **4.8.17.3,*** by deleting the term ***"Members"*** and replacing it with the phrase ***"Members or P4HB Participants"*** throughout this section of the Contract.

LVII. To amend *Section **4.8.17.6,*** by deleting the term ***"Member's"*** and replacing it with the phrase ***"Member's or P4HB Participant's"*** throughout this section of the Contract.

LVIII. To amend *Section **4.8.18 Network Changes***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases *"**Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

LIX. To amend *Section **4.9.2.1***, by adding the following language:

- Description of the Demonstration;
- Practice protocols for the Demonstration;
- Other Provider responsibilities pertaining to the Demonstration;
- Coding requirements pertaining to the Demonstration;
- Prior Authorization, Pre-Certification, and Referral procedures pertaining to the Demonstration;
- P4HB Participant rights and responsibilities

LX. To amend *Section **4.9.3 Education and Training***, by adding the following provision:

4.9.3.1.1 The Contractor shall provide training to all Demonstration Family Planning and IPC service Providers and their staffs regarding the requirements of the Demonstration and the Contract provisions related to the Demonstration and special needs of the P4HB Participants. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a newly contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or DCH in order to ensure compliance with the Demonstration's standards and the Contract.

4.9.3.1.2 The Contractor's Demonstration Provider network will utilize the Preconception Care Toolkit for Georgia for preconception health education and counseling.

LXI. To amend *Section* ***4.10 PROVIDER CONTRACTS AND PAYMENTS***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

LXII. To amend *Section* ***4.10.4.4.1****,* by adding the following language:

- Demonstration related Services as a separate report

LXIII. To amend *Section* ***4.11.4***, by adding the following provisions:

4.11.4.1.1 The Contractor shall identify and facilitate transitions for P4HB Participants that are moving from one CMO to another and require additional or distinctive assistance during the period of transition. When relinquishing P4HB Participants, the Contractor shall cooperate with the receiving CMO plan regarding the course of ongoing care.

4.11.4.1.2 The Contractor will monitor Providers to ensure transition of care from one entity to another. Demonstration related procedures that are scheduled to occur after a P4HB Participant's new CMO effective date, but that were authorized by the P4HB Participant's original CMO prior to her new CMO effective date will be covered by the P4HB Participant's new CMO for thirty (30) days.

4.11.4.1.3 P4HB Participants that are in ongoing Demonstration related outpatient treatment or that are receiving Demonstration related medication that has been covered by another CMO prior to their new CMO effective date will be covered by the new CMO for at least thirty (30) days to allow time for clinical review, and if necessary, transition of care. If it is determined the P4HB Participant is still in need of those treatments and/or medications, the CMO will be obligated to cover those Demonstration related Services beyond thirty (30) days.

4.11.4.2.1.7 A P4HB Participant that is hospitalized in an acute inpatient hospital facility will remain the responsibility of that P4HB Participant's original CMO until she is discharged from the facility, even if she changes to a different CMO or becomes eligible for other coverage during her inpatient stay. The CMO is not required to cover Demonstration related Services for a P4HB Participant that has no Demonstration benefits. If the P4HB Participant remains an acute inpatient and loses Demonstration eligibility during the stay, the CMO is only responsible for payment until the last day of Demonstration eligibility.

LXIV. To amend *Section* ***4.11.9 Case Management***, by adding the following provisions:

4.11.9.1.1 The Contractor's Case Management system shall emphasize prevention, continuity of care, and coordination of care for P4HB Participants in the IPC component of the Demonstration.

4.11.9.2.1 Case Management functions for the IPC component of the Demonstration include:

- Early identification of P4HB IPC Participants who have or may have special needs;
- Assessment of a P4HB IPC Participant's risk factors;
- Development of a plan of care;
- Referrals and assistance to ensure timely access to Providers included and external to the Contractor's network;
- Coordination of care actively linking the P4HB IPC Participant to In-Network and out of network Providers, medical services, residential, social and other support services where needed;
- Resource Mothers Outreach
- Monitoring;
- Continuity of care;
- Follow up; and
- Documentation

4.11.9.2.2 Details pertaining to Resource Mothers Outreach are incorporated in Attachment P to this Contract. The Contractor must utilize the Resource Mothers Training Manual specified by DCH as the training manual for the Resource Mothers Outreach.

4.11.9.2.3 The Contractor must monitor the effectiveness of the Resource Mothers Outreach and ensure such Outreach activities comply with the Resource Mothers Training Manual.

LXV. To amend *Section* ***4.11.12 Reporting Requirements****,* by adding the following provision:

4.11.12.3 The Contractor shall submit to DCH all reports as outlined in the Demonstration Quality Strategy identified in Attachment O of this Contract.

LXVI. To amend *Section* ***4.14 INTERNAL GRIEVANCE SYSTEM***, by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

LXVII. To amend *Section* ***4.16 CLAIMS MANAGEMENT***, by deleting the term "Medicaid claims" as well as any reference thereto and replacing it with the phrase "Medicaid and Demonstration claims". (Demonstration claims will be processed as all other Medicaid claims are processed.)

LXVIII. To amend *Section* ***4.17 INFORMATION MANAGEMENT AND SYSTEMS,*** by deleting the terms ***"Member"*** and ***"Members"*** and replacing them with the phrases ***"Member or P4HB Participant"*** and ***"Members or P4HB Participants"*** respectively throughout this section of the Contract.

LXIX. To amend *Section* ***5.8 CONTRACT REPORTS***, by adding Demonstration Reports with a Due Date as – per Attachments O and Q.

LXX. To amend ***Section 7.1.1***, by adding the following language:

7.1.1.1 DCH will compensate the Contractor on a per member per month basis for each P4HB Participant enrolled in the Contractor's plan (See Attachment R). The number of enrolled P4HB Participants in each rate cell category will be determined by the records maintained in the Medicaid Member Information System (MMIS) maintained by DCH's fiscal agent. The monthly compensation will be the final negotiated rate for each rate cell multiplied by the number of enrolled P4HB Participants in each rate cell category. The Contractor must provide to DCH, and keep current, its tax identification number, billing address, and other contact information. Pursuant to the terms of this Contract, should DCH assess liquidated damages or other remedies or actions for noncompliance or deficiency with the terms of this Contract, such amount shall be withheld from the monthly compensation for the following month, and for continuous consecutive months thereafter until such noncompliance or deficiency is corrected.

LXXI. To amend ***Section 23.4.1*** by adding the following language:

- Failure to comply with the required Demonstration Reports and Deliverables as prescribed in Attachments O and Q.

- Failure to achieve annual targeted reductions in the Pregnancy Rate as identified in Attachment O.

- Failure to deliver effective Demonstration services as evidenced by lack of achievement of annual targeted LBW and VLBW reduction targets as identified in Attachment O.

LXXII. To amend the Contract by appending Exhibits 2, 3, 4, 5, 6 and 7 hereto as Attachments N, O, P, Q, and R respectively, to the Contract.

LXXIII. DCH and Contractor agree that they have assumed an obligation to perform the covenants, agreements, duties and obligations of the Contract, as modified and amended herein, and agree to abide by all the provisions, terms and conditions contained in the Contract as modified and amended.

LXXIV. This Amendment shall be binding and inure to the benefit of the parties hereto, their heirs, representatives, successors and assigns. Whenever the provisions of this Amendment and the Contract are in conflict, the provisions of this Amendment shall take precedence and control.

LXXV. It is understood by the Parties hereto that, if any part, term, or provision of this Amendment or this entire Amendment is held to be illegal or in conflict with any law of this State, then DCH, at its sole option, may enforce the remaining unaffected portions or provisions of this Amendment or of the Contract and the rights and obligations of the parties shall be construed and enforced as if the Contract or Amendment did not contain the particular part, term or provision held to be invalid.

LXXVI. This Amendment shall become effective as stated herein and shall remain effective for so long as the Contract is in effect.

LXXVII. This Amendment shall be construed in accordance with the laws of the State of Georgia.

LXXVIII. All other terms and conditions contained in the Contract and any amendment thereto, not amended by this Amendment, shall remain in full force and effect.

SIGNATURES ON THE FOLLOWING PAGE
SIGNATURE PAGE

IN WITNESS WHEREOF, DCH and Contractor, through their authorized officers and agents, have caused this Amendment to be executed on their behalf as of the date indicated.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

/s/ David A. Cook _____ 2/19/11
David A. Cook, Commissioner Date

/s/ Jerry Dubberly _____ 2/15/11
Jerry Dubberly, Chief – Medicaid Division Date

PEACH STATE HEALTH PLAN

BY: /s/ Patrick M. Healy 12/23/10
*SIGNATURE Date

Patrick M. Healy
Please Print/Type Name Here

AFFIX CORPORATE SEAL HERE

(Corporations without a seal, attach a Certificate of Corporate Resolution)

ATTEST: /s/ Gwelda Swilley-Burke
**SIGNATURE

Secretary
TITLE

* Must be President, Vice President, CEO or Other Authorized Officer
**Must be Corporate Secretary

Section 1.4 Definitions

Whenever capitalized in this Contract, the following terms have the respective meaning set forth below, unless the context clearly requires otherwise.

Abandoned Call: A call in which the caller elects a valid option and is either not permitted access to that option or disconnects from the system.

Abuse: Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for Health Care. It also includes Member and P4HB Participant practices that result in unnecessary cost to the Medicaid program.

Administrative Law Hearing: The appeal process administered by the State in accordance with O.C.G.A. § 49-4-153 and as required by federal law, available to Members, P4HB Participants and Providers after they exhaust the Contractor's Grievance System and Complaint Process.

Administrative Review: means the formal reconsideration, as a result of the proper and timely submission of a Provider's, Member's or P4HB Participant's request, by an Office or Unit of the Division, which has proposed an adverse action.

Administrative Service(s): The contractual obligations of the Contractor that include but may not be limited to utilization management, credentialing providers, network management, quality improvement, marketing, enrollment, Member and P4HB Participant services, claims payment, management information systems, financial management, and reporting.

Action: The denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMO to act within the time frames provided in 42 CFR 438.408(b).

Advance Directives: A written instruction, such as a living will or durable power of attorney for Health Care, recognized under State law (whether statutory or as recognized by the courts of the State), relating to the provision of Health Care when the individual is incapacitated.

After-Hours: Provider office/visitation hours that extends beyond the normal business hours of a provider, which are Monday-Friday 9-5:30 and may extend to Saturday hours.

Agent: An entity that contracts with the State of Georgia to perform administrative functions, including but not limited to: fiscal agent activities; outreach, eligibility, and Enrollment activities; Systems and technical support; etc.
Appeal: A request for review of an action, as "action" is defined in 438.400.

Assess: Means the process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

At Risk: Any service for which the Provider agrees to accept responsibility to provide, or arrange for, in exchange for the Capitation payment and Obstetrical: Delivery Payments.

Authoritative Host: A system that contains the master or "authoritative" data for a particular data type, e.g. Member, Provider, CMO, etc. The Authoritative Host may feed data from its master data files to other systems in real time or in batch mode. Data in an Authoritative Host is expected to be up-to-date and reliable.

Authorized Representative: A person authorized by the Member or P4HB Participant in writing to make health-related decisions on behalf of a Member or P4HB Participant, including, but not limited to Enrollment and Disenrollment decisions, filing Appeals and Grievances with the Contractor, and choice of a Primary Care Physician (PCP). The authorized representative is either the Parent or Legal Guardian for a child. For an adult this person is either the legal guardian (guardianship action), health care or other person that has power of attorney, or another signed HIPAA compliant document indicating who can make decisions on behalf of the member.

Automatic Assignment (or Auto-Assignment): The Enrollment of an eligible person, for whom Enrollment is mandatory, in a CMO plan chosen by DCH or its Agent. Also the assignment of a new Member or P4HB Participant to a PCP chosen by the CMO Plan, pursuant to the provisions of this Contract.

Benefits: The Health Care services set forth in this Contract, for which the Contractor has agreed to provide, arrange, and be held fiscally responsible.

Blocked Call: A call that cannot be connected immediately because no circuit is available at the time the call arrives or the telephone system is programmed to block calls from entering the queue when the queue backs up beyond a defined threshold.

Business Days: Any day from Monday to Friday typically from 9 A.M. to 5 P.M. and does not include State holidays.

Calendar Days: All seven days of the week.

Capitation: A Contractual agreement through which a Contractor agrees to provide specified Health Care services to Members or P4HB Participants for a fixed amount per month.

Capitation Payment: A payment, fixed in advance, that DCH makes to a Contractor for each Member or P4HB Participant covered under a Contract for the provision of medical services and assigned to the Contractor. This payment is made regardless of whether the Member or P4HB Participant receives Covered Services or Benefits during the period covered by the payment.

Capitation Rate: The fixed monthly amount that the Contractor is paid by DCH for each Member or P4HB Participant assigned to the Contractor to ensure that Covered Services and Benefits under this Contract are provided.

Capitated Service: Any Covered Service for which the Contractor receives an actuarially sound Capitation Payment.

Care Coordination: A set of Member-centered, goal-oriented, culturally relevant, and logical steps to assure that a Member receives needed services in a supportive, effective, efficient, timely, and cost-effective manner. Care Coordination is also referred to as Care Management.

Care Management Organization (CMO): An entity organized for the purpose of providing Health Care, has a Health Maintenance Organization Certificate of Authority granted by the State of Georgia, which contracts with Providers, and furnishes Health Care services on a capitated basis to Members and P4HB Participants in a designated Service Region.

Case Management: Any intensive intervention undertaken with the purpose of helping a P4HB Participant receive appropriate care following the delivery of a Very Low Birth Weight infant, where that P4HB Participant has any disease(s) or condition(s). It is distinguished from utilization management in that it is voluntary, and it is distinguished from disease management by its intensity and focus on any disease(s) conditions the P4HB Participant has.

Centers for Medicare & Medicaid Services (CMS): The Agency within the U.S. Department of Health and Human Services with responsibility for the Medicare, Medicaid and the State Children's Health Insurance Program.

Certified Nurse Midwife (CNM): A registered professional nurse who is legally authorized under State law to practice as a nurse-midwife, and has completed a program of study and clinical experience for nurse-midwives or equivalent.

Children's Health Insurance Program (CHIP formerly State Children's Health Insurance Program (SCHIP)): A joint federal-state Health Care program for targeted, low-income children, established pursuant to Title XXI of the Social Security Act. Georgia's CHIP is called PeachCare for Kids™.

Chronic Condition: Any ongoing physical, behavioral, or cognitive disorder, including chronic illnesses, impairments and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms (medications, special diet, assistive device, etc) and service use or need beyond that which is lly considered Routine Care.

Claim: A bill for services, a line item of services, or all services for one recipient within a bill.
Claims Administrator: The entity engaged by DCH to provide Administrative Service(s) to the CMO Plans in connection with processing and adjudicating risk-based payment, and recording health benefit encounter Claims for Members and P4HB Participants.

Clean Claim: A claim received by the CMO for adjudication, in a nationally accepted format in compliance with standard coding guidelines, which requires no further information, adjustment, or alteration by the Provider of the services in order to be processed and paid by the CMO. The following exceptions apply to this definition: i. A Claim for payment of expenses incurred during a period of time for which premiums are delinquent; ii. A Claim for which Fraud is suspected; and iii. A Claim for which a Third Party Resource should be responsible.

Cold-Call Marketing: Any unsolicited personal contact by the CMO Plan, with a potential Member or P4HB Participant, for the purposes of marketing.

Community Mental Health Rehabilitation Services (CMHRS): Services that are intended for the maximum reduction of mental disability and restoration of an individual to his or her best possible functional level.

Completion/Implementation Timeframe: The date or time period projected for a project goal or objective to be met, for progress to be demonstrated or for a proven intervention to be established as the standard of care for the Contractor.

Condition: A disease, illness, injury, disorder, of biological, cognitive, or psychological basis for which evaluation, monitoring and/or treatment are indicated.

Consecutive Enrollment Period: The consecutive twelve (12) month period beginning on the first day of Enrollment or the date the notice is sent, whichever is later. For Members and P4HB Participants that use their option to change CMO plans without cause during the first ninety (90) Calendar Days of Enrollment, the twelve-month consecutive Enrollment period will commence when the Member or P4HB Participant enrolls in the new CMO plan. This is not to be construed as a guarantee of eligibility during the consecutive Enrollment period.

Contested Claim: A Claim that is denied because the Claim is an ineligible Claim, the Claim submission is incomplete, the coding or other required information to be submitted is incorrect, the amount Claimed is in dispute, or the Claim requires special treatment.

Contract: The written agreement between the State and the Contractor; comprised of the Contract, any addenda, appendices, attachments, or amendments thereto.

Contract Award: The date upon which DCH issues the Apparent Successful Offeror Letters.

Contract Execution: The date upon which all parties have signed the Contract.

Contractor: The Care Management Organization with a valid Certificate of Authority in Georgia that contracts hereunder with the State for the provision of comprehensive Health Care services to Members on a capitated basis.

Contractor's Representative: The individual legally empowered to bind the Contractor, using his/her signature block, including his/her title. This individual will be considered the Contractor's Representative during the life of any Contract entered into with the State unless amended in writing.

Co-payment: The part of the cost-sharing requirement for Members in which a fixed monetary amount is paid for certain services/items received from the Contractor's Providers.

Core Services: Covered services for both the Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) programs defined as follows: Physician services, including required physician supervision of Physician Assistants (PAs), Nurse Practitioners (NPs), and Certified Nurse Midwives (CNMs); services and supplies furnished as incident to physician professional services; services of PAs, NPs and CNMs; services of clinical psychologists and clinical social workers (when providing diagnosis and treatment of mental illness); services and supplies furnished as incident to professional services provided by PAs, NPs, CNMs, clinical psychologists, and clinical social workers; Visiting nurse services on a part time or intermittent basis to homebound patients (limited to areas in which there is a designated shortage of home health agencies).

Corrective Action Plan: The detailed written plan required by DCH to correct or resolve a deficiency or event causing the assessment of a liquidated damage or sanction against the CMO.

Corrective Action Preventive Action (CAPA): CAPA focuses on the systematic investigation of discrepancies (failures and/or deviations) in an attempt to prevent their reoccurrence. To ensure that corrective and preventive actions are effective, the systematic investigation of the failure incidence is pivotal in identifying the corrective and preventive actions undertaken.

Cost Avoidance: A method of paying Claims in which the Provider is not reimbursed until the Provider has demonstrated that all available health insurance has been exhausted.

Covered Services: Those Medically Necessary Health Care services provided to Members, the payment or indemnification of which is covered under this Contract or those Demonstration services provided to P4HB Participants, the payment or indemnification of which is covered under this Contract.

Credentialing: The Contractor's determination as to the qualifications and ascribed privileges of a specific Provider to render specific Health Care services.

Critical Access Hospital (CAH): Critical access hospital means a hospital that meets the requirements of the federal Centers for Medicare and Medicaid Services to be designated as a critical access hospital and that is recognized by the Department of Community Health as a critical access hospital for purposes of Medicaid.

Cultural Competency: A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members and P4HB Participants. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Member and P4HB Participant needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications, and other supports.

Deliverable: A document, manual or report submitted to DCH by the Contractor to fulfill requirements of this Contract.

Demonstration: The 1115 Demonstration waiver program in Georgia supported by CMS that expands the delivery of family planning services to uninsured women, ages 18

through 44, who have family income at or below 200 percent of the Federal poverty level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). Also referred to as the Family Planning Waiver or the P4HB Program.

Demonstration Enrollee: An individual meeting P4HB Program eligibility requirements who selects or is otherwise assigned to a Georgia Families Care Management Organization in order to receive Demonstration services.

Demonstration Enrollment: The process by which an individual eligible for the P4HB program applies to utilize a Georgia Families Care Management Organization to receive Demonstration services and such application is approved by DCH or its Agent.

Demonstration Disenrollment: The removal of a P4HB Participant from participation in the Demonstration.

Demonstration Period: The period from January 1, 2011 through December 31, 2013 in which the Demonstration will be effective.

Demonstration Provider: A physician, advanced practice nurse or other health care provider who meets the State's Medicaid provider enrollment requirements for the Demonstration, hospital, facility, or pharmacy licensed or otherwise authorized to provide Demonstration related Services to P4HB Participants within the State or jurisdiction in which they are furnished. Also known as P4HB Provider.

Demonstration related Emergency Medical Condition: A medical condition resulting from a Demonstration related Service and manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the woman in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. A Demonstration related Emergency Medical condition shall not be defined on the basis of lists of diagnoses or symptoms.

Demonstration related Post Stabilization Services: Covered Services related to Demonstration related Emergency Medical Condition that are provided after a P4HB Participant is stabilized in order to maintain the stabilized condition or to improve or resolve the P4HB Participant's condition.

Demonstration related Services: Those Demonstration Services identified in the CMS Special Terms and Conditions and approved by CMS that are available to P4HB Participants.

Demonstration related Urgent Care Services: Medically Necessary treatment of a Demonstration related injury, illness or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Dental Subspecialty Providers: Endodontists; Oral Pathologist; Orthodontist; Oral Surgeon; Periodontist; Pedodontist; Public Health Dentist; and Prosthodontist.

Department of Community Health (DCH): The Agency in the State of Georgia responsible for oversight and administration of the Medicaid program, the PeachCare for Kids program, the Planning for Healthy Babies Program and the State Health Benefits Plan (SHBP).

Department of Insurance (DOI): The Agency in the State of Georgia responsible for licensing, overseeing, regulating, and certifying insuring entities.

Diagnostic Related Group (DRG): Any of the payment categories that are used to classify patients and especially Medicare patients for the purpose of reimbursing hospitals for each case in a given category with a fixed fee regardless of the actual costs incurred and that are based especially on the principal diagnosis, surgical procedure used, age of patient, and expected length of stay in the hospital.

Diagnostic Services: Any medical procedures or supplies recommended by a physician or other licensed medical practitioner, within the scope of his or her practice under State law, to enable him or her to identify the existence, nature or extent of illness, injury, or other health deviation in a Member or P4HB Participant.

Discharge: Point at which Member or P4HB Participant is formally released from a hospital, by the treating physician, an authorized member of the physician's staff or by the Member or P4HB Participant after they have indicated, in writing, their decision to leave the hospital contrary to the advice of their treating physician.

Disenrollment: The removal of a Member from participation in the Contractor's plan, but not necessarily from the Medicaid or PeachCare for Kids program.

Documented Attempt: A bona fide, or good faith, attempt to contract with a Provider. Such attempts may include written correspondence that outlines contracted negotiations between the parties, including rate and contract terms disclosure, as well as documented verbal conversations, to include date and time and parties involved.

Durable Medical Equipment (DME): Equipment, including assistive technology, which: a) can withstand repeated use; b) is used to service a health or functional purpose; c) is ordered by a qualified practitioner to address an illness, injury or disability; and d) is appropriate for use in the home, work place, or school.

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program: A Title XIX mandated program that covers screening and Diagnostic Services to determine physical and mental deficiencies in Members less than 21 years of age, and Health Care, treatment, and other measures to correct or ameliorate any deficiencies and Chronic Conditions discovered. P4HB Participants are not eligible to participate in the EPSDT Program.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairments of bodily functions, or serious dysfunction of any bodily organ or part. An Emergency Medical Condition shall not be defined on the basis of lists of diagnoses or symptoms.

Emergency Services: Covered inpatient and outpatient services furnished by a qualified Provider that are needed to evaluate or stabilize an Emergency Medical Condition that is found to exist using the prudent layperson standard.

Encounter: A distinct set of health care services provided to a P4HB Participant, Medicaid or PeachCare for Kids Member enrolled with a Contractor on the dates that the services were delivered.

Encounter Data: Health Care Encounter Data include: (i) All data captured during the course of a single Health Care encounter that specify the diagnoses, comorbidities, procedures (therapeutic, rehabilitative, maintenance, or palliative), pharmaceuticals, medical devices and equipment associated with the Member or P4HB Participant receiving services during the Encounter; (ii) The identification of the Member or P4HB Participant receiving and the Provider(s) delivering the Health Care services during the single Encounter; and, (iii) A unique, i.e. unduplicated, identifier for the single Encounter.

Enrollee: See Member.

Enrollment: The process by which an individual eligible for Medicaid or PeachCare for Kids applies (whether voluntary or mandatory) to utilize the Contractor's plan in lieu of fee for service and such application is approved by DCH or its Agent.

Enrollment Broker: The entity engaged by DCH to assist in outreach, education and Enrollment activities associated with the GF program.

Enrollment Period: The twelve (12) month period commencing on the effective date of Enrollment.

Evaluate: The process used to examine and determine the level of quality or the progress toward improvement of quality and/or performance related to Contractor service delivery systems.

External Quality Review (EQR): The analysis and evaluation by an external quality review organization of aggregated information on quality, timeliness, and access to the Health Care services that a CMO or its Subcontractors furnish to Members and to DCH.

External Quality Review Organization (EQRO): An organization that meets the competence and independence requirements set forth in 42 CFR 438.354 and performs external quality review, and other related activities.

Family Planning Provider: A physician, advanced practice nurse or other health care provider who meets the State's Medicaid provider enrollment requirements for the Demonstration and delivers or prescribes Family Planning Services.

Family Planning Services: Family planning services and supplies include at a minimum:

- Education and counseling necessary to make informed choices and understand contraceptive methods;
- Initial and annual complete physical examinations;
- Follow-up, brief and comprehensive visits;
- Pregnancy testing;
- Contraceptive supplies and follow-up care;
- Diagnosis and treatment of sexually transmitted diseases; and
- Infertility assessment

Family Planning Waiver: See Demonstration.

Federal Financial Participation (FFP): The funding contribution that the federal government makes to the Georgia Medicaid and PeachCare for Kids programs.

Federally Qualified Health Center (FQHC): An entity that provides outpatient health programs pursuant to Section 1905(l) (2) (B) of the Social Security Act.

Fee-for-Service (FFS): A method of reimbursement based on payment for specific services rendered to a Member.

Financial Relationship: A direct or indirect ownership or investment interest (including and option or non vested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes any indirect ownership or investment interest no matter how many levels removed from a direct interest, or a compensation arrangement with an entity.

Fraud: An intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit or financial gain to him/herself or some other person. It includes any act that constitutes Fraud under applicable federal or State law.

Georgia Families (GF): The risk-based managed care delivery program for Medicaid and PeachCare for Kids™ in which the Department contracts with Care Management Organizations to manage the care of eligible Members and P4HB Participants.

Georgia Technology Authority (GTA): The state agency that manages the state's information technology (IT) infrastructure i.e. data center, network and telecommunications services and security, establishes policies, standards and guidelines for state IT, promotes an enterprise approach to state IT, and develops and manages the state portal.

Grievance: An expression of dissatisfaction about any matter other than an Action. Possible subjects for grievances include, but are not limited to, the quality of care or services provided or aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Enrollee's or P4HB Participant's rights.

Grievance System: The overall system that includes Grievances and Appeals at the Contractor level and access to the State Fair Hearing process (the State's Administrative Law Review).

Health Care: Health Care means care, services, or supplies related to the health of an individual. Health Care includes, but is not limited to, the following: (i) Preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental Condition, or functional status, of an individual or that affects the structure or function of the body; and (ii) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

Health Care Professional: A physician or other Health Care Professional, including but not limited to podiatrists, optometrists, chiropractors, psychologists, dentists, physician's assistants, physical or occupational therapists and therapists assistants, speech-language pathologists, audiologists, registered or licensed practical nurses (including nurse practitioners, clinical nurse specialist, certified registered nurse anesthetists, and certified nurse midwives), licensed certified social workers, registered respiratory therapists, and certified respiratory therapy technicians licensed in the State of Georgia.

Health Check: The State of Georgia's Early and Periodic Screening, Diagnostic, and Treatment program pursuant to Title XIX of the Social Security Act.

Health Information Technology: Hardware, software, integrated technologies or related licenses, intellectual property, upgrades, or packaged solutions sold as services that are designed for our support the use of health care entities or patients for the electronic creation, maintenance, access, or exchange of health information. Source is ARRA - H.R.1 - 115 Sec. 3000 (5)

Health Information Technology for Economic and Clinical Health Act (HITECH Act) Title IV: The legislation establishes a transparent and open process for the development of standards that will allow for the nationwide electronic exchange of information between doctors, hospitals, patients, health plans, the government and others by the end of 2009. It establishes a voluntary certification process for health information technology products. The National Institute of Standards and Technology will provide for the testing of such products to determine if they meet the national standards that allow for the secure electronic exchange and use of health information.

Health Insurance Portability and Accountability Act (HIPAA): A law enacted in 1996 by the Congress of the United States. When referenced in this Contract it includes all related rules, regulations and procedures.

Health Maintenance Organization: As used in Section 8.6 a Health Maintenance Organization is an entity that is organized for the purpose of providing Health Care and has a Health Maintenance Organization Certificate of Authority granted by the State of Georgia, which contracts with Providers and furnishes Health Care services on a capitated basis to Members in a designated Service Region.

Health Professional Shortage Area (HPSA): An area designated by the United States Department of Health and Human Services' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental or mental health providers. These areas can be geographic, demographic or institutional in nature. A care area can be found using the following website: http://hpsafind.hrsa.gov/.

Healthcare Effectiveness Data and Information Set (HEDIS): A widely used set of performance measures developed and maintained by the National Committee for Quality Assurance (NCQA).

Historical Provider Relationship: A Provider who has been the main source of Demonstration, Medicaid or PeachCare for Kids services for the Member or P4HB Participant during the previous year (decided on by the most recent provider on the Member's or P4HB Participant's claim history).

Immediately: Within twenty-four (24) hours.

In-Network Provider: A Provider that has entered into a Provider Contract with the Contractor to provide services.

Incentive Arrangement: Any mechanism under which a Contractor may receive additional funds over and above the Capitation rates, for exceeding targets specified in the Contract.

Incurred-But-Not-Reported (IBNR): Estimate of unpaid Claims liability, includes received but unpaid Claims.

Individuals with Disabilities Education Act (IDEA): A United States federal law that ensures services to children with disabilities throughout the United States. IDEA governs how states and public agencies provide early intervention, special education and related services to children with disabilities.

Information: i. Structured Data: Data that adhere to specific properties and Validation criteria that is stored as fields in database records. Structured queries can be created and run against structured data, where specific data can be used as criteria for querying a larger data set; ii. Document: Information that does not meet the definition of structured data includes text, files, spreadsheets, electronic messages and images of forms and pictures.

Information System/Systems: A combination of computing hardware and software that is used in: (a) the capture, storage, manipulation, movement, control, display, interchange and/or transmission of information, i.e. structured data (which may include digitized audio and video) and documents; and/or (b) the processing of such information for the purposes of enabling and/or facilitating a business process or related transaction.

Inpatient Facility: Hospital or clinic for treatment that requires at least one overnight stay.

Insolvent: Unable to meet or discharge financial liabilities.

Interpregnancy Care (IPC): An additional benefit available to some P4HB Participants who meet the Demonstration's eligibility requirements and who delivered a very low birth weight baby on or after initiation of the Demonstration.

Interpregnancy Care Services: Services available under the Demonstration for P4HB Participants who meet the eligibility criteria for the IPC program. These services are in addition to Family Planning Services and include: limited primary care services; management and treatment of chronic diseases; substance abuse treatment (detoxification and intensive outpatient rehabilitation) case management including Resource Mothers Outreach; limited dental; prescription drugs (non-family planning) for the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery and non-emergency transportation.

Interpregnancy Care Service Providers: Those Demonstration Providers serving the IPC P4HB Participants including nurse case managers and Resource Mothers.

Limited-English-Proficient Population: Individuals with a primary language other than English who must communicate in that language if the individual is to have an equal opportunity to participate effectively in, and benefit from, any aid, service or benefit provided by the health Provider.

Low Birth Weight: Birth weight below 2,500 grams (5.5 pounds).

Mandatory Enrollment: The process whereby an individual eligible for the Demonstration, Medicaid or PeachCare for Kids is required to enroll in a Contractor's plan, unless otherwise exempted or excluded, to receive covered Demonstration, Medicaid or PeachCare for Kids services.

Marketing: Any communication from a CMO plan to any Demonstration, Medicaid or PeachCare for Kids eligible individual that can reasonably be interpreted as intended to influence the individual to enroll in that particular CMO plan, or not enroll in or disenroll from another CMO plan.

Marketing Materials: Materials that are produced in any medium, by or on behalf of a CMO, and can reasonably be interpreted as intended to market to any Demonstration, Medicaid or PeachCare for Kids eligible individual.

Measurable: Applies to a Contractor objective and means the ability to determine definitively whether, or not the objective has been met, or whether progress has been made toward a positive outcome.

Medicaid: The joint federal/state program of medical assistance established by Title XIX of the Social Security Act, which in Georgia is administered by DCH.

Medicaid Care Management Organizations Act: O.C.G.A. 33-21-1, et seq MEDICAID CARE MANAGEMENT ORGANIZATIONS ACT. A bill passed by the Georgia General Assembly, signed into law by the Governor, and effective July 1, 2008 which speaks to several administrative requirements for the administrators of the Medicaid Managed Care plan, Georgia Families, to comply. Some of the requirements include dental provider networks; emergency room claims payment requirements, eligibility verification, and others.

Medicaid Eligible: An individual eligible to receive services under the Medicaid Program but not necessarily enrolled in the Medicaid Program.

Medicaid Management Information System (MMIS): Computerized system used for the processing, collecting, analysis and reporting of Information needed to support Medicaid and SCHIP functions. The MMIS consists of all required subsystems as specified in the State Medicaid Manual.

Medical Director: The licensed physician designated by the Contractor to exercise general supervision over the provision of health service Benefits by the Contractor.

Medical Records: The complete, comprehensive records of a Member or P4HB Participant including, but not limited to, x-rays, laboratory tests, results, examinations and notes, accessible at the site of the Member's or P4HB Participant's participating Primary Care or Demonstration physician or Provider, that document all medical services received by the Member or P4HB Participant, including inpatient, ambulatory, ancillary, and emergency care, prepared in accordance with all applicable DCH rules and regulations, and signed by the medical professional rendering the services.

Medical Screening: An examination: i. provided on hospital property, and provided for that patient for whom it is requested or required, ii. performed within the capabilities of the hospital's emergency room (ER) (including ancillary services routinely available to its ER) iii. the purpose of which is to determine if the patient has an Emergency Medical Condition, and iv. performed by a physician (M.D. or D.O.) and/or by a nurse practitioner, or physician assistant as permitted by State statutes and regulations and hospital bylaws.

Medically Necessary Services: Those services that meet the definition found in Section 4.5.

Member: A Medicaid or PeachCare for Kids recipient who is currently enrolled in a CMO plan.

Methodology: The planned process, steps, activities or actions taken by a Contractor to achieve a goal or objective, or to progress toward a positive outcome.

Monitoring: The process of observing, evaluating, analyzing and conducting follow-up activities.

National Committee for Quality Assurance (NCQA): An organization that sets standards, and evaluates and accredits health plans and other managed care organizations.

Net Capitation Payment: The Capitation Payment made by DCH to Contractor less any quality assessment fee made by Contractor to DCH. This payment amount also excludes a payment to a Contractor for obstetrical or other medical services that are on a per occurrence basis rather than a per member basis.

Non-Emergency Transportation (NET): A ride, or reimbursement for a ride, provided so that a Member or P4HB Participant with no other transportation resources can receive services from a medical provider. NET does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.
Non-Institutional Claims: Claims submitted by a medical Provider other than a hospital, nursing facility, or intermediate care facility/mentally retarded (ICF/MR).

Normal Birth Weight: Birth weight greater than or equal to 2,500 grams (5.5 pounds).

Nurse Practitioner Certified (NP-C): A registered professional nurse who is licensed by the State of Georgia and meets the advanced educational and clinical practice requirements beyond the two or four years of basic nursing education required of all registered nurses.

Objective: Means a measurable step, generally in a series of progressive steps, to achieve a goal.

Obstetrical Delivery Payment: A payment, fixed in advance, that DCH makes to a Contractor for each birth of a child to a Member. The Contractor is responsible for all medical services related to the delivery of the Member's child.

Out-of-Network Provider: A Provider of services that does not have a Provider contract with the Contractor.

Participating Provider: Providers that have signed a contract with CMOs to provide services to Georgia Families members and P4HB Participants.

Patient Protection and Affordable Care Act (PPACA): The Patient Protection and Affordable Care Act is a federal statute, signed into law on March 23, 2010. Along with the Health Care and Education Reconciliation Act signed into law on March 30, 2010, the Act is the product of the health care reform agenda of the Democratic 111th Congress and the Obama administration. The law includes numerous health-related provisions that will take effect over a four year period, including expanding Medicaid eligibility, subsidizing insurance premiums, establishing health insurance exchanges and support of medical research.

P4HB Participant: An individual meeting the eligibility requirements for the Demonstration who is enrolled in and/or receiving Demonstration Services through the Contractor. Also referred to as Participant.

P4HB Provider: See Demonstration Provider.

PeachCare for Kids: The State of Georgia's State Children's Health Insurance Program established pursuant to Title XXI of the Social Security Act.

Performance Concern: The informal documentation of an issue. The CMO is required to respond to the Performance Concern by defining a process to detect, analyze and eliminate non-compliance and potential causes of non-compliance. This is a "warning" and failure to complete the Corrective Action Preventive Action/Performance Concern (CAPA/PC) form may result in formal action against the contractor (CAPA). If the concern is a Performance Concern, the following information must be completed by the offending CMO:

- Direct Cause: The cause that directly resulted in the event (the first cause in the chain).
- Corrective Action: actions taken to correct the root cause generally a reactive process used to address problems after they have occurred

Performance Improvement Project (PIP): Means a planned process of data gathering, evaluation and analysis to determine interventions or activities that are projected to have a positive outcome. A PIP includes measuring the impact of the interventions or activities toward improving the quality of care and service delivery.

Pharmacy Benefit Manager (PBM): An entity responsible for the provision and administration of pharmacy benefit management services including but not limited to claims processing and maintenance of associated systems and related processes.

Physician Assistant (PA) - A trained, licensed individual who performs tasks that might otherwise be performed by physicians or under the direction of a supervising physician.

Physician Incentive Plan: Any compensation arrangement between a Contractor and a physician or physician group that may directly have the effect of reducing or limiting services furnished to Members.

Planning for Healthy Babies Program: The name of the 1115 Family Planning Demonstration Waiver Program in Georgia.

Post-Stabilization Services: Covered Services, related to an Emergency Medical Condition that are provided after a member is stabilized in order to maintain the stabilized condition or to improve or resolve the member's condition.

Potential P4HB Participant: An individual meeting the eligibility requirements for the Demonstration who is subject to mandatory Enrollment in a care management program but is not yet enrolled in a specific CMO plan.

Potential Enrollee: See Potential Member.

Potential Member: A Medicaid or SCHIP recipient who is subject to mandatory Enrollment in a care management program but is not yet the Member of a specific CMO plan.

Pre-Certification: Review conducted prior to a Member's or P4HB Participant's admission, stay or other service or course of treatment in a hospital or other facility.

Preconception Health Care: The primary prevention of maternal and perinatal morbidity and mortality, comprised of interventions that identify and modify biomedical, behavioral and social risks to pregnancy outcomes for women and their offspring. To have maximal impact on pregnancy outcomes, strategies to address risks must occur before conception or before prenatal care is typically initiated.

Preferred Health Organization (PHO): A coordinated care plan that: (a) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; (b) provides for reimbursement for all covered benefits regardless of whether the benefits are provided with the network of providers; and (c) is offered by an organization that is not licensed or organized under State law as an HMO.

Pregnancy Rate: The number of pregnancies occurring per 1,000 females aged 18 – 44.

Prevalent Non-English Language: A language other than English, spoken by a significant number or percentage of potential Members or P4HB Participants.

Preventive Services: Services provided by a physician or other licensed health practitioner within the scope of his or her practice under State law to: prevent disease, disability, and other health Conditions or their progression; treat potential secondary Conditions before they happen or at an early remediable stage; prolong life; and promote physical and mental health and efficiency.

Primary Care: All Health Care services and laboratory services, including periodic examinations, preventive Health Care and counseling, immunizations, diagnosis and treatment of illness or injury, coordination of overall medical care, record maintenance, and initiation of Referrals to specialty Providers described in this Contract, and for maintaining continuity of patient care. These services are customarily furnished by or through a general practitioner, family physician, internal medicine physician, obstetrician/gynecologist, or pediatrician, and may be furnished by a nurse practitioner to the extent the furnishing of those services is legally authorized in the State in which the practitioner furnishes them.

Primary Care Provider (PCP): A licensed medical doctor (MD) or doctor of osteopathy (DO) or certain other licensed medical practitioner who, within the scope of practice and in accordance with State certification/licensure requirements, standards, and practices, is responsible for providing all required Primary Care services to Members or IPC P4HB Participants. A PCP shall include general/family practitioners, pediatricians, internists, physician's assistants, CNMs or NP-Cs, provided that the practitioner is able and willing to carry out all PCP responsibilities in accordance with these Contract provisions and licensure requirements.

Prior Authorization: Authorization granted in advance of the rendering of a service after appropriate medical review. (Also known as "pre-authorization" or "prior approval").

Proposed Action: The proposal of an action for the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial, in whole or part of payment for a service; the failure to provide services in a timely manner; or the failure of the CMO to act within the time frames provided in 42 CFR 438.408(b).

Prospective Payment System (PPS): A method of reimbursement in which Medicare payment is made based on a predetermined, fixed amount. The payment amount for a particular service is derived based on the classification system of that service (for example, DRGs for inpatient hospital services). CMS uses separate PPSs for reimbursement to acute inpatient hospitals, home health agencies, hospice, hospital outpatient, inpatient psychiatric facilities, inpatient rehabilitation facilities, long-term care hospitals, and skilled nursing facilities.

Provider: Any physician, hospital, facility, or other Health Care Professional who is licensed or otherwise authorized to provide Health Care services in the State or jurisdiction in which they are furnished.

Provider Complaint: A written expression by a Provider, which indicates dissatisfaction or dispute with the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions, including a Proposed Action.

Provider Contract: Any written contract between the Contractor and a Provider that requires the Provider to perform specific parts of the Contractor's obligations for the provision of Health Care services under this Contract.

Provider Directory: A listing of health care service providers under contract with the CMO that is prepared by the CMO as a reference tool to assist members and P4HB Participants in locating providers that are available to provide services.

Provider Number (or Provider Billing Number): An alphanumeric code utilized by health care payers to identify providers for billing, payment, and reporting purposes.

Provider Payment Agreement Act (PPA): A law enacted by the Georgia state legislature and codified as O.C.G.A. § 31-8-179 et seq.

PPA Provider: An institution licensed pursuant to Chapter 7 of Title 31 of the Official Code of Georgia Annotated which is primarily engaged in providing to inpatients, by or under the supervision of physicians, diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. Such term includes public, private, rehabilitative, geriatric, osteopathic, and other specialty hospitals but shall not include psychiatric hospitals as defined in paragraph (7) of Code Section 37-3-1, critical access hospitals as defined in paragraph (3) of Code Section 33-21A-2, or any state owned or state operated hospitals.

Prudent Layperson: A person with average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in an emergency medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that could cause:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Qualified Electronic Health Record: "An Electronic record of health-related information on an individual that includes patient demographic and clinical health information, such as medical history and problem lists; and has the capacity to provide clinical decision support; to support physician order entry; to capture and query information relevant to health care quality; and to exchange electronic health information with and integrate such information from other sources." Source is ARRA - H.R.1 -115 Sec. 3000 (13)

Quality: The degree to which a CMO increases the likelihood of desired health outcomes of its Members and P4HB Participants through its structural and operational characteristics, and through the provision of health services that are consistent with current professional knowledge.

Re-admission: Subsequent admissions of a patient to a hospital or other health care institution for treatment.

Referral: A request by a PCP for a Member or P4HB Participant to be evaluated and/or treated by a different physician, usually a specialist.

Referral Services: Those Health Care services provided by a health professional other than the Primary Care Provider and which are ordered and approved by the Primary Care Provider or the Contractor.

Reinsurance: An agreement whereby the Contractor transfers risk or liability for losses, in whole or in part, sustained under this Contract. A reinsurance agreement may also exist at the Provider level.

(Claims) Reprocessing: Upon determination of the need to correct the outcome of one or more claims processing transactions, the subsequent attempt to process a single claim or batch of claims.

Remedy: The State's means to enforce the terms of the Contract through performance guarantees and other actions.

Risk Contract: A Contract under which the Contractor assumes financial risk for the cost of the services covered under the Contract, and may incur a loss if the cost of providing services exceeds the payments made by DCH to the Contractor for services covered under the Contract.

Routine Care: Treatment of a Condition that would have no adverse effects if not treated within twenty-four (24) hours or could be treated in a less acute setting (e.g., physicians office) or by the patient.

Rural Health Clinic (RHC): A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner. RHCs may also provide other health care services, such as mental health or

vision services, but reimbursement for those services may not be based on their allowable costs.

Rural Health Services: Medical services provided to rural sparsely populated areas isolated from large metropolitan counties.

Scope of Services: Those specific Health Care services for which a Provider has been credentialed, by the plan, to provide to Members and P4HB Participants.

Service Authorization: A Member's or P4HB Participant's request for the provision of a service.

Service Region: A geographic area comprised of those counties where the Contractor is responsible for providing adequate access to services and Providers.

Short Term: A period of thirty (30) Calendar Days or less.

Significant Traditional Providers: Those Providers that provided the top eighty percent (80%) of Medicaid encounters for the GMC-eligible population in the base year of 2004.

Span of Control: Information systems and telecommunications capabilities that the CMO itself operates or for which it is otherwise legally responsible according to the terms and Conditions of this Contract. The CMO span of control also includes Systems and telecommunications capabilities outsourced by the CMO.

Stabilized: With respect to an emergency medical condition; that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or , with respect to a woman in labor, the woman has delivered (including the placenta).

State: The State of Georgia.

State Fair Hearing: See Administrative Law Hearing

Subcontract: Any written contract between the Contractor and a third party, including a Provider, to perform a specified part of the Contractor's obligations under this Contract.

Subcontractor: Any third party who has a written Contract with the Contractor to perform a specified part of the Contractor's obligations under this Contract.

Subcontractor Payments: Any amounts the Contractor pays a Provider or Subcontractor for services they furnish directly, plus amounts paid for administration and amounts paid (in whole or in part) based on use and costs of Referral Services (such as Withhold amounts, bonuses based on Referral levels, and any other compensation to the physician or physician group to influence the use for Referral Services). Bonuses and other compensation that are not based on Referral levels (such as bonuses based solely on quality of care furnished, patient satisfaction, and participation on committees) are not considered payments for purposes of Physician Incentive Plans.

System Access Device: A device used to access System functions; can be any one of the following devices if it and the System are so configured: i. Workstation (stationary or mobile computing device) ii. Network computer/"winterm" device, iii. "Point of Sale" device, iv. Phone, v. Multi-function communication and computing device, e.g. PDA.

System Unavailability: Failure of the system to provide a designated user access based on service level agreements or software/hardware problems within the contractors span of control.

System Function Response Time: Based on the specific sub function being performed,
Record Search Time-the time elapsed after the search command is entered until the list of matching records begins to appear on the monitor.
Record Retrieval Time-the time elapsed after the retrieve command is entered until the record data begin to appear on the monitor.
Print Initiation Time- the elapsed time from the command to print a screen or report until it appears in the appropriate queue.
On-line Claims Adjudication Response Time- the elapsed time from the receipt of the transaction by the Contractor from the Provider and/or switch vendor until the Contractor hands-off a response to the Provider and/or switch vendor.

Systems: See Information Systems.

Telecommunication Device for the Deaf (TDD): Special telephony devices with keyboard attachments for use by individuals with hearing impairments who are unable to use conventional phones.

Third Party Resource: Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in Contract, tort, or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of an applicant for or recipient of medical assistance.

Transition of Care: The movement of patients made between health care practitioners and/or settings as their condition and care needs change during the course of a chronic or acute illness.

Urgent Care: Medically Necessary treatment for an injury, illness, or another type of Condition (usually not life threatening) which should be treated within twenty-four (24) hours.

Utilization: The rate patterns of service usage or types of service occurring within a specified time.

Utilization Management (UM): A service performed by the Contractor which seeks to assure that Covered Services provided to Members and P4HB Participants are in accordance with, and appropriate under, the standards and requirements established by the Contractor, or a similar program developed, established or administered by DCH.

Utilization Review (UR): Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of Health Care services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.
Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

Very Low Birth Weight (VLBW): Birth weight below 1,500 grams (3.3 pounds).

Week: The traditional seven-day week, Sunday through Saturday.

Withhold: A percentage of payments or set dollar amounts that a Contractor deducts from a practitioner's service fee, Capitation, or salary payment, and that may or may not be returned to the physician, depending on specific predetermined factors.

Working Days: Monday through Friday but shall not include Saturdays, Sundays, or State and Federal Holidays.

Work Week: The traditional work week, Monday through Friday.

Exhibit 2

ATTACHMENT N

DEMONSTRATION COVERED SERVICES

Family Planning Demonstration Services: Services provided to P4HB Participants must be provided by a physician or an advanced practice nurse.
Services Include:

- Family planning initial or annual exams
- Follow up, brief and comprehensive visits – up to four (4) such visits
- Contraceptive services and supplies
- Patient education and counseling
- Counseling and referrals to:
  - Social services
  - Primary health care providers
- Family planning lab tests:
  - Pregnancy tests
  - Pap Smear and Pelvic exam
    - A colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit. Only those colposcopies which can generally be performed in the office or clinic setting are coverable as a family planning-related service under this Demonstration. Colposcopies which are generally provided in an ambulatory surgery center/facility, a special procedure room/suite, an emergency room, an urgent care center or a hospital are not covered under this waiver as family planning-related services
- Screening, treatment and follow up for sexually transmitted infections (STIs), except HIV/AIDS and Hepatitis
  - Antibiotic treatment for STIs when the infections are identified during a routine family planning visit.
  - A follow up visit for the treatment/drugs may be covered
  - Subsequent follow-up visits to re-screen for STIs based on the Centers for Disease Control and Prevention guidelines
- Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified or diagnosed during a routine/periodic family planning visit. A follow-up visit for the treatment/ drugs may be covered.
- Treatment of major complications related to the delivery of Demonstration related services such as:
  - Treatment of a perforated uterus due to an intrauterine device insertion;
  - Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or,
  - Treatment of surgical or anesthesia-related complications during a sterilization procedure.
- Tubal Ligation (Sterilization)
  - Treatment and follow-up of an STI diagnosed at the time of sterilization.
- Family Planning pharmacy visits
- Folic acid and/or a multivitamin with folic acid.
- Select immunizations for P4HB Participants aged 19 and 20. The Contractor shall provide all P4HB Participants ages nineteen (19) and twenty (20) with Hepatitis B, Tetanus-Diphtheria (Td) and combined Tetanus, Diphtheria, Pertussis vaccinations according to the Advisory Committee on Immunization Practices (ACIP) guidelines as needed
- P4HB Participants age 18 receive vaccines at no cost under the Vaccines for Children (VFC) program
- Additionally women who have delivered a very low birth weight baby following implementation of the Demonstration will be eligible for Interpregnancy Care services including the Resource Mother Outreach benefit.

Interpregnancy Care (IPC) covered services:

In addition to the family planning and family planning related services listed above, P4HB Participants enrolled in the IPC component of the waiver will receive:

- Primary Care services, up to 5 office/outpatient visits
- Limited Dental Services
- Management and treatment of chronic diseases
- Substance abuse treatment including detoxification and intensive outpatient rehabilitation
- Case Management/Resource Mother Outreach
- Prescription drugs (non-family planning) for the treatment of chronic conditions that may increase the risk of a subsequent VLBW delivery
- Non emergency transportation

Resource Mother Outreach only

Resource Mothers Outreach only services are available to women who are currently enrolled in and are receiving Title XIX services and benefits but who meet all other IPC Demonstration eligibility criteria.

Exhibit 3

ATTACHMENT O

Demonstration Quality Strategy

In order to assess and improve the quality of services delivered under this Demonstration, DCH will implement a rigorous quality strategy and evaluation process formally documented as the Demonstration Evaluation Design. This design or plan will be developed with assistance from Emory University, the independent contractor charged with evaluating the effectiveness of the Demonstration. The evaluation design must incorporate key goals, objectives and a set of performance measures that align well with the logical sequence through which the Demonstration can and will affect Provider's and P4HB Participant's behavior such that the key outcomes - longer inter partum intervals, lower low birth weight rates and cost savings - can be achieved. The evaluation design must receive final approval from CMS. Reporting to CMS will occur on a quarterly and annual basis with a final report due to CMS at the end of the Demonstration period. CMO reporting will be due on a quarterly and annual basis as identified below and in the CMS Special Terms and Conditions.

The Evaluation Design will include:

- Key Goals, Objectives and Performance Targets
- Program Hypotheses
- Performance Measures
- Analysis pertaining to the achievement of the Performance Targets
- Assessment of the rate at which the Demonstration was implemented
- Assessment of the Demonstration Providers' understanding of program eligibility, service coverage and payment rates across sites of care
- Assessment of the Providers' and P4HB Participants satisfaction with the Demonstration
- Assessment of the per Demonstration year changes in family planning visits regardless of payer source, per poor and near poor women in Georgia
- Determination of averted births among P4HB Participants and tests of budget neutrality

- The relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for "targeted" versus control group women
- The relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among "targeted" and control groups
- The relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

Key Goals:
If participation in the Demonstration penetrates the eligible population to the extent hoped for and P4HB Participants are consistent users of family planning and IPC services and supplies, the DCH anticipates the following major outcomes can be achieved:

- Reduction of Georgia's low birth weight and very low birth weight rates over the course of the Demonstration period
- Reduction in the number of unintended pregnancies in Georgia
- Reduction in Georgia's Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy related services.

Program Objectives

- Improve access to family planning services by extending eligibility for family planning services to all women aged 18 – 44 years who are at or below 200% of the federal poverty level (FPL) during the three year term of the Demonstration. Achievement of this objective will be measured by:
  - Total family planning visits pre and post the Demonstration;
  - Use of contraceptive services/supplies pre and post the Demonstration;
- Provide access to inter-pregnancy primary care health services for eligible women who have previously delivered a very low birth weight infant. Achievement of this objective will be measured by:
  - Use of inter-pregnancy care services (primary care and Resource Mothers Outreach) by women with a very low birth weight delivery;
- Decrease unintended and high-risk pregnancies among Medicaid eligible women and increase child spacing intervals through effective contraceptive use to foster reduced low birth weight rates and improved health status of women. Achievement of this objective will be measured by:
  - Average inter-pregnancy intervals for women pre and post the Demonstration;
  - Average inter-pregnancy intervals for women with a very low birth weight delivery pre and post the Demonstration;
- Decrease in late teen pregnancies by reducing the number of repeat teen births among Medicaid eligible women. Achievement of this objective will be documented by:
  - The number of repeat teen births assessed annually
- Decrease the number of Medicaid-paid deliveries beginning in the second year of the Demonstration, thereby reducing annual pregnancy-related expenditures. Achievement of this objective will be measured by:
  - The number of Medicaid paid deliveries assessed annually
- Increase consistent use of contraceptive methods by incorporating care coordination and patient-directed counseling into family planning visits. Achievement of this objective will be measured by:
  - Utilization statistics for family planning methods
  - Number of Deliveries to P4HB Participants
- Increase family planning utilization among Medicaid eligible women by using an outreach and public awareness program designed with input from family planning patients and providers as well as women who are in need of services but who are not receiving them. Achievement of this objective will be measured by:
  - Enrollment statistics for the Demonstration.
- Increase the overall savings in Medicaid spending attributable to this Demonstration. Achievement of this objective will be measured by:
  - Documentation of achievement of financial savings targets

Program Hypotheses
- That the Demonstration will bring sufficient numbers of women into the program to increase the overall use of family planning services/supplies and will promote the more consistent use of effective contraceptive methods among program users.
- That increased use of contraceptives will lead to reduced unintended pregnancies and in turn, unintended births among this population of women (as well as improved inter-pregnancy intervals).
- That teens are at high risk of unintended pregnancy a related hypothesis is that the rate of unintended births and repeat teen births will also fall post implementation of the waiver.
- That these changes will be sufficient to lower the number of overall Medicaid paid deliveries/births and hence, costs, such that the state and federal government will realize a net cost savings despite increased spending on family planning services.

Performance Reporting
In order for the program objectives to be achieved there must be sufficient outreach, uptake, and implementation of the Demonstration benefits. The performance measures identified below and in the CMS Special Terms and Conditions must be reported by each CMO quarterly and annually or as identified in the CMS Special Terms and Conditions. Each CMO will report their respective CMO specific data. Reports are to be submitted to DCH within thirty (30) Calendar Days from the close of the previous quarter (April 30 for the quarter ending March 31). Semi annual survey reports are due October 1st and April 1st.

I. Assessment of the rate at which the Demonstration was implemented using Enrollment, Participation and Use of Services as Performance Measures:

- Total number of Demonstration Enrollees per CMO stratified by Demonstration component – Family Planning only; IPC; Resource Mothers only
- Total number of Demonstration Enrollees per CMO stratified by age, race and ethnicity, county;
- Average months enrolled per CMO by Age, Race/Ethnicity and County;
- Proportion of LIM population per CMO enrolled in Resource Mothers Outreach
- Total number of P4HB Participants per CMO stratified by age, race , ethnicity, county;
- Number of IPC P4HB Participants per CMO stratified by age, race and ethnicity, county;
- Number of P4HB Participants per CMO in the Resource Mothers only Outreach

- Overview of the Geographic variations in enrollment per CMO;

- Rate of use per CMO of:
  - All Family Planning Services by type;
  - All Contraceptives by type (inclusive of hormonal and non-hormonal contraceptives);
  - Counts of primary care visits for those in the IPC component of the Demonstration.
- Utilization statistics per CMO for all IPC services and IPC services by type

Sufficient "take up" of the Demonstration can only occur if both providers and women understand their new eligibility and coverage. An explanatory design component of the evaluation will help understand if there are barriers in the provider system that could prevent take up and/or visit rates.

II. Assessment of the Demonstration Providers' and P4HB Participants' understanding of program eligibility, service coverage and payment rates across sites of care

- Semi-annual CMO conducted Provider Surveys with analysis reports highlighting responses to questions regarding knowledge, understanding of the Demonstration, level of participation and training/outreach.

- Semi-annual CMO conducted P4HB Participant Surveys with analysis reports highlighting responses to questions pertaining to: satisfaction with eligibility and enrollment processes
  1. Satisfaction with CMO selection process
  2. Satisfaction with educational materials regarding the Demonstration
  3. Satisfaction with service options and services
  4. Satisfaction with contraceptive method
  5. Contraceptive failures/unintended births
  6. Satisfaction with provider selection
  7. Results and analysis of semi-annual member satisfaction surveys

The above data will be gathered through standardized semi annual Provider and P4HB Participant Surveys administered by each CMO. Survey tools will be developed by the Demonstration's evaluator and made available to each CMO for review and comment prior to being finalized. A summary of each CMO's Provider and P4HB Participant survey data and qualitative interviews must be compiled by each CMO and submitted to DCH by October 1st and April 1st of each Demonstration Year beginning with October 1st of Demonstration year 1.

III. Assessment of the per Demonstration year changes in family planning visits

- Total Demonstration expenses per CMO and stratified by Demonstration component – Family Planning Only, IPC, and Resource Mothers Outreach only
- The average per person expenditures for the IPC component per CMO
- The total expenditures per CMO for the first year infant life costs stratified by birth weight categories
- The average per person expenditures per CMO for the first year of life costs stratified by birth weight categories
- The total expenditures for VLBW deliveries per CMO
- The average per person expenditures for VLBW deliveries per CMO

IV. Determination of the number of averted births among P4HB Participants and tests of budget neutrality

- Total Pregnancies per CMO stratified by age, race/ethnicity, county/region
- Total Pregnancies per Demonstration population paid per CMO stratified by age, race/ethnicity, county/region, FP only and IPC
- Contraceptive failures per CMO stratified by age, race/ethnicity, county/region
- Actual Live Births per CMO stratified by Age, Race/Ethnicity, county/region and weight categories

V. Determination of the relationship between the Demonstration implementation and changes in pregnancy and birth rates, low birth weight rate and inter-pregnancy interval for "targeted" versus control group women

- To be calculated by the Demonstration evaluator

VI. Assessment of the relationship between the Demonstration and changes in pregnancies, unintended births, intra-partum intervals and post-partum birth control use among "targeted" and control groups:

- CMO documentation of events that occurred during the quarter or are anticipated to occur in the near future affecting the CMO's health care delivery; benefits; enrollment; grievances; quality of care; access; other operational issues
- Total Births – Live Births and Fetal Deaths stratified by age, race/ethnicity, county/region per CMO
- Unintended Births-Percent of Births Reported as Unwanted or Mistimed per CMO

VII. Assessment of the relationship of the Demonstration to changes in inter-pregnancy intervals, rate of repeat very low birth weight and preterm delivery rates

- Average number of months between pregnancies to the same woman (number of months between initial birth/fetal death event and subsequent birth/fetal death event – the gestational age of the subsequent event) per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in low birth weight or very low birth weight per CMO
- Proportion of women with a very low birth weight delivery whose next pregnancy ends in a preterm delivery per CMO

Performance Targets

- Reduction of Georgia's low birth weight and very low birth weight rates over the course of the Demonstration period as measured by:
  - 3.5% annual reduction from CY 2010 baseline in the Medicaid reported LBW and VLBW rates; or
  - 10% cumulative reduction from CY 2010 baseline in the Medicaid LBW and VLBW rates over the Demonstration period (by December 31, 2013).
  - Reports are due from the CMOs to DCH by June 30 of each Demonstration year, beginning in Demonstration year 2 which begins January 1, 2012.
  - Reports are due from the DCH MMIS by June 30 of each Demonstration Year, beginning in Demonstration Year 2 which begins January 1, 2012.

- Reduction in the number of unintended pregnancies in Georgia as measured by:
  - Percent births reported as unintended in the Medicaid population compared with baseline; and
  - 4% annual reduction in the Pregnancy Rate in the Medicaid population

- Reduction in Georgia's Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy related services. Projected state fund savings due to reductions in pregnancies and subsequent care for normal weight, low birth weight and very low birth weight infants are:

    - $9.3M in FY 12;
    - $15.5M in FY 13
    - $24.9M in FY 14

Quarterly Report Data per CMO

- Demonstration expenditures including administrative costs;
- Total number of Demonstration enrollees;
- Total number of P4HB Participants
- Total number of Demonstration enrollees stratified by age, race and ethnicity;
- Total number of P4HB Participants stratified by age, race and ethnicity
- Total number of IPC enrollees stratified by age, race and ethnicity
- Total number of IPC P4HB Participants stratified by age, race and ethnicity
- Total number of Family Planning only enrollees stratified by age, race and ethnicity
- Total number of Family Planning only P4HB Participants stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only Enrollees stratified by age, race and ethnicity
- Total number of Resource Mothers Outreach only P4HB Participants stratified by age, race and ethnicity
- Total number of P4HB Participants utilizing services
- Utilization statistics for Family Planning only services by type
- IPC Problem and Strength Identification Quarterly Summary
- Total number of Care Plans for IPC Participants
- Utilization statistics for IPC Services by type;
- Contraceptive types utilized;
- Geographic variations in enrollment;
- Total number of P4HB Participants (Participants include all individuals who obtain one or more covered family planning services through the Demonstration);
- Events occurring during the quarter, or anticipated to occur in the near future that affect:
    - health care delivery
    - benefits
    - enrollment
    - grievances
    - quality of care
    - access
    - pertinent legislative activity
    - eligibility verification activities
    - other operational issues;
- Action plans for addressing any policy and administrative issues identified; and
- Evaluation activities and interim findings.

Annual Report Data per CMO – for Demonstration year 1, appropriate baseline calculations should also be reported using Calendar Year 2010 as the baseline year. Baseline calculations to include but not be limited to: total deliveries, pregnancy rate, total births, number of still births, LBW and VLBW rates, etc.

- Top five (5) Chronic Diseases/Conditions affecting P4HB Participants in the IPC Demonstration component ;
- The total number of deliveries to Contractor's Medicaid Members;
- The pregnancy rate for Contractor's Medicaid Members;
- The number of deliveries to the P4HB Participants stratified by Demonstration component: FP Only; FP and IPC; Resource Mothers Only.
- The number of total births to the Contractor's Medicaid Members stratified by birth weight categories;
- The number of live births to P4HB Participants in the FP only component of the Demonstration stratified by birth weight categories – Normal (2,500 grams or more), LBW (1,500 grams to 2,499 grams), VLBW (less than 1,500 grams);
- The number of live births to P4HB Participants in the IPC component of the Demonstration stratified by birth weight category;
- The number of stillbirths to the IPC P4HB Participants;
- IPC Problem and Strength Identification Yearly Summary
- The number of estimated averted births (using the baseline fertility rate) in the waiver application;
- The total and average per person Medicaid expenditures for the Demonstration;
- The total and average per person Medicaid expenditures for the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for the first year infant life costs stratified by birth weight categories;
- The number of VLBW deliveries to Contractor's P4HB participants;
- The number of VLBW deliveries that occur to P4HB Participants in the IPC component of the Demonstration;
- The total and average per person Medicaid expenditures for VLBW deliveries;
- Results of P4HB Participant and Provider satisfaction surveys.

Exhibit 4

ATTACHMENT P

RESOURCE MOTHER OUTREACH

Resource Mother:

The Resource Mother provides a broad range of paraprofessional services to P4HB Participants in the Interpregnancy Care component of the Planning for Healthy Babies Program and their families. She performs certain aspects of case management including the provision of assistance in dealing with personal and social problems and may provide supportive counseling to P4HB Participants and their families and/or serve as a liaison for social services.

The Contractor has the responsibility for training the Resource Mother and must utilize the standardized Resource Mothers Training Manual specified by DCH. DCH will also provide the Resource Mother Job description and technical support for the Resource Mother Outreach program.

The Contractor must ensure the Resource Mother Outreach is effective through monitoring of the Resource Mother's performance including an evaluation of the Resource Mother's P4HB Participant contact activities and contact documentation.

The Resource Mother will carry out the following responsibilities:

- Complete P4HB Participant intakes based on interviews with P4HB Participants, their families, significant others and appropriate community agencies.

- Demonstrate skillful use of observation and assessment tools to evaluate the P4HB Participant's needs and monitor the P4HB Participant's progress towards treatment goals.

- Meet with P4HB Participants via phone or in person to increase participants' adoption of healthy behaviors, including healthy eating choices and smoking cessation; increase participants' adoption of health behaviors such as healthy eating choices and smoking cessation.

- Support P4HB Participants' compliance with primary care medical appointments including assistance with non-emergency transportation arrangements; serve as the liaison between P4HB Participants and family members, significant others, nurses, physicians, and organizational components to facilitate communication, linkage and continuity of service.

- Consult with physicians, nurses, social workers, and case managers about problems identified and assist in the development of an appropriate action plan.

- Document compliance with appointments and enrollment and participation in planned services and benefits in the P4HB Participant's case management record and/or required Demonstration forms.

- Prepare and disseminate pertinent reports for/to supervisors, colleagues and other appropriate individuals. Maintain program statistics for purposes of evaluation and research.

- Submit all data, forms and documentation per Demonstration guidelines.

- Provide short-term case management and referral services to P4HB Participants with emergency situations.

- Support P4HB Participants' compliance with medications to treat chronic health conditions including assisting the P4HB Participant with obtaining needed medications and reinforcing the need for medication compliance;

- Assist the P4HB Participant with the coordination of social services support for family and life issues; implement and organize the delivery of specific social services within the community and maintain an updated resource file.

- Assists Participants in locating and utilizing community resources including legal, medical, financial assistance, and other referral services; assist with linking mothers to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC).

- Provide emotional support for P4HB Participants following substance abuse treatment;

- Provide mentoring for P4HB Participants;

- Assist mothers of VLBW babies to obtain regular preventive health visits and appropriate immunizations for their child;

- Link the VLBW infant's mother with community resources such as WIC;

- Provide the mother with the peer and emotional support needed to meet the health demands of her VLBW infant;

- Encourage the VLBW infant's mother to implement the parenting and child safety concepts taught during classes the mother will be encouraged to attend.

Technical Competencies of the Resource Mother

Successfully complete Resource Mother training module and participate in ongoing in-service training as provided
Knowledge of agency policies and procedures.
Ability to coordinate and organize the delivery services.
Ability to monitor client's progress toward meeting established goals.
Knowledge of client's treatment goals.
Ability to interview clients and/or families using established techniques.
Ability to develop client profile.
Knowledge of agency confidentiality policies.
Knowledge of state and federal confidentiality laws and regulations.
Knowledge of available community resources.
Ability to make appropriate referrals.
Knowledge of crisis intervention.
Ability to develop P4HB Participant service plan to habilitate and P4HB Participant in attaining social, educational and vocational goals
Ability to contact health care professionals to obtain additional background information.
Knowledge of target population.
Knowledge of agency specific software.
Knowledge of available databases.
Ability to prepare reports and case history records.
Knowledge of eligibility requirements.
Knowledge of what qualifies as an emergency situation.

Entry Qualifications

High school diploma or GED and two years experience in a social services related position or Bachelor's degree in a social services related field
Valid driver's license
Reliable vehicle with motor vehicle insurance coverage
Good communication skills. Comfortable communicating with both professionals (physicians, nurses, social workers, etc.) and with lay persons

NUMBER: **11-W-00249/4**

TITLE: **Planning for Healthy Babies (P4HB)**

AWARDEE: **Georgia Department of Community Health**

I. PREFACE

The following are the Special Terms and Conditions (STCs) for Georgia's section 1115(a) Medicaid Demonstration (hereinafter "Demonstration"). The parties to this agreement are the Georgia Department of Community Health and the Centers for Medicare & Medicaid Services (CMS). The STCs set forth in detail the nature, character, and extent of Federal involvement in the Demonstration and the State's obligations to CMS during the life of the Demonstration. The STCs are effective January 1, 2011, unless otherwise specified. This Demonstration is approved through December 31, 2013.

The STCs have been arranged into the following subject areas:

I. Preface
II. Program Description and Objectives
III. General Program Requirements
IV. Eligibility
V. Benefits and Delivery Systems
VI. General Reporting Requirements
VII. General Financial Requirements
VIII. Monitoring Budget Neutrality
IX. Evaluation of the Demonstration
X. Schedule of State Deliverables for the Demonstration

II. PROGRAM DESCRIPTION AND OBJECTIVES

The Georgia P4HB section 1115(a) Medicaid Demonstration expands the provision of family planning (FP) services to uninsured women, ages 18 through 44, who have family income at or below 200 percent of the Federal poverty level (FPL), and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP).

In addition, the Demonstration provides Interpregnancy Care (IPC) services to women who meet the same eligibility requirements above and who deliver a very low birth weight (VLBW) baby (less than 1,500 grams or 3 pounds, 5 ounces) on or after January 1, 2011.

Women, ages 18 through 44, who have family income at or below 200 percent of the FPL, who deliver a VLBW baby on or after January 1, 2011, and who qualify under the Low Income Medicaid Class of Assistance, or the Aged Blind and Disabled Classes of Assistance, under the Georgia Medicaid State plan are also eligible for the Resource Mothers Outreach component of the IPC services which are not otherwise available under the Georgia Medicaid State plan.

Under this Demonstration, Georgia expects to achieve the following to promote the objectives of title XIX:

- Reduce Georgia's low birth weight (LBW) and VLBW rates;
- Reduce the number of unintended pregnancies in Georgia;
- Reduce Georgia's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services;
- Provide access to IPC health services for eligible women who have previously delivered a VLBW baby; and
- Increase child spacing intervals through effective contraceptive use.

III. GENERAL PROGRAM REQUIREMENTS

1. **Compliance with Federal Non-Discrimination Statutes.** The State must comply with all applicable Federal statutes relating to non-discrimination. These include, but are not limited to, the Americans with Disabilities Act of 1990, title VI of the Civil Rights Act of 1964, section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975.

2. **Compliance with Medicaid Law, Regulation, and Policy.** All requirements of the Medicaid programs expressed in law, regulation, court order, and policy statement not expressly waived or identified as not applicable in the waiver and expenditure authority documents (of which these terms and conditions are part), must apply to the Demonstration.

3. **Changes in Medicaid Law, Regulation, and Policy.** The State must, within the timeframes specified in law, regulation, court order, or policy statement, come into compliance with any changes in Federal law, regulation, court order, or policy affecting the Medicaid programs that occur during this Demonstration approval period, unless the provision being changed is explicitly waived or identified as not applicable.

4. **Impact on Demonstration of Changes in Federal Law, Regulation, and Policy Statements.**

   a) To the extent that a change in Federal law, regulation, final court order, or policy requires either a reduction or an increase in Federal financial participation (FFP) for expenditures made under this Demonstration, the State must adopt, subject to CMS approval, a modified budget neutrality agreement for the Demonstration as necessary to comply with such change. The modified agreement will be effective upon the implementation of the change.

   b) If mandated changes in Federal law require State legislation, the changes must take effect on the day such State legislation becomes effective, or on the last day such legislation was required to be in effect under the law.

5. **State Plan Amendments.** The State will not be required to submit title XIX or title XXI State plan amendments for changes affecting any populations made eligible solely through the Demonstration. If a population eligible through the Medicaid State plan is affected by a change to the Demonstration, a conforming amendment to the appropriate State plan may be required, except as otherwise noted in these STCs.

6. **Changes Subject to the Amendment Process.** Changes related to eligibility, enrollment, benefits, delivery systems, cost sharing, sources of non-Federal share of funding, budget neutrality, and other comparable program elements in these STCs must be submitted to CMS as amendments to the Demonstration. All amendment requests are subject to approval at the discretion of the Secretary of the Department of Health and Human Services in accordance with section 1115 of the Act. The State must not implement changes to these elements without prior approval by CMS. Amendments to the Demonstration are not retroactive and FFP will not be available for changes to the Demonstration that have not been approved through the amendment process set forth in paragraph 7 below. The State will notify CMS of proposed Demonstration changes during the quarterly monitoring call, as well as in the written quarterly report, to determine if a formal amendment is necessary.

7. **Amendment Process.** Requests to amend the Demonstration must be submitted to CMS for approval no later than 120 days prior to the planned date of implementation of the change and may not be implemented until approved. CMS reserves the right to deny or delay approval of a Demonstration amendment based on non-compliance with these STCs, including, but not limited to, failure by the State to submit required reports and other deliverables in a timely fashion according to the deadlines specified therein. Amendment requests must include, but are not limited to, the following:

   a) An explanation of the public process used by the State consistent with the requirements of paragraph 12 to reach a decision regarding the requested amendment;

   b) A data analysis which identifies the specific "with waiver" impact of the proposed amendment on the current budget neutrality expenditure limit. Such analysis must include current "with waiver" and "without waiver" status on both a summary and detailed level through the current extension approval period using the most recent actual expenditures, as well as summary and detailed projections of the change in the "with waiver" expenditure total as a result of the proposed amendment which isolates (by Eligibility Group) the impact of the amendment;

   c) A detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation; and

   d) If applicable, a description of how the evaluation design must be modified to incorporate the amendment provisions.

8. **CMS Right to Terminate or Suspend.** CMS may suspend or terminate the Demonstration, in whole or in part, at any time before the date of expiration, whenever it determines, following a hearing, that the State has materially failed to comply with the terms of the project. CMS will promptly notify the State in writing of the determination and the reasons for the suspension or termination, together with the effective date.

9. **Finding of Non-Compliance.** The State does not relinquish its rights to challenge the CMS finding that the State materially failed to comply.

10. **Withdrawal of Waiver Authority.** CMS reserves the right to withdraw waivers or expenditure authorities at any time it determines that continuing the waivers or expenditure authorities would no longer be in the public interest or promote the objectives of title XIX. CMS must promptly notify the State in writing of the determination and the reasons for the withdrawal, together with the effective date, and must afford the State an opportunity to request a hearing to challenge CMS' determination prior to the effective date. If a waiver or expenditure authority is withdrawn, FFP is limited to normal closeout costs associated with terminating the waiver or expenditure authorities, including services and administrative costs of disenrolling participants.

11. **Adequacy of Infrastructure.** The State must ensure the availability of adequate resources for implementation and monitoring of the Demonstration, including education, outreach, and enrollment; maintaining eligibility systems; compliance with cost sharing requirements to the extent they apply; and reporting on financial and other Demonstration components.

12. **Public Notice, Tribal Consultation, and Consultation with Interested Parties.** The State must continue to comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994) and the tribal consultation requirements pursuant to section 1902(a)(73) of the Act as amended by section 5006(e) of the ARRA, when any program changes to the Demonstration, including, but not limited to, those referenced in STC 7, are proposed by the State. In States with Federally recognized Indian Tribes, Indian health programs, and/or Urban Indian organizations, the State is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any Demonstration proposal, amendment and/or renewal of this Demonstration.

13. FFP. No Federal matching funds for expenditures for this Demonstration will take effect until the effective date identified in the Demonstration approval letter.

14. Citizenship Documentation Requirements. For individuals who have declared that they are United States citizens or nationals, the State must only enroll individuals into the Demonstration who document citizenship or nationality in accordance with sections 1902(a)(46) and 1903 of the Act. The State may establish citizenship or nationality using the process set out in section 1902(ee) of the Act in lieu of the documentation requirements set forth in sections 1902(a)(46) and 1903 of the Act to the extent permitted by that section.

IV. ELIGIBILITY

15. **Eligibility Requirements.** The State must enroll only individuals meeting the following eligibility criteria into the family planning component of the Demonstration:

    1. Uninsured women, ages 18 through 44, losing Medicaid pregnancy coverage at the conclusion of 60 days postpartum, who are not otherwise eligible for Medicaid or CHIP; and
    2. Uninsured women, ages 18 through 44, who have family income up to and including 200 percent of the FPL, who are not otherwise eligible for Medicaid or CHIP.

    The State must enroll only individuals meeting the following eligibility criteria into the IPC component of the Demonstration:

    · Uninsured women, ages 18 through 44, who deliver a VLBW baby on or after January 1, 2011, who have family income up to and including 200 percent of the FPL, who are not otherwise eligible for Medicaid or CHIP.

    The State will enroll individuals into the Resource Mothers Outreach component of the Demonstration who are:

    · Women, ages 18 through 44, who qualify under the Low Income Medicaid Class of Assistance or Aged Blind and Disabled Classes of Assistance under the Georgia Medicaid State plan and deliver a VLBW baby on or after January 1, 2011.

16. **Demonstration Enrollment.** Women already enrolled in a Georgia Families Care Management Organization (CMO) due to pregnancy will have an expedited enrollment into the plan with which they are currently affiliated. These women will be afforded the opportunity to choose a new CMO if desired. The enrollment processes for each component of the Demonstration are described below:

a) **FP Component.** The State will follow applicable Federal law and regulations for determining eligibility and enrolling those deemed eligible into one of the CMOs. Individuals must enroll in a managed care plan to receive family planning and family planning-related services.

b) **IPC Component.** Women in the IPC component must enroll in a managed care plan to receive Family Planning and IPC services.

c) **Resource Mothers Outreach.**

   i. Women ages 18 through 44 who qualify under the Low Income Medicaid Class of Assistance under the Georgia Medicaid State plan are mandatorily enrolled into one of the CMOs per the Medicaid State plan. These women will receive Resource Mothers Outreach through the CMOs in which they are enrolled at the time of delivery of their VLBW baby. The State will follow standard Medicaid managed care rules regarding choice of plans.

   ii. Women ages 18 through 44 who qualify under the Aged Blind and Disabled Classes of Assistance under the Georgia Medicaid State Plan and who deliver a VLBW baby on or after January 1, 2011, will receive Resource Mothers Outreach via a CMO. They will not be enrolled into a CMO, but will be allowed to choose a CMO through which they will receive only Resource Mothers Outreach services.

17. **Demonstration Disenrollment.** If a woman becomes pregnant while enrolled in the Demonstration, she may be determined eligible for Medicaid under the State plan. An individual who is enrolled in a Medicaid State plan eligibility category will only be eligible for Resource Mothers Outreach services under the Demonstration if they have had a VLBW delivery on or after January 1, 2011.

    The State must not submit claims under the Demonstration for any individual who is found to be eligible under the Medicaid State plan except for those individuals eligible under the Medicaid State plan who are eligible for Resource Mothers Outreach services.

    In addition, women who receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled from the Demonstration.

    Women in the IPC component will be disenrolled after 2 years of participation.

18. **Redeterminations.** The State must ensure that redeterminations of eligibility for the Demonstration are conducted at least every 12 months.

19. **Primary Care Referral.** The State assures CMS that providers of family planning services will make appropriate referrals to primary care providers as medically indicated. The State also assures that individuals enrolled in this Demonstration receive information about how to access primary care services.

V. BENEFITS AND DELIVERY SYSTEMS

20. **Benefits.** Family planning services and supplies described in section 1905(a)(4)(C) of the Act are reimbursable at the 90 percent matching rate, including:
    a) Approved methods of contraception;
    b) Sexually transmitted infection testing, including Pap tests and pelvic exams;
    c) Drugs, supplies, or devices related to women's health services described above that are prescribed by a health care provider who meets the State's provider enrollment requirements; (subject to the national drug rebate program requirements); and,
    d) Contraceptive management, patient education, and counseling.

21. **Family Planning-Related Benefits.** Family planning-related services are provided as part of, or as follow-up to, a family planning visit and are reimbursable at the State's regular FMAP rate. The following are examples of family-planning related services:

    a) Drugs for the treatment of sexually-transmitted infections (STIs), except for HIV/AIDS and hepatitis, when the STI is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered. In addition, subsequent follow-up visits to rescreen for STIs based on the Centers for Disease Control and Prevention guidelines may be covered.

    b) Drugs for the treatment of lower genital tract and genital skin infections/disorders, and urinary tract infections, when the infection/disorder is identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may be covered.

22. **Primary Care Referrals.** Primary care referrals to other social service and health care providers as medically indicated are provided; however, the costs of those primary care services are only covered for women enrolled in the IPC component of the Demonstration. These primary care services are not covered for enrollees who are not in the IPC component of this Demonstration.

23. **Vitamins.** Participants will have access to folic acid and/or a multivitamin with folic acid, and this benefit will be reimbursable at the State's FMAP rate.

24. **Immunization Benefits.** Participants ages 19 and 20, will be eligible to receive the Hepatitis B, tetanus-diphtheria (Td), and combined tetanus, diphtheria, and pertussis (TdAP) vaccinations. Participants who are 18 years old are eligible to receive immunizations at no cost via the Vaccines for Children (VFC) Program. These services are reimbursable at the State's FMAP rate.

25. **IPC Component Benefits.** In addition to the family planning and family planning-related services described above, women who are enrolled in the IPC component of the Demonstration are also eligible for the benefits described in the table below. These services are reimbursable at the State's FMAP rate.

Services	Notes/ Limitations
Primary care	
5 office/outpatient visits	
Management and treatment of chronic diseases	
Substance use disorder treatment (detoxification and intensive outpatient rehabilitation)	Referral required
Case management/ Resource Mother Outreach	
Limited Dental	
Prescription Drugs (non-family planning)	

    Women enrolled in the IPC component will also have access to non-emergency medical transportation.

26. **Resource Mother Outreach.** Women served under the IPC and Resource Mother components of the Demonstration, will have access to Resource Mother Outreach. The CMOs will employ or contract with Resource Mothers, and the Resource Mothers will assist nurse case managers to achieve the following goals:
    a) Increase the participant's adoption of healthy behaviors such as healthy eating choices and smoking cessation;
    b) Support the participant's compliance with primary care medical appointments, including assisting with arranging non-emergency medical transportation;
    c) Assist the mother of a VLBW baby to obtain regular preventive health visits and appropriate immunizations for her child;
    d) Support the participant's compliance with medications to treat chronic health conditions
    e) Assist with coordination of social services support; and,
    f) Assist with linking mothers to community resources such as the Special Supplemental Nutrition Program for Women, Infants, and Children.

27. **Delivery System.** Services provided through this Demonstration are paid via a managed care delivery system via CMOs. Standard Medicaid managed care rules will apply including freedom of choice of provider for family planning services as specified in 42 CFR 431.51(a)(5).

VI.GENERAL REPORTING REQUIREMENTS

28. **General Financial Requirements.** The State must comply with all general financial requirements under title XIX set forth in section VII of these STCs.

29. **Reporting Requirements Relating to Budget Neutrality.** The State must comply with all reporting requirements for monitoring budget neutrality as set forth in section VIII of these STCs.

30. **Compliance with Managed Care Reporting Requirements.** The State must comply with all managed care reporting regulations at 42 CFR Part 438*et seq.*, except as expressly waived or referenced in the expenditure authorities incorporated into these STCs.

31. **Monitoring Calls.** CMS will schedule quarterly monitoring calls with the State, unless CMS determines that more frequent calls are necessary to adequately monitor the Demonstration. The purpose of these calls is to discuss any significant actual or anticipated developments affecting the Demonstration. Areas to be addressed include, but are not limited to, health care delivery, enrollment, quality of care, access, benefits, audits, lawsuits, financial reporting and budget neutrality issues, progress on evaluations, State legislative developments, quarterly reports, and any Demonstration amendments the State is considering submitting.

The State and CMS will discuss quarterly expenditure reports submitted by the State for purposes of monitoring budget neutrality. CMS will update the State on any amendments under review as well as Federal policies and issues that may affect any aspect of the Demonstration. The State and CMS will jointly develop the agenda for the calls.

32. **Quarterly Progress Reports.** The State must submit progress reports no later than 60 days following the end of each quarter. The intent of these reports is to present the State's data along with an analysis of the status of the various operational areas under the Demonstration. These quarterly reports must include, but are not limited to:
    a) An updated budget neutrality monitoring worksheet;
    b) Expenditures including administrative costs;
    c) Total number of enrollees;
    d) Total number of participants (Participants include all individuals who obtain one or more covered family planning services through the Demonstration);
    e) Events occurring during the quarter, or anticipated to occur in the near future that affect health care delivery, benefits, enrollment, grievances, quality of care, access, pertinent legislative activity, eligibility verification activities, and other operational issues;
    f) Action plans for addressing any policy and administrative issues identified; and
    g) Evaluation activities and interim findings.

33. **Annual Report.** The annual report is due 120 days following the end of the fourth quarter of each Demonstration year, and must include a summary of the year's preceding activity as well as the following:

    a) The number of actual births that occur to participants in the FP component of the Demonstration broken out by birth weight category;
        i. Normal (2,500 grams or more)
        ii. LBW (1,500 grams to 2,499 grams)
        iii. VLBW (less than 1,500 grams)

    b) The number of total Medicaid births broken out by birth weight category;

    c) The number of actual births that occur to women in the IPC component of the Demonstration broken out by birth weight category;

    d) The average total Medicaid expenditures for the first-year infant life costs broken out by birth weight category;

    e) Results of member and provider satisfaction surveys; and

    f) An interim evaluation report as described in paragraph 54 of these STCs.

34. Transition Plan. The State is required to prepare, and incrementally revise a Transition Plan, consistent with the provisions of the Affordable Care Act, for individuals enrolled in the Demonstration, including how the State plans to coordinate the transition of these individuals to a coverage option available under the Affordable Care Act without interruption in coverage to the maximum extent possible. The State must submit a draft to CMS by July 1, 2012, with progress updates included in each quarterly and annual report thereafter. The State will revise the Transition Plan as needed.

35. Final Report. The State must submit a final report to CMS to describe the impact of the Demonstration, including the extent to which the State met the goals of the Demonstration. The draft report will be due to CMS 6 months after the expiration of the Demonstration. The State must submit a final report within 60 days of receipt of CMS comments.

VII.GENERAL FINANCIAL REQUIREMENTS

36. **Quarterly Expenditure Reports.** The State must provide quarterly expenditure reports using the form CMS-64 to report total expenditures for services provided under the Medicaid program, including those provided through the Demonstration under section 1115 authority. This project is approved for expenditures applicable to services rendered during the Demonstration period. CMS must provide FFP for allowable Demonstration expenditures only as long as they do not exceed the pre-defined limits on the costs incurred as specified in Section VIII of these STCs.

37. **Reporting Expenditures Subject to the Title XIX Budget Neutrality Agreement.** The following describes the reporting of expenditures subject to the budget neutrality limit:

    a) **Tracking Expenditures.** In order to track expenditures under this Demonstration, Georgia must report Demonstration expenditures through the Medicaid and CHIP Budget and Expenditure System (MBES/CBES); following routine CMS-64 reporting instructions outlined in section 2500 of the State Medicaid Manual. All Demonstration expenditures claimed under the authority of title XIX of the Act and subject to the budget neutrality expenditure limit must be reported each quarter on separate Forms CMS-64.9 Waiver and/or CMS-64.9P Waiver, identified by the Demonstration project number assigned by CMS, including the project number extension, which indicates the Demonstration Year (DY) in which services were rendered or for which capitation payments were made.

    b) **Cost Settlements.** For monitoring purposes, cost settlements attributable to the Demonstration must be recorded on the appropriate prior period adjustment schedules (Form CMS-64.9P Waiver) for the Summary Sheet Line 10B, in lieu of Lines 9 or 10C. For any other cost settlements not attributable to this Demonstration, the adjustments should be reported on lines 9 or 10C as instructed in the State Medicaid Manual.

    c) **Use of Waiver Forms.** The following 3 waiver forms CMS-64.9 Waiver and/or CMS-64.9 P Waiver must be submitted each quarter (when applicable) to report title XIX expenditures for individuals enrolled in the Demonstration. The expressions in quotation marks are the waiver names to be used to designate these waiver forms in the MBES/CBES system.

        (i) "FP Benefits" expenditures – This includes expenditures for all family planning and family planning-related benefits for women enrolled in the Demonstration.
        (ii) "IPC Benefits" expenditures – This includes only expenditures for IPC benefits for women enrolled in the IPC component of the Demonstration.
        (iii) **"Outreach"** expenditures – This includes only expenditures for the Resource Mother Outreach that women eligible under the Medicaid State plan receive.

d) **Pharmacy Rebates.** The State may propose a methodology for assigning a portion of pharmacy rebates to the Demonstration, in a way that reasonably reflects the actual rebate-eligible pharmacy utilization of the Demonstration population, and which reasonably identifies pharmacy rebate amounts with DYs. Use of the methodology is subject to the approval in advance by the CMS Regional Office, and changes to the methodology must also be approved in advance by the Regional Office. The portion of pharmacy rebates assigned to the Demonstration using the approved methodology will be reported on the appropriate Form CMS-64.9 Waiver for the Demonstration, and not on any other CMS-64.9 form (to avoid double-counting). Each rebate amount must be distributed as State and Federal revenue consistent with the Federal matching rates under which the claim was paid.

e) **Title XIX Administrative Costs.** Administrative costs will not be included in the budget neutrality agreement, but the State must separately track and report additional administrative costs that are directly attributable to the Demonstration. All administrative costs must be identified on the Forms CMS-64.10.

f) **Claiming Period.** All claims for expenditures subject to the budget neutrality agreement (including any cost settlements) must be made within 2 years after the calendar quarter in which the State made the expenditures. All claims for services during the Demonstration period (including any cost settlements) must be made within 2 years after the conclusion or termination of the Demonstration. During the latter 2-year period, the State must continue to identify separately net expenditures related to dates of service during the operation of the Demonstration on the CMS-64 waiver forms in order to properly account for these expenditures in determining budget neutrality.

38. **Standard Medicaid Funding Process.** The standard Medicaid funding process must be used during the Demonstration. The State must estimate matchable Demonstration expenditures (total computable and Federal share) subject to the budget neutrality expenditure limit and separately report these expenditures by quarter for each Federal fiscal year on the Form CMS-37 for both the Medical Assistance Payments (MAP) and State and

Local Administration Costs (ADM). CMS shall make Federal funds available based upon the State's estimate, as approved by CMS. Within 30 days after the end of each quarter, the State must submit the Form CMS-64 quarterly Medicaid expenditure report, showing Medicaid expenditures made in the quarter just ended. CMS shall reconcile expenditures reported on the Form CMS-64 with Federal funding previously made available to the State, and include the reconciling adjustment in the finalization of the grant award to the State.

39. **Extent of FFP for Family Planning and Family Planning Related Services.** CMS shall provide FFP for services (including prescriptions) provided to women at the following rates:

a) For procedures or services clearly provided or performed for the primary purpose of family planning (i.e., contraceptive initiation, periodic or inter-periodic contraceptive management, and sterilizations), and which are provided in a family planning setting, FFP will be available at the 90 percent Federal matching rate. Reimbursable procedure codes for office visits, laboratory tests, and certain other procedures must carry a primary diagnosis or a modifier that specifically identifies them as a family planning service. Note: The laboratory tests performed during an initial family planning visit for contraception include a Pap smear, screening tests for STIs, blood counts, and pregnancy test. Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or needed during an inter-periodic family planning visit for contraception.

   Allowable family planning expenditures eligible for reimbursement at the enhanced family planning match rate should be entered in Column (D) on the appropriate waiver sheets.

b) In order for family planning-related services to be reimbursed at the FMAP rate they must be defined as those services generally performed as part of, or as follow-up to, a family planning service for contraception. Such services are provided because a "family planning-related" problem was identified/diagnosed during a routine/periodic family planning visit. These expenditures should be entered in Column (B) on the appropriate waiver sheets. Four kinds of family planning related services are recognized:

   i. A colposcopy (and procedures done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.

   ii. Treatment/drugs for STIs, except for HIV/AIDS and hepatitis, where the STIs are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered at the applicable Federal matching rate for the State. Subsequent follow-up visits to rescreen for STIs based on the Centers for Disease Control and Prevention guidelines may be covered at the applicable Federal matching rate for the State.

   iii. Treatment/drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a routine/periodic family planning visit. A follow-up visit/encounter for the treatment/drugs may be covered at the applicable Federal matching rate for the State.

   iv. Treatment of major complications such as:

   · Treatment of a perforated uterus due to an intrauterine device insertion;
   · Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring a dilation and curettage; or
   · Treatment of surgical or anesthesia-related complications during a sterilization procedure.

c) FFP will not be available for the costs of any services, items, or procedures that do not meet the requirements specified above, even if family planning clinics or providers provide them. For example, in the instance of testing for STIs as part of a family planning visit, FFP will be available at the 90 percent Federal matching rate. The match rate for the subsequent treatment would be paid at the applicable Federal matching rate for the State. For testing or treatment not associated with a family planning visit, no FFP will be available.

d) CMS will provide FFP at the appropriate 50 percent administrative match rate for general administration costs, such as, but not limited to, claims processing, eligibility assistance and determinations, outreach, program development, evaluation, and program monitoring and reporting.

40. Extent of FFP for IPC Services. CMS shall provide FFP for services described in paragraph 25 for women who enrolled in the IPC component of the Demonstration at the State's regular Federal matching rate.

41. **Sources of Non-Federal Share.** The State must certify that the non-Federal share of funds for the Demonstration are State/local monies. The State further certifies that such funds must not be used to match for any other Federal grant or contract, except as permitted by law. All sources of non-Federal funding must be compliant with section 1903(w) of the Act and applicable regulations. In addition, all sources of the non-Federal share of funding are subject to CMS approval.

a) CMS reserves the right to review the sources of the non-Federal share of funding for the Demonstration at any time. The State agrees that all funding sources deemed unacceptable by CMS must be addressed within the time frames set by CMS.
b) Any amendments that impact the financial status of the program must require the State to provide information to CMS regarding all sources of the non-Federal share of funding.

42. **State Certification of Funding Conditions.** The State must certify that the following conditions for non-Federal share of Demonstration expenditures are met:

a) Units of government, including governmentally operated health care providers, may certify that State or local tax dollars have been expended as the non-Federal share of funds under the Demonstration.

b) To the extent the State utilizes certified public expenditures (CPEs) as the funding mechanism for title XIX (or under section 1115 authority) payments, CMS must approve a cost reimbursement methodology. This methodology must include a detailed explanation of the process by which the State would identify those costs eligible under title XIX (or under section 1115 authority) for purposes of certifying public expenditures.

c) To the extent the State utilizes CPEs as the funding mechanism to claim Federal match for payments under the Demonstration, governmental entities to which general revenue funds are appropriated must certify to the State the amount of such tax revenue (State or local) used to satisfy Demonstration expenditures. The entities that incurred the cost must also provide cost documentation to support the State's claim for Federal match.

d) The State may use intergovernmental transfers to the extent that such funds are derived from State or local tax revenues and are transferred by units of government within the State. Any transfers from governmentally-operated health care providers must be made in an amount not to exceed the non-Federal share of title XIX payments. Under all circumstances, health care providers must retain 100 percent of the claimed expenditure. Moreover, no pre-arranged agreements (contractual or otherwise) exist between health care providers and State and/or local government to return and/or redirect any portion of the Medicaid payments. This confirmation of Medicaid payment retention is made with the understanding that payments that are the normal operating expenses of conducting business, such as payments related to taxes, (including health care provider-related taxes), fees, business relationships with governments that are unrelated to Medicaid and in which there is no connection to Medicaid payments, are not considered returning and/or redirecting a Medicaid payment.

43. **Monitoring the Demonstration.** The State must provide CMS with information to effectively monitor the Demonstration, upon request, in a reasonable time frame.

44. **Program Integrity.** The State must have processes in place to ensure that there is no duplication of Federal funding for any aspect of the Demonstration. Specifically, the State must ensure that there is no duplication of Federal funding between the State's Maternal, Infant, and Early Childhood Home Visiting Program and the Demonstration. In addition, the State must ensure that there is no duplication of Federal funding between the State's VFC Program and the Demonstration. The State must confirm in each quarterly and annual report that there is no duplication of funding.

VIII. MONITORING BUDGET NEUTRALITY

45. **Limit on Title XIX Funding.** The State shall be subject to a limit on the amount of Federal title XIX funding that the State may receive on selected Medicaid expenditures during the period of approval of the Demonstration. The budget neutrality expenditure targets are set on a yearly basis with a cumulative budget neutrality expenditure limit for the length of the entire Demonstration. Actual expenditures subject to the budget neutrality expenditure limit shall be reported by the State using the procedures described in section VII, paragraph 37 of these STCs.

46. **Risk.** Georgia shall be at risk for the per capita cost (as determined by the method described below in this section) for Medicaid eligibles in the "FP Benefits" eligibility group, but not for the number of Demonstration eligibles in this group. By providing FFP for enrollees in this eligibility group, Georgia shall not be at risk for changing economic conditions that impact enrollment levels. However, by placing Georgia at risk for the per capita costs for enrollees in the family planning component of the Demonstration, CMS assures that Federal Demonstration expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration. Georgia will be at risk for both per capita costs and enrollment for "IPC Benefits."

47. **Budget Neutrality Annual Expenditure Limits.** For each DY, two annual limits are calculated: one for the FP component of the Demonstration and one for the IPC component of the Demonstration, as described in paragraphs 48 and 49 below.

48. **FP Component Budget Limit.** The FP Component budget limit is calculated as the projected per member/per month (PMPM) cost times the actual number of member months for "FP Benefits," multiplied by the Composite Federal Share.

a) **PMPM Cost.** The following table gives the projected PMPM (Federal share) costs for the calculation described above by DY.

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b) **Composite Federal Share.** The Composite Federal Share is the ratio calculated by dividing the sum total of FFP received by the State on actual Demonstration expenditures during the 3-year approval period, as reported on the forms listed in paragraph 37 above, by total computable Demonstration expenditures for the same period as reported on the same forms. Should the Demonstration be terminated prior to the end of the 3-year approval period (see paragraph 8), the Composite Federal Share will be determined based on actual expenditures for the period in which the Demonstration was active. For the purpose of interim monitoring of budget neutrality, a reasonable Composite Federal Share may be used.

c) The FP Component is structured as a "pass-through" or "hypothetical" population. Therefore, the State may not derive savings from this component.

49. **IPC Component Budget Limit.** The annual budget limit for the IPC component of the Demonstration will be the estimated cost-savings of the VLBW and LBW births averted as described below:

a) VLBW Birth Averted = Birth Averted * Medicaid Costs for VLBW Infants up to 1 year of life

- The Medicaid Cost of a VLBW Infant equals (the cost of VLBW infants up to 1 year of life)/ number of VLBW live births, where the costs and number of VLBW live births pertain to the Georgia Medicaid Program.

b) LBW Birth Averted = Birth Averted * Medicaid Costs for LBW Infants up to 1 year of life

- The Medicaid Cost of a LBW Infant equals (the cost of LBW infants up to 1 year of life)/ number of LBW live births, where the costs and number of LBW live births pertain to the Georgia Medicaid Program.

c) Application of the IPC Budget Limit. The budget limit calculated above will apply to IPC expenditures, as reported by the State on the CMS-64 forms. If, at the end of the Demonstration period, the costs of the Demonstration services exceed the IPC budget limit, the excess Federal funds will be returned to CMS.

50. **Future Adjustments to the Budget Neutrality Expenditure Limit.** CMS reserves the right to adjust the budget neutrality expenditure limit to be consistent with enforcement of impermissible provider payments, health care-related taxes, new Federal statutes, or policy interpretations implemented through letters, memoranda, or regulations with respect to the provision of services covered under the Demonstration.

51. **Enforcement of Budget Neutrality.** CMS will enforce budget neutrality over the life of the Demonstration, rather than annually. However, no later than 6 months after the end of each DY, or as soon thereafter as data are available, the State will calculate annual expenditure targets for the IPC component of the Demonstration for the completed year. This amount will be compared with the actual claimed FFP for Medicaid. Using the schedule below as a guide, if the State exceeds these targets, it will submit a corrective action plan to CMS for approval. The State will subsequently implement the corrective action plan.

Year	Cumulative Target Expenditures	Percentage

2011	DY 1 budget limit amount	+4 percent
2012	DY 1 and 2 combined budget limit amount	+2 percent
2013	DYs 1 through 3 combined budget limit amount	+0 percent

a) Failure to Meet Budget Neutrality Goals. The State, whenever it determines that the Demonstration is not budget neutral or is informed by CMS that the Demonstration is not budget neutral, must immediately collaborate with CMS on corrective actions, which must include submitting a corrective action plan to CMS within 21 days of the date the State is informed of the problem. While CMS will pursue corrective actions with the State, CMS will work with the State to set reasonable goals that will ensure that the State is in compliance.

b) Use of "Savings." The State may only use savings from averting LBW and VLBW births to provide IPC services to women who have delivered a VLBW baby.

c) Definition of "With" and "Without" Waiver IPC Component Demonstration Costs. The "with"(WW) and "without" (WOW) Demonstration costs (Federal share) follow. The "without" Demonstration costs are estimates of the costs of VLBW and LBW births that would occur in the absence of the Demonstration. The "with" Demonstration costs are estimates of IPC services provided with the Demonstration in effect. Total "with" and "without" Demonstration costs (Federal share) including the cost of the FP Component is also shown in the table below.

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IX. PRIMARY CARE REFERRAL AND EVALUATION

52. **Access to Primary Care Services.** The State must facilitate access to primary care services for enrollees in the Demonstration. The State must assure CMS that written materials concerning access to primary care services are distributed to the Demonstration participants. The written materials must explain to the participants how they can access primary care services.

53. Submission of Draft Evaluation Design. A draft evaluation design report must be submitted to CMS for approval within 120 days from the award of the Demonstration. At a minimum, the evaluation design should include a detailed analysis plan that describes how the effects of the Demonstration will be isolated from those of other initiatives occurring in the State. The report should also include an integrated presentation and discussion of the specific hypotheses (including those that focus specifically on the target population for the Demonstration) that are being tested. The report will also discuss the outcome measures that will be used in evaluating the impact of the Demonstration, particularly among the target population. It will also discuss the data sources and sampling methodology for assessing these outcomes. The State must implement the evaluation design and report its progress in each of the Demonstration's quarterly and annual reports.

The evaluation design must be based on a quasi-experimental design. In addition, the experimental and control groups must exhibit baseline equivalence on the following characteristics: (1) the parent or baby's race and ethnicity; and (2) socioeconomic status.

The State must ensure that the draft evaluation design will address the following evaluation questions:

1. To what extent is the Demonstration reducing the LBW and VLBW rates in Georgia?
2. To what extent is the Demonstration reducing the infant mortality rate in Georgia?
3. To what extent is the Demonstration reducing the number of unintended pregnancies in Georgia?
4. To what extent is the Demonstration reducing Georgia's Medicaid costs by reducing the number of unintended pregnancies by women who otherwise would be eligible for Medicaid pregnancy-related services?\
5. To what extent is the Demonstration increasing child spacing intervals?
6. To what extent is the Demonstration improving the health status of women enrolled in the IPC component of the Demonstration?

54. **Interim Evaluation Reports.** The State must provide an interim evaluation report in each annual report as required in paragraph 33. In the event the State requests to extend the Demonstration beyond the current approval period under the authority of section 1115(a) of the Act, the State must submit an interim evaluation report as part of the State's request for each subsequent renewal.

55. **Final Evaluation Plan and Implementation.** CMS shall provide comments on the draft evaluation design within 60 days of receipt and the State must submit a final plan for the

overall evaluation of the Demonstration described in paragraph 53, within 60 days of receipt of CMS comments.

a) The State must implement the evaluation designs and report its progress in each quarterly report.

b) The State must submit to CMS a draft of the evaluation report within 120 days after expiration of the Demonstration. CMS must provide comments within 60 days after receipt of the report. The State must submit the final evaluation report within 60 days after receipt of CMS comments.

X. SCHEDULE OF STATE DELIVERABLES DURING THE DEMONSTRATION

Date	Deliverable	STC Reference
02/15/2011	Submit Draft Evaluation Design	Section IX, paragraph 53
07/01/2012	Submit Draft Transition Plan	Section VI, paragraph 34
07/01/2014	Submit Draft Final Report	Section VI, paragraph 35

	Deliverable	STC Reference
Annual	By May 1st - Draft Annual Report	Section VI, paragraph 33
Quarterly	Quarterly Progress Reports	Section VI, paragraph 32

Exhibit 6

ATTACHMENT R

Attachment R is a table displaying the contracted rates by rate cell for each contracted region. These rates will be the basis for calculating capitation payments in each contracted Region.

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EXPLANATORY NOTE: "*" INDICATES THE PORTION OF THIS EXHIBIT THAT HAS BEEN OMITTED AND SEPARATELY FILED WITH THE SECURITIES AND EXCHANGE COMMISSION PURSUANT TO A REQUEST FOR CONFIDENTIAL TREATMENT.**

HHSC Contract No. 529-06-0280-00014-S

Version 1.18.1

Part 1: Parties to the Contract:

This Contract Amendment (the "Amendment") is between the Texas Health and Human Services Commission (HHSC), an administrative agency within the executive department of the State of Texas, having its principal office at 4900 North Lamar Boulevard, Austin, Texas 78751, and Superior HealthPlan, Inc. (HMO) a corporation organized under the laws of the State of Texas, having its principal place of business at: 2100 South IH-35, Suite 202, Austin, Texas 78704. HHSC and HMO may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their original contract, HHSC contract number 529-06-0280-00014 (the "Contract") as set forth herein. The Parties agree that the terms of the Contract will remain in effect and continue to govern except to the extent modified in this Amendment.

This Amendment is executed by the Parties in accordance with the authority granted in Attachment A to the HHSC Managed Care Contract document, "HHSC Uniform Managed Care Contract Terms & Conditions," Article 8, "Amendments and Modifications."

Part 2: Effective Date of Amendment:	**Part 3: Contract Expiration Date**	**Part 4: Operational Start Date:**
March 1, 2011	August 31, 2013	STAR and CHIP HMOs: September 1, 2006 STAR+PLUS HMOs: February 1, 2007 CHIP Perinatal HMOs: January 1, 2007

Part 5: Project Managers:

HHSC:
Scott Schalchlin
Director, Health Plan Operations
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: 512-491-1866
Fax: 512-491-1969

HMO:
Susan Erickson
Director of Contract Management
2100 South IH-35, Suite 202
Austin, Texas 78704
Phone: 512-692-1465
Fax: 512-692-1474
E-mail: serickson@centene.com

Part 6: Deliver Legal Notices to:

HHSC:
General Counsel
4900 North Lamar Boulevard, 4th Floor
Austin, Texas 78751
Fax: 512-424-6586

HMO:
Superior HealthPlan
2100 South IH-35, Suite 202
Austin, Texas 78704
Fax: 512-692-1435

Part 7: HMO Programs and Service Areas:

This Contract applies to the following HHSC HMO Programs and Service Areas (*check all that apply*). All references in the Contract Attachments to HMO Programs or Service Areas that are not checked are superfluous and do not apply to the HMO.

☒ **Medicaid STAR HMO Program**

Service Areas:

☒ Bexar	☒ Lubbock
☐ Dallas	☒ Nueces
☒ El Paso	☐ Tarrant
☐ Harris	☒ Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the STAR Service Areas.

☒ **Medicaid STAR+PLUS HMO Program**

Service Areas:

☒Bexar	☒ Nueces
☐Harris	☐Travis

See Attachment B-6.1, "Map of Counties with STAR+PLUS HMO Program Service Areas," for listing of counties included within the STAR+PLUS Service Areas.

☒**CHIP HMO Program**

Core Service Areas:

☒ Bexar ☒ Nueces
☐ Dallas ☐Tarrant
☒ El Paso ☒ Travis
☐ Harris
☒ Lubbock

Optional Service Areas:

☒ Bexar ☒ Lubbock
☒ El Paso ☒Nueces
☐ Harris ☒Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the CHIP Core Service Areas and CHIP Optional Service Areas.

☒**CHIP Perinatal Program**

Core Service Areas:

☒Bexar ☒ Nueces
☐ Dallas ☐Tarrant
☒El Paso ☒ Travis
☐Harris
☒Lubbock

Optional Service Areas:

☒Bexar ☒ Lubbock
☒El Paso ☒Nueces
☐Harris ☒Travis

See Attachment B-6.2, "Map of Counties with CHIP Perinatal HMO Program Service Areas," for a list of counties included within the CHIP Perinatal Service Areas.

Part 8: Payment

Part 8 of the HHSC Managed Care Contract document, "Payment," is modified to add the capitation rates for Rate Period 5.

☒**Medicaid STAR HMO PROGRAM**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

***

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the STAR Program.

Bariatric Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Bariatric Supplemental Payment for the STAR Program.

☒**Medicaid STAR+PLUS HMO Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR+PLUS Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

***

Bariatric Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Bariatric Supplemental Payment for the STAR+PLUS Program.

☒**CHIP HMO PROGRAM**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Program. The following Rate Cells and Capitation Rates will apply to Rate Period 5:

***

☒**CHIP Perinatal Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Perinatal Program.

***

Part 9: Contract Attachments:

Modifications to Part 9 of the HHSC Managed Care Contract document, "Contract Attachments," are italicized below:

A: HHSC Uniform Managed Care Contract Terms & Conditions - *Version 1.18 is replaced with Version 1.18.1*

B: Scope of Work/Performance Measures – *Version 1.18 is replaced with Version 1.18.1 for all attachments, except if noted.*

- B-1: HHSC RFP 529-04-272, Sections 6-9
- B-2: Covered Services
  - B-2.1 STAR+PLUS Covered Services
  - B-2.2 CHIP Perinatal Program Covered Services
- B-3: Value-added Services
  - B-3.1 STAR+PLUS Value-added Services
  - B-3.2 CHIP Perinatal Program Value-added Services
- B-4: Performance Improvement Goals
  - B-4.1 SFY 2008 Performance Improvement Goals
- B-5: Deliverables/Liquidated Damages Matrix
- B-6: Map of Counties with STAR and CHIP HMO Program Service Areas
  - B-6.1 STAR+PLUS Service Areas
  - B-6.2 CHIP Perinatal Program Service Areas

B-7: STAR+PLUS Attendant Care Enhanced Payment Methodology
C: HMO's Proposal and Related Documents
C-1: HMO's Proposal
C-2: HMO Supplemental Responses
C-3: Agreed Modifications to HMO's Proposal

Part 10: Special Provision for Nueces Service Area

Attachment A, Section 10.04 is amended to include sub-part (b) as follows:
(b) In addition to the reasons set forth in Section 10.04(a), the Parties expressly understand and agree that HHSC may, at any time, unilaterally adjust the Rate Period 2 STAR Program Capitation Rates for the Nueces Service Area. HHSC is entitled to unilaterally adjust such rates, prospectively and/or retrospectively, if it determines that: (1) the cumulative Rate Period 2 Encounter Data for all HMOs in the Nueces Service Area does not support the Capitation Rates; or (2) economic factors in the Nueces Service Area significantly and measurably impact providers or the delivery of Covered Services to Members. For adjustments made pursuant to this Section 10.04(b), HHSC will provide written notice at least ten (10) Business Days before: (1) the effective date of a prospective adjustment; (2) offsetting Capitation Payments to recover retrospective adjustments. Any adjustments to the Rate Period 2 Capitation Rates must meet the actuarial soundness requirements of Attachment A, Section 10.03, "Certification of Capitation Rates."

Part 11: Signatures:

The Parties have executed this Contract Amendment in their capacities as stated below with authority to bind their organizations on the dates set forth by their signatures. By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made part of the Contract as though it were set out word for word in the Contract.

Texas Health and Human Services Commission
/s/ Charles E. Bell, M.D.
Charles E. Bell, M.D.
Deputy Executive Commissioner for Health Services
Date: 6/13/11

Superior HealthPlan, Inc.
/s/ Thomas Wise
By: Thomas Wise
Title: President and CEO
Date: 5/10/11

Exhibit 12.1

Centene Corporation
Computation of ratio of earnings to fixed charges
($ in thousands)

	For The Six Months Ended 6/30/2011	Year Ended December 31, 2010	2009	2008	2007	2006
Earnings:						
Pre-tax earnings from continuing operations	$ 81,643	$ 154,282	$ 137,508	$ 136,616	$ 64,071	$ 27,165
Addback:						
Fixed charges	14,407	26,141	23,104	23,128	20,612	13,909
Subtract:						
Non-controlling interest	1,233	(3,435)	(2,574)	-	-	-
Interest capitalized	-	(1,089)	(116)	-	-	-
Total earnings	$ 97,283	$ 175,899	$ 157,922	$ 159,744	$ 84,683	$ 41,074
Fixed Charges:						
Interest expensed and capitalized	$ 10,951	$ 19,081	$ 16,434	$ 16,673	$ 15,626	$ 10,574
Interest component of rental payments (1)	3,456	7,060	6,670	6,455	4,986	3,335
Total fixed charges	$ 14,407	$ 26,141	$ 23,104	$ 23,128	$ 20,612	$ 13,909
Ratio of earnings to fixed charges	6.75	6.73	6.84	6.91	4.11	2.95

(1) Estimated at 33% of rental expense as a reasonable approximation of the interest factor.

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

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 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 in 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 financial 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.

Dated: July 26, 2011

/s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, William N. Scheffel, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of Centene Corporation;

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 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 in 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 financial 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.

Dated: July 26, 2011

/s/ WILLIAM N. SCHEFFEL
Executive Vice President and Chief Financial Officer
(principal financial officer)

EXHIBIT 32.1

CERTIFICATION 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 quarterly report on Form 10-Q of Centene Corporation (the Company) for the period ended June 30, 2011, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman, President and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operationsof the Company.

Dated: July 26, 2011

/s/ MICHAEL F. NEIDORFF
Chairman, President and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION 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 quarterly report on Form 10-Q of Centene Corporation (the Company) for the period ended June 30, 2011, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: July 26, 2011

/s/ WILLIAM N. SCHEFFEL
Executive Vice President and Chief Financial Officer
(principal financial officer)