SECURITIES AND EXCHANGE COMMISSION

WASHINGTON, DC 20549

FORM 10-Q

(Mark One)

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

For the quarterly period ended March 31, 2004

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 000-33395

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)**
7711 Carondelet Avenue, Suite 800 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 is an accelerated filer (as defined in Rule 12b-2 of the Act). ☒ Yes ☐ No

As of April 20, 2004, the registrant had 20,260,097 shares of common stock outstanding.

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CENTENE CORPORATION

QUARTERLY REPORT ON FORM 10-Q

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PART I

FINANCIAL INFORMATION

ITEM 1. ***Financial Statements***

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS

(In thousands, except share data)

	March 31, 2004	December 31, 2003
	(Unaudited)	
ASSETS		
Current assets:		
Cash and cash equivalents	$ 44,363	$ 64,346
Premium and related receivables, net of allowances of $718 and $607, respectively	21,634	20,308
Short-term investments, at fair value (amortized cost $32,705 and $15,192, respectively)	32,708	15,160
Deferred income taxes	3,174	2,732
Other current assets	9,231	7,755
Total current assets	111,110	110,301
Long-term investments, at fair value (amortized cost $189,432 and $183,749, respectively)	191,057	184,811
Restricted deposits, at fair value (amortized cost $20,190 and $20,201, respectively)	20,592	20,364
Property, software and equipment	24,056	23,106
Goodwill	18,408	13,066
Intangible assets	7,428	6,294
Other assets	4,732	4,750
Total assets	$ 377,383	$ 362,692
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liabilities	$ 109,841	$ 106,569
Accounts payable and accrued expenses	17,733	17,965
Unearned revenue	3,736	3,673
Current portion of long-term debt and notes payable	288	579
Total current liabilities	131,598	128,786
Long-term debt	7,544	7,616
Other liabilities	5,613	6,175
Total liabilities	144,755	142,577
Stockholders' equity:		
Common stock, $.001 par value; authorized 40,000,000 shares; issued and outstanding 20,255,580 and 20,131,924 shares, respectively	20	20
Additional paid-in capital	159,237	157,380
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	1,258	740
Retained earnings	72,113	61,975
Total stockholders' equity	232,628	220,115
Total liabilities and stockholders' equity	$ 377,383	$ 362,692

See notes to consolidated financial statements.

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CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF EARNINGS
(In thousands, except share data)

	Three Months Ended March 31,	
	2004	2003
	(Unaudited)	
Revenues:		
Premiums	$ 222,690	$ 176,212
Services	2,835	1,222
Total revenues	225,525	177,434
Expenses:		
Medical costs	180,448	146,907
Cost of services	2,016	975
General and administrative expenses	28,377	19,405
Total operating expenses	210,841	167,287
Earnings from operations	14,684	10,147
Other income (expense):		
Investment and other income	1,510	974
Interest expense	(90)	(27)
Earnings before income taxes	16,104	11,094
Income tax expense	5,966	4,233
Minority interest	—	300
Net earnings	$ 10,138	$ 7,161
Earnings per share:		
Basic earnings per common share	$ 0.50	$ 0.44
Diluted earnings per common share	$ 0.47	$ 0.40
Weighted average number of shares outstanding:		
Basic	20,192,009	16,348,274
Diluted	21,533,870	17,757,266

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES
CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Three Months Ended March 31,	
	2004	2003
	(Unaudited)	
Cash flows from operating activities:		
Net earnings	$ 10,138	$ 7,161
Adjustments to reconcile net earnings to net cash provided by operating activities —		
Depreciation and amortization	2,271	1,379
Stock compensation expense	19	5
Minority interest	—	(300)
Gain on sale of investments	(253)	(293)
Changes in assets and liabilities —		
Premium and related receivables	(1,326)	(1,982)
Other current assets	(1,476)	(626)
Deferred income taxes	(755)	803
Other assets	13	58
Medical claims liabilities	3,272	3,586
Accounts payable and accrued expenses	1,211	(187)
Unearned revenue	63	19
Other operating activities	(812)	236
Net cash provided by operating activities	12,365	9,859
Cash flows from investing activities:		
Purchase of property, software and equipment	(2,126)	(684)
Purchase of investments	(93,742)	(42,055)
Sales and maturities of investments	69,814	35,218
Acquisitions, net of cash acquired	(6,983)	(2,283)
Net cash used in investing activities	(33,037)	(9,804)
Cash flows from financing activities:		
Reduction of long-term debt and notes payable	(363)	—
Proceeds from stock options and employee stock purchase plan	1,052	259
Net cash provided by financing activities	689	259
Net (decrease) increase in cash and cash equivalents	(19,983)	314
Cash and cash equivalents, beginning of period	64,346	59,656
Cash and cash equivalents, end of period	$ 44,363	$ 59,970
Interest paid	$ 91	$ 18
Income taxes paid	$ 3,390	$ 1,230

See notes to consolidated financial statements.

CENTENE CORPORATION AND SUBSIDIARIES

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

1. Organization

Centene Corporation (Centene or the Company) provides multi-line managed care programs and related services to individuals receiving benefits under government subsidized programs including Medicaid, Supplemental Security Income (SSI), and the State Children's Health Insurance Program (SCHIP). Centene's Medicaid Managed Care segment operates under its own state licenses in Indiana, New Jersey, Ohio, Texas and Wisconsin and contracts with other managed care organizations to provide risk and nonrisk management services. As of January 1, 2004, the Company commenced operations in Ohio. Centene's Specialty Services segment contracts with other healthcare organizations, as well as Centene owned companies, to provide specialty services including behavioral health, nurse triage and pharmacy compliance.

2. Basis of Presentation

The unaudited interim financial statements herein have been prepared by the Company pursuant to the rules and regulations of the Securities and Exchange Commission. 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 for the latest fiscal year ended December 31, 2003. Accordingly, footnote disclosures, which would substantially duplicate the disclosures contained in the December 31, 2003 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 2003 amounts in the consolidated financial statements have been reclassified to conform to the 2004 presentation. These reclassifications have no effect on net earnings or stockholders' equity as previously reported.

The Company accounts for stock-based compensation under APB Opinion No. 25, "Accounting for Stock Issued to Employees." The Company has adopted the disclosure-only provisions of SFAS No. 123, "Accounting for Stock-Based Compensation," and SFAS No. 148, "Accounting for Stock-Based Compensation-Transition and Disclosure." The following table illustrates the effect on net income and earnings per share if the fair value based method had been applied to all awards.

	Three Months Ended March 31,	
	2004	2003
Net earnings	$ 10,138	$ 7,161
Pro forma stock-based employee compensation expense determined under fair value based method, net of related tax effects	223	144
Pro forma net earnings	$ 9,915	$ 7,017
Basic earnings per common share:		
As reported	$ 0.50	$ 0.44
Pro forma	0.49	0.43
Diluted earnings per common share:		
As reported	$ 0.47	$ 0.40
Pro forma	0.46	0.40

3. Acquisitions

Family Health Plan, Inc.

Effective January 1, 2004, the Company commenced operations in Ohio through the acquisition of certain Medicaid-related assets from Family Health Plan, Inc. for a cash purchase price of approximately $6,800. The cost has been allocated to the assets acquired and liabilities assumed according to estimated fair values and is subject to adjustment when additional information concerning asset and liability valuations are finalized.

The preliminary purchase price allocation resulted in identified intangible assets of $1,500, representing purchased contract rights and a non-compete agreement. The intangibles are being amortized over ten and five years, respectively. Goodwill of approximately $5,300 is deductible for tax purposes.

Group Practice Affiliates

During 2003, the Company acquired a 100% ownership interest in Group Practice Affiliates, LLC (GPA), a behavioral healthcare services company (63.7% in March 2003 and 36.3% in August 2003). The consolidated financial statements include the results of operations of GPA since March 1, 2003. The Company paid $1,800 for its purchase of GPA. The cost to acquire the ownership interest has been allocated to the assets acquired and liabilities assumed according to estimated fair values. The allocation has resulted in goodwill of $3,895 which is not deductible for tax purposes.

4. Earnings Per Share

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

	Three Months Ended March 31,	
	2004	2003
Net earnings	$ 10,138	$ 7,161
Shares used in computing per share amounts:		
Weighted average number of common shares outstanding	20,192,009	16,348,274
Common stock equivalents (as determined by applying the treasury stock method)	1,341,861	1,408,992
Weighted average number of common shares and potential dilutive common shares outstanding	21,533,870	17,757,266
Basic earnings per common share	$ 0.50	$ 0.44
Diluted earnings per common share	$ 0.47	$ 0.40

5. Segment Information

Factors used in determining the reportable business segments include the nature of operating activities, existence of separate senior management teams, and the type of information presented to the Company's chief operating decision maker to evaluate all results of operations.

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 including behavioral health, nurse triage and pharmacy compliance functions.

Segment information for the three months ended March 31, 2004, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 223,115	$ 2,410	$ —	$ 225,525
Revenue from internal customers	14,530	4,705	(19,235)	—
Total revenue	$ 237,645	$ 7,115	$ (19,235)	$ 225,525
Earnings before income taxes	$ 16,338	$ (234)	$ —	$ 16,104

Segment information for the three months ended March 31, 2003, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Revenue from external customers	$ 176,311	$ 1,123	$ —	$ 177,434
Revenue from internal customers	1,561	1,874	(3,435)	—
Total revenue	$ 177,872	$ 2,997	$ (3,435)	$ 177,434
Earnings before income taxes	$ 9,837	$ 1,257	$ —	$ 11,094

6. Comprehensive Earnings

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

	Three Months Ended March 31,	
	2004	2003
Net earnings	$10,138	$7,161
Reclassification adjustment, net of tax	(51)	(89)
Change in unrealized gain on investments, net of tax	569	143
Total comprehensive earnings	$10,656	$7,215

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 and in our annual report on Form 10-K for the year ended December 31, 2003. The discussion contains forward-looking statements that involve known and unknown risks and uncertainties, including those set forth below under "Factors That May Affect Future Results and The Trading Price of Our Common Stock."

OVERVIEW

We are a multi-line managed care organization that provides Medicaid and Medicaid-related programs to organizations and individuals through government subsidized programs, including Medicaid, Supplemental Security Income (SSI) and the State Children's Health Insurance Program (SCHIP). We have health plans in Indiana, New Jersey, Ohio, Texas and Wisconsin. We also provide specialty services in Arizona, California, Colorado, Indiana, Texas and Wisconsin. These specialty services include behavioral health, nurse triage and pharmacy compliance.

RECENT ACQUISITIONS

Effective January 1, 2004, we commenced operations in Ohio through the acquisition of the Medicaid-related assets of Family Health Plan, Inc. (FHP) for a purchase price of $6.8 million. We are now serving 23,800 members in Toledo, Ohio, a new market for us. The results of operations of this entity are included in our consolidated financial statements beginning January 1, 2004. The preliminary purchase price allocation resulted in identified intangible assets of $1.5 million, representing purchased contract rights and a non-compete agreement. The intangibles are being amortized over ten and five years, respectively. The preliminary allocation also resulted in goodwill of $5.3 million.

Effective August 1, 2003, we acquired the Medicaid-related contract rights of HMO Blue Texas in the San Antonio, Texas market. This transaction allows us to serve approximately 17,000 additional members in the State. The purchase price of $1.0 million was allocated to acquired contracts. The contracts are being amortized on a straight-line basis over a period of five years, the expected period of benefit.

During 2003, we acquired a 100% ownership interest in Group Practice Affiliates, LLC (63.7% in March 2003 and 36.3% in August 2003). GPA, a behavioral healthcare services company, serves over 700,000 individuals in five states through a combination of networks, groups and schools, including a portion of our membership. This acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. We paid an aggregate purchase price of $1.8 million for GPA and recorded goodwill of $3.9 million related to the acquisition.

In March 2003, we purchased certain assets of ScriptAssist, a treatment compliance company. We are administering the purchased contracts under the ScriptAssist name. ScriptAssist uses various approaches and medical expertise to promote adherence to prescription drugs. The asset acquisition is consistent with our strategy to provide diversified medical services to the managed Medicaid population. The purchase price of $563,000 was allocated to acquired contracts. We are amortizing the contracts on a straight-line basis over five years, the expected period of benefit.

REVENUE AND EXPENSE DISCUSSION AND KEY METRICS

We are providing certain non-GAAP financial measures in this discussion of revenues and expenses. These measures exclude the impact of a premium tax enacted by one state in September 2003 which totaled $1.1 million in the three months ended March 31, 2004 and $0 in the three months ended March 31, 2003. We believe these figures are helpful in allowing the reader to more accurately assess the ongoing nature of our operations and better measure our performance on a comparable basis. We use the presented non-GAAP financial measures internally to focus management on period-to-period changes in our business. Therefore, we believe this information is meaningful in addition to the information contained in the GAAP presentation of financial information. The presentation of this additional non-GAAP financial information is not intended to be considered in isolation or as a substitute for the financial information prepared and presented in accordance with GAAP.

Revenues

We generate revenues in our Medicaid Managed Care segment primarily from premiums we receive from the states in which we operate to provide health benefits to our members. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premiums during the month we provide services and recognize premium revenue during the period in which we are obligated to provide services to our members.

Our Specialty Services companies generate revenues from a variety of sources. Our behavioral health company generates revenue via capitation payments from our health plans and others. It also receives fees for the direct provision of care and certain school programs in Arizona. Our treatment compliance program receives fee income from the manufacturers of pharmaceuticals. NurseWise receives fees from health plans, physicians and other organizations for providing continuous access to nurse advisors.

Premiums collected in advance are recorded as unearned revenue. Premiums due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our judgment regarding the collectibility of these accounts. As we generally receive premiums during the month in which services are provided, the allowance is typically not significant in comparison to total premium revenue and does not have a material impact on the presentation of our financial condition, changes in financial position or results of operations.

The primary drivers of our increasing revenue have been membership growth in our Medicaid Managed Care segment and our entry into the Specialty Services segment. We have increased our membership through internal growth as well as acquisitions. From March 31, 2003 to March 31, 2004, we increased our membership by 24.6%. The following table sets forth our membership by state:

	March 31,	
	2004	2003
Indiana	125,400	104,800
New Jersey	54,000	52,700
Ohio	23,800	—
Texas	154,000	122,700
Wisconsin	165,200	139,100
Total	522,400	419,300

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

	March 31,	
	2004	2003
Medicaid	446,900	344,700
SCHIP	65,900	66,600
SSI	9,600	8,000
Total	522,400	419,300

During the last 12 months our membership increased by 23,800 members in Ohio due to the acquisition of Medicaid-related assets from FHP and 17,000 members in Texas due to the purchase of contract rights from HMO Blue Texas. Our membership also increased in each of our markets from additions to our provider networks, increases in counties served and growth in the number of Medicaid beneficiaries.

Operating Expenses

Our operating expenses include medical costs, cost of services, and general and administrative expenses.

Our medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty product claims. Medical costs also include estimates of medical expenses incurred but not yet reported, or IBNR, and estimates of the cost to process unpaid claims. Monthly, we estimate our IBNR based on a number of factors, including inpatient hospital utilization data and prior claims experience. As part of this review, we also consider the costs to process medical claims and estimates of amounts to cover uncertainties related to fluctuations in physician billing patterns, membership, products and inpatient hospital trends. These estimates are adjusted as more information becomes available. We utilize the services of independent actuaries who are contracted to review our estimates quarterly. While we believe that our process for estimating IBNR is actuarially sound, we cannot assure you that healthcare claim costs will not materially differ from our estimates.

Our results of operations depend on our ability to manage expenses related to health benefits and to accurately predict costs incurred. Our health benefits ratio represents medical costs as a percentage of premium revenues and reflects the direct relationship between the premium received and the medical services provided. The table below depicts our health benefits ratios by member category and in total:

	Three Months Ended March 31,	
	2004	2003
Medicaid and SCHIP	80.6%	82.4%
SSI	99.3	104.2
Total (GAAP)	81.0	83.4
Total (non-GAAP), excluding effect of premium tax	81.4	83.4

Our Medicaid and SCHIP ratio decreased in 2004 from 2003 due primarily to initiatives to reduce inappropriate emergency department usage and to establish preferred drug lists. The health benefits ratio for SSI is affected by a low membership base and is subject to greater volatility as a percentage of premiums (although relatively immaterial in total dollars to total medical costs).

Our cost of services expenses include all direct costs to support the local functions responsible for generation of our services revenues. These expenses primarily consist of the salaries and wages of the physicians, clinicians, therapists and teachers who provide the services and expenses related to the clinics and supporting facilities and equipment used to provide services.

Our general and administrative expenses primarily reflect wages and benefits and other administrative costs related to health plans, specialty companies and the centralized functions that support all of our business units. The major centralized functions are claims processing, information systems and finance. In September 2003, concurrent with a rate increase received in one state, we began to be charged premium taxes by that state. Premium taxes are classified as general and administrative expenses. Our general and administrative expense ratio represents general and administrative expenses as a percentage of total revenues and reflects the relationship between revenues earned and the costs necessary to drive those revenues. The following table sets forth the general and administrative expense ratios by business segment and in total:

	Three Months Ended March 31,		
	2004		2003
	GAAP	Non-GAAP*	
Medicaid Managed Care	10.4%	9.9%	10.5%
Specialty Services	52.9	52.9	26.6
Total	12.6	12.2	10.9

* excluding effect of premium tax

The improvement in the Medicaid Managed Care general and administrative expense ratio reflects growth in membership and leveraging of our overall infrastructure. This ratio decreased in 2004 from 2003 despite the levying of the premium tax from one of our states which resulted in $1.1 million additional general and administrative expense. The Specialty Services ratio may vary depending on the various contracts and nature of the service provided and will have a higher general and administrative expense ratio than the Medicaid Managed Care segment. During the quarter ended March 31, 2004, an additional provision for uncollectible accounts of $450,000 was recorded related to write offs associated with transitioning certain activities within Specialty Services.

Other Income (Expense)

Other income (expense) consists principally of investment and other income and interest expense.

- Investment income is derived from our cash, cash equivalents and investments. Information about our investments is included below under “Liquidity and Capital Resources.”
- Interest expense reported in 2004 reflects mortgage interest on our corporate headquarters’ building and fees paid to a bank in conjunction with our credit facility. Interest expense reported in 2003 reflected fees paid to a bank in conjunction with our credit facility.

RESULTS OF OPERATIONS

Three Months Ended March 31, 2004 Compared to Three Months Ended March 31, 2003

Summarized comparative financial data are as follows ($ in millions):

	Three Months Ended March 31,		
	2004	2003	% Change 2003-2004
Premium revenue	$222.7	$176.2	26.4%
Services revenue	2.8	1.2	132.0%
Total revenues	225.5	177.4	27.1%
Medical costs	180.4	146.9	22.8%
Cost of services	2.0	1.0	106.8%
General and administrative expenses	28.4	19.4	46.2%
Earnings from operations	14.7	10.1	44.7%
Investment and other income, net	1.4	1.0	49.9%
Earnings before income taxes	16.1	11.1	45.2%
Income tax expense	6.0	4.2	40.9%
Minority interest	—	.3	—
Net earnings	$ 10.1	$ 7.2	41.6%
Diluted earnings per common share	$ 0.47	$ 0.40	17.5%

Revenues

Premiums for the three months ended March 31, 2004 increased 26.4% from the comparable period in 2003. This increase was due to organic growth in our existing markets, changes in our member mix by product category, the purchase of the Texas contracts from HMO Blue and the addition of our Ohio membership through our acquisition of the Medicaid-related assets of FHP.

Services revenues increased 132.0% due to a full three months of operations of GPA which we acquired on March 1, 2003.

Operating Expenses

Medical costs increased 22.8% due to the growth in our membership as discussed above. Our health benefits ratio decreased to 81.0% from 83.4% due to our initiatives to reduce emergency department usage and to establish preferred drug lists as previously discussed.

Cost of services increased 106.8% due to a full three months of direct costs related to the services revenues of GPA which we acquired on March 1, 2003.

General and administrative expenses increased 46.2% primarily due to expenses for additional staff to support our membership growth, expansion into the Specialty Services segment and the institution of a premium tax.

Other Income

Investment and other income increased 49.9% for the three months ended March 31, 2004 from the comparable period in 2003. The increase was due to higher investment balances in 2004 primarily as a result of our $81.3 million stock offering completed in August 2003.

Income Tax Expense

Our effective tax rate in 2004 was 37.0%, compared to 38.2% in 2003. The decrease was primarily due to a lower effective state tax rate.

Earnings Per Share and Shares Outstanding

Our earnings per share calculations reflect an increase in the weighted average shares outstanding in 2004 primarily resulting from the follow-on offering of 3,450,000 shares sold in August 2003.

LIQUIDITY AND CAPITAL RESOURCES

Our operating activities provided cash of $12.4 million in the three months ended March 31, 2004 compared to $9.9 million in the comparable period in 2003. The increase was primarily due to increased net income.

Our investing activities used cash of $33.0 million in the three months ended March 31, 2004 compared to $9.8 million in the comparable period in 2003. The largest component of investing activities related to increases in our investment portfolio. Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our investment 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 March 31, 2004, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.4 years. Cash is invested in investment vehicles such as municipal bonds, commercial paper and instruments of the U.S. Treasury. The states in which we operate prescribe the types of instruments in which our regulated subsidiaries may invest their cash. The average annualized portfolio yield was 3.0% for the three months ended March 31, 2004 and 2.6% for the comparable period in 2003.

Our financing activities provided cash of $689,000 in the three months ended March 31, 2004 compared to $259,000 in the comparable period in 2003.

We spent $2.1 million and $684,000 in the three months ended March 31, 2004 and 2003, respectively, on capital assets. We anticipate spending $9.7 million on additional capital expenditures in 2004 related to office and market expansions and system upgrades.

At March 31, 2004, we had working capital, defined as current assets less current liabilities, of ($20.5) million as compared to ($18.5) million at December 31, 2003. Our working capital is negative 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. Our investment policies are also designed to provide liquidity and preserve capital. We manage our short-term and long-term investments to ensure that a sufficient portion is held in investments that are highly liquid and can be sold to fund working capital as needed.

Cash, cash equivalents and short-term investments were $77.1 million at March 31, 2004 and $79.5 million at December 31, 2003. Long-term investments were $211.6 million at March 31, 2004 and $205.2 million at December 31, 2003, including restricted deposits of $20.6 million and $20.4 million, respectively. Cash and investments held by our unregulated entities totaled $119.1 million at March 31, 2004. Based on our operating plan, we expect that our available funding will be sufficient to finance our operations and capital expenditures for at least 12 months from the date of this filing.

CONTRACTUAL COMMITMENTS

In April 2004, we amended our revolving line of credit facility with LaSalle Bank N.A. (LaSalle), increasing it to $50 million effective May 1, 2004. The new facility expires in May 2005. The facility has interest rates based on LaSalle's prime rate or LIBOR. The line is secured by the common stock of our subsidiaries. The facility includes financial covenants, including requirements of minimum EBITDA and minimum tangible net worth. We are required to obtain LaSalle's consent to any proposed acquisition that would result in a violation of any of the covenants contained in the facility. As of March 31, 2004, we were in compliance with all covenants and no funds were outstanding on the facility.

There were no material changes outside the ordinary course of our business in lease obligations or other contractual obligations.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our Medicaid Managed Care 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 March 31, 2004, our subsidiaries had aggregate statutory capital and surplus of $72.4 million, compared with the required minimum aggregate statutory capital and surplus requirements of $31.7 million.

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 March 31, 2004, our Ohio, Texas and Wisconsin health plans were in compliance with the risk-based capital requirements adopted by these states. Indiana has adopted risk-based capital rules that will take effect as of December 31, 2004. If adopted by New Jersey, risk-based capital requirements may increase the minimum capital required for our health plan in New Jersey. We continue to monitor the requirements in Indiana and New Jersey and do not expect that they will have a material impact on our results of operations, financial position or cash flows.

FORWARD-LOOKING STATEMENTS

This filing contains forward-looking statements that relate to future events or our future financial performance. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “goal,” “may,” “will,” “should,” “can,” “continue” or the negative of these terms or other comparable terminology. 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 section of this filing entitled “Management’s Discussion and Analysis of Financial Condition and Results of Operations”. 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.

Actual results may differ from projections or estimates due to a variety of important factors. Our results of operations and projections of future earnings depend in large part on accurately predicting and effectively managing health benefits and other operating expenses. A variety of factors, including competition, changes in healthcare practices, changes in federal or state laws and regulations or their interpretations, inflation, provider contract changes, new technologies, government-imposed surcharges, taxes or assessments, reduction in provider payments by governmental payers, major epidemics, disasters and numerous other factors affecting the delivery and cost of healthcare, such as major healthcare providers’ inability to maintain their operations, may in the future affect our ability to control our medical costs and other operating expenses. Governmental action or business conditions could result in premium revenues not increasing to offset any increase in medical costs and other operating expenses. Once set, premiums are generally fixed for one-year periods and, accordingly, unanticipated costs during such periods cannot be recovered through higher premiums. The expiration, cancellation or suspension of our Medicaid managed care contracts by the state governments would also negatively impact us. Due to these factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

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 and SCHIP Funding Could Substantially Reduce Our Profitability.

Most of our revenues come from Medicaid and SCHIP 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 and SCHIP premium rates may be affected by continued government efforts to contain medical costs and may further be affected by state and federal budgetary constraints. Changes to Medicaid and SCHIP programs could reduce the number of persons enrolled or eligible, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under those programs. States periodically consider reducing or reallocating the amount of money they spend for Medicaid and SCHIP. We believe that reductions in Medicaid and SCHIP 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 Our Medicaid and SCHIP 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, SSI and SCHIP. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. The contracts expire on various dates between August 31, 2004 and June 30, 2005. Our contracts may be terminated if we fail to perform up to the standards set by state regulatory agencies. In addition, the Indiana contract under which we operate can be terminated by the state without cause. Our contracts are generally intended to run for two years and may be extended for one or two additional years if the state or its contractor elects to do so. 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. If any of our contracts are terminated, not renewed, or renewed on less favorable terms, our business will suffer, and our operating results may be materially affected.

Changes in Government Regulations Designed to Protect Providers and Members Rather than Our Stockholders 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 health plan providers and members rather than stockholders. Changes in existing laws and rules, the enactment of new laws and rules or changing interpretations of these 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 premiums 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.

For example, Congress has considered various forms of patient protection legislation commonly known as the Patients' Bill of Rights and the legislation is currently pending in Congress. We cannot predict the impact of this legislation, if adopted, on our business.

Regulations May Decrease the Profitability of Our Health Plans.

Our Texas plan is required to pay a rebate to the state in the event profits exceed established levels. Similarly, our New Jersey plan is required to pay a rebate to the state in the event its health benefits ratio is less than 80%. These regulatory requirements, changes in these requirements or the adoption of similar requirements by our other regulators may limit our ability to increase our overall profits

as a percentage of revenues. The states of Indiana, New Jersey and Texas have implemented prompt-payment laws and 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 operating results.

Also, on January 18, 2002, the federal Centers for Medicare and Medicaid Services, or CMS, published a final rule that removed a provision contained in the federal Medicaid reimbursement regulations permitting states to reimburse non-state government-owned or operated hospitals for inpatient and outpatient hospital services at amounts up to 150% of a reasonable estimate of the amount that would be paid for the services furnished by these hospitals under Medicaid payment principles. The upper payment limit was reduced to 100% of Medicare payments for comparable services. This development in federal regulation decreased the profitability of our health plans.

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. 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, SSI and SCHIP 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 impact our ability to operate our business. For example, failure to pay our providers promptly could result in the imposition of fines and other penalties. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations.

The Health Insurance Portability and Accountability Act of 1996, or 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. Further, HIPAA imposes 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. 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.

Compliance With New Government Regulations May Require Us to Make Significant Expenditures.

On August 17, 2000, the United States Department of Health and Human Services, or HHS, issued a new regulation under HIPAA requiring the use of uniform electronic data transmission standards for healthcare claims and payment transactions submitted or received electronically. We were originally required to comply with this regulation by October 16, 2003. On July 24, 2003, CMS issued guidance allowing covered entities to implement contingency plans and accept legacy transaction formats if they were not able to meet the October 16th, 2003 compliance date. The objective of the guidance was to "ensure the smooth flow of payments" within the health care industry. Many of the states that we operate in implemented contingency plans, which resulted in staggered compliance dates for the organization from October 16, 2003 to April 16, 2004. Based on additional guidance released by CMS and due to problems experienced by many of our trading partners in creating HIPAA compliant transactions, we have extended the effective date of the current contingency plans by three months until July 16, 2004.

In December 2000, HHS issued a new regulation mandating heightened privacy and confidentiality protections under HIPAA that became effective on April 14, 2001 and for which compliance was required by April 14, 2003. We have begun to integrate GPA into our privacy program. GPA's privacy policies and procedures are being updated to align with our policies and procedures and all GPA employees are receiving job specific education and training on our privacy practices. Full integration of our privacy program at GPA is expected in the second quarter of 2004.

On February 20, 2003 HHS published the final HIPAA health data security regulations. The security regulations became effective on April 21, 2003. Compliance with the security regulations is required by April 21, 2005. These regulations will require covered entities to implement administrative, physical and technical safeguards to protect electronic health information maintained or transmitted by the organization.

The issuance of future judicial or regulatory guidance regarding the interpretation of regulations, the states' ability to promulgate stricter rules, and continuing uncertainty regarding many aspects of the regulations' implementation may make compliance with the

relatively new regulatory landscape difficult. For example, our existing programs and systems may not enable us to comply in all respects with the new security regulations. In order to comply with the regulatory requirements, we will be required to employ additional or different programs and systems, the costs of which were $310,000 in 2003 and are not expected to exceed $500,000 in 2004. Further, compliance with these regulations would 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 new regulations and the related compliance costs could have a material adverse effect on our business.

Changes in Healthcare Law May Reduce Our Profitability.

Numerous proposals relating to changes in healthcare law have been introduced, some of which have been passed by Congress and the states in which we operate or may operate in the future. 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 for Medicaid and reduce the reimbursement or payment levels for medical services. More generally, we are unable to predict whether new laws or proposals will favor or hinder the growth of managed healthcare. Legislation or regulations that require us to change our current manner of operation, provide additional benefits or change our contract arrangements may seriously harm our operations and financial results.

Changes in Federal Funding Mechanisms May Reduce Our Profitability.

In February 2003, the Bush Administration proposed a major long-term change in the way Medicaid and SCHIP are funded. The proposal, if adopted, would allow states to elect to receive combined Medicaid-SCHIP "allotments" for acute and long-term health care for low-income, uninsured persons. Participating states would be given flexibility in designing their own health insurance programs, subject to federally-mandated minimum coverage requirements. It is uncertain whether this proposal will be enacted, or if so, how it may change from the initial proposal. Accordingly, it is unknown whether or how many states might elect to participate or how their participation may affect the net amount of funding available for Medicaid and SCHIP programs. If such a proposal is adopted and decreases the number of persons enrolled in Medicaid or SCHIP in the states in which we operate or reduces the volume of healthcare services provided, our growth, operations and financial performance could be adversely affected.

If We Are Unable to Participate in SCHIP Programs, Our Growth Rate May be Limited.

SCHIP 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 SCHIP 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 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 our company as a whole would be limited, which could harm our ability to implement our business strategy.

Risks Related to Our Business

Receipt of Inadequate Premiums Would Negatively Affect Our Revenues and Profitability.

Nearly all of our revenues are generated by premiums consisting of fixed monthly payments per member. 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 customers. 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 revenues, to increase and our profits to decline. In addition, it is possible for a state to increase the rates payable to the hospitals 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.

Failure to Effectively Manage Our Medical Costs or Related Administrative 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. Historically, our health benefits ratio has fluctuated. For example, our health benefits ratio was 82.4% for the year ended December 31, 2003, 82.3% for 2002, 82.8% for 2001 and 84.3% for 2000, but was 88.9% for 1999 and 88.4% for 1998. 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, 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. 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.

Failure to Accurately Predict Our Medical Expenses Could Negatively Affect Our Reported Results.

Our medical expenses include estimates of IBNR medical expenses. We estimate our IBNR medical expenses monthly based on a number of factors. Adjustments, if necessary, are made to medical expenses in the period during which the actual claim costs are ultimately determined or when criteria used to estimate IBNR change. We cannot be sure that our IBNR estimates are adequate or that adjustments to those estimates will not harm our results of operations. 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. Our failure to estimate IBNR accurately may also affect our ability to take timely corrective actions, further harming our results.

Difficulties in Executing Our Acquisition Strategy Could Adversely Affect Our Business.

Historically, the acquisition of Medicaid 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. For example, our acquisition of 80% of the equity of UHP on December 1, 2002, accounted for 30.3% of the increase in our membership for the year ended December 31, 2002 compared to 2001. Many of the other potential purchasers of Medicaid assets 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 assure you 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. Furthermore, our credit facility may prohibit some acquisitions without the consent of our bank lender.

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;
- existing 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.

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

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 2003, for example, we acquired GPA, a behavioral health services company, and purchased contract and name rights of ScriptAssist, a medication compliance company. In order to diversify our business, we must succeed in selling the services of GPA, ScriptAssist and any other 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.

Start-up 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 start-up 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.

We Derive a Majority of Our Premium Revenues From Operations in Five States, and Our Operating Results Would be Materially Affected by a Decrease in Premium Revenues or Profitability in Any One of Those States.

Operations in Indiana, New Jersey, Ohio, Texas and Wisconsin account for a majority of our premium revenues. If we were unable to continue to operate in each of those states or if our current operations in any portion of one of those states were significantly curtailed, our revenues would decrease materially. Our reliance on operations in a limited number of states could cause our revenue and profitability to change suddenly and unexpectedly, depending on legislative actions, economic conditions and similar factors in those states. 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. 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 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 Satisfactory Relationships With Our Provider Networks, Our Profitability Will 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 assure you 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 noncancelable 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 operating results could be harmed. We do not have an employment agreement with Mr. Neidorff, and we cannot assure you that we will be able to retain his services. 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 Operating Results.

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 operating results.

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, including Texas, 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 During Economic Downturns Could Cause Our Operating Results and Stock Prices 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. 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 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 Operating Results 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 operating results to suffer, which could lead to decreases in our stock price during periods in which stock prices in general are increasing.

We Intend to Expand Our Medicaid Managed Care Business Primarily into Markets Where Medicaid Recipients are Required to Enroll in Managed Care Plans.

We expect to continue to focus our business in states in which Medicaid enrollment in managed care is mandatory. Currently, approximately two-thirds of the states require health plan enrollment for Medicaid eligible participants in all or a portion of their counties. The programs are voluntary in other states. Because we concentrate on markets with mandatory enrollment, we expect the geographic expansion of our Medicaid Managed Care segment to be limited to those states.

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. 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 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 assure you 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.

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

INVESTMENTS

As of March 31, 2004, we had short-term investments of $32.7 million and long-term investments of $211.6 million, including restricted deposits of $20.6 million. The short-term investments consist of highly liquid securities with maturities between three and twelve months. The long-term investments consist of municipal, corporate and U.S. agency bonds and U.S. Treasury investments 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. These investments are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. These investments are subject to interest rate risk and will decrease in value if market rates increase. We have the ability to hold the short-term investments to maturity which would mitigate the risk of a significant increase in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2004, the fair value of our fixed income investments would decrease by approximately $7.1 million. Declines in interest rates over time will reduce our investment income.

INFLATION

Although the general rate of inflation has remained relatively stable and healthcare cost inflation has stabilized in recent years, the national healthcare cost inflation rate still exceeds the general inflation rate. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through 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.

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.

COMPLIANCE COSTS

Federal and state regulations governing standards for electronic transactions, data security and confidentiality of patient information have been issued recently. Due to the uncertainty surrounding the regulatory requirements, we cannot be sure that the systems and programs that we have implemented will comply adequately with the security regulations that are ultimately adopted. Implementation of additional systems and programs will be required, the cost of which we estimate not to exceed $500,000 in 2004. We incurred implementation costs of $11,000 in the three months ended March 31, 2004. Further, compliance with these regulations would 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 our costs of complying with these new regulations from the states.

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

Our management, with the participation of our chief executive officer and chief financial officer, evaluated the effectiveness of our disclosure controls and procedures (as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act) as of March 31, 2004. Based on this evaluation, our chief executive officer and chief financial officer concluded that, as of March 31, 2004, our disclosure controls and procedures were (1) designed to ensure that material information relating to us, and our consolidated subsidiaries, is made known to our chief executive officer and chief financial officer by others within those entities, particularly during the period in which this report was being prepared, and (2) effective, in that they provide reasonable assurance that information required to be disclosed by us in the reports that we file or submit under the Exchange Act are recorded, processed, summarized and reported within the time periods specified in the SEC's rules and forms.

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 fiscal quarter ended March 31, 2004 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.***

Aurora Health Care, Inc. (Aurora) provides medical professional services to our Wisconsin health plan subsidiary. In May 2003, Aurora filed a lawsuit in the Milwaukee County Circuit Court claiming we had failed to adequately reimburse Aurora for services rendered during the period from 1998 to 2003. The claim seeks damages totaling $9.4 million. We dispute the claim, have filed answer and discovery requests against Aurora, and plan to vigorously defend against the matter.

We are routinely subject to legal proceedings in the normal course of business. While the ultimate resolution of such matters are uncertain, we do not expect the result of these matters to have a material effect on our financial position or results of operations.

ITEM 2. ***Changes in Securities, Use of Proceeds and Issuer Purchases of Equity Securities.***

None.

ITEM 3. ***Defaults Upon Senior Securities.***

None.

ITEM 4. ***Submission of Matters to a Vote of Security Holders.***

None.

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

None.

ITEM 6. ***Exhibits and Reports on Form 8-K.***

(a) Exhibits.

EXHIBIT NUMBER	DESCRIPTION
10.1	Amendment to contract included as Exhibit 10.4 to Form 10-K filed February 25, 2004.
10.2	Amendment to contract included as Exhibit 10.5 to Form 10-K filed February 25, 2004.
10.3	Amendment to contract included as Exhibit 10.6 to Form 10-K filed February 25, 2004.
31.1	Certification of 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 Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to Rule 13(a)-14(a) under the Securities Exchange Act of 1934, as amended.
32.1	Certification of 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 Senior Vice President, Chief Financial Officer, Secretary and Treasurer pursuant to 18 U.S.C. Section 1350, as Adopted Pursuant to Section 906 of the Sarbanes-Oxley Act of 2002.

(b) Reports on Form 8-K.

On February 10, 2004, we furnished a current report on Form 8-K under Item 12 announcing our financial results for the fourth quarter and year ended December 31, 2003.

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 April 26, 2004.

CENTENE CORPORATION

By: /s/ Michael F. Neidorff

Michael F. Neidorff
President and Chief Executive Officer
(principal executive officer)

By: /s/ Karey L. Witty

Karey L. Witty
Senior Vice President,
Chief Financial Officer,
Secretary and Treasurer
(principal financial and accounting officer)

STATE OF TEXAS

COUNTY OF TRAVIS

AMENDMENT 12
TO THE AGREEMENT BETWEEN THE
HEALTH & HUMAN SERVICES COMMISSION
AND
SUPERIOR HEALTH PLAN, INC.
FOR HEALTH SERVICES
TO THE
MEDICAID STAR PROGRAM
IN THE
EL PASO SERVICE DELIVERY AREA

THIS CONTRACT AMENDMENT (the "Amendment") is entered into between the HEALTH & HUMAN SERVICES COMMISSION ("HHSC"), an administrative agency within the executive department of the State of Texas, and **Superior Health Plan, Inc.** ("HMO"), a health maintenance organization organized under the laws of the State of Texas, possessing a certificate of authority issued by the Texas Department of Insurance to operate as a health maintenance organization, and having its principal office at **2100 S. IH 35, Suite 202, Austin, Texas 78704** HHSC and CONTRACTOR may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their Agreement as set forth in Article 2 of this Amendment.

ARTICLE 1. PURPOSE.

Section 1.01 ***Authorization.***

This Amendment is executed by the Parties in accordance with Article 15.2 of the Agreement.

Section 1.02 ***Effective date.***

The effective date of this amendment is **March 1, 2004.**

ARTICLE 2. AMENDMENT TO THE OBLIGATIONS OF THE PARTIES

Section 2.01 ***Modification of Appendix C, Value-added Services***

Appendix C of the Contract is modified to revise the value-added services provided by the HMO on or after March 1, 2004 as follows:

1. In the "Physical Health Value-added Services" category, replace the "Prenatal Program with Gifts," benefit description with the language in the revised Appendix C, attached.
2. In the "Physical Health Value-added Services" category, replace the "Additional Vision Benefits" benefit description with the language in the revised Appendix C, attached.

The revised Appendix C is attached to this amendment and incorporated by reference into the Contract.

ARTICLE 3. REPRESENTATIONS AND AGREEMENT OF THE PARTIES

The Parties contract and agree that the terms of the Agreement will remain in effect and continue to govern except to the extent modified in this Amendment.

By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made a part of the Agreement as though it were set out word for word in the Agreement.

IN WITNESS HEREOF, HHSC and the CONTRACTOR have each caused this Amendment to be signed and delivered by its duly authorized representative.

SUPERIOR HEALTH PLAN, INC.	**HEALTH & HUMAN SERVICES COMMISSION**
By: _____	By: _____
Christopher Bowers President and CEO	Albert Hawkins Executive Commissioner
Date: _____	Date: _____

Exhibit 10.1

HHSC Contract No. 529-03-044-M

STATE OF TEXAS

COUNTY OF TRAVIS

AMENDMENT 13
TO THE AGREEMENT BETWEEN THE
HEALTH & HUMAN SERVICES COMMISSION
AND
SUPERIOR HEALTH PLAN, INC.
FOR HEALTH SERVICES
TO THE
MEDICAID STAR PROGRAM
IN THE
EL PASO SERVICE DELIVERY AREA

THIS CONTRACT AMENDMENT (the "Amendment") is entered into between the HEALTH & HUMAN SERVICES COMMISSION ("HHSC"), an administrative agency within the executive department of the State of Texas, and **Superior Health Plan, Inc.** ("HMO"), a health maintenance organization organized under the laws of the State of Texas, possessing a certificate of authority issued by the Texas Department of Insurance to operate as a health maintenance organization, and having its principal office at **2100 S. IH 35, Suite 202, Austin, Texas 78704** HHSC and CONTRACTOR may be referred to within this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their Agreement as set forth herein.

ARTICLE 1. PURPOSE.

Section 1.01 ***Authorization.***

This Amendment is executed by the Parties in accordance with Article 15.2 of the Agreement.

Section 1.02 ***Effective Date.***

Except as otherwise provided in this Amendment, the provisions of this Amendment are effective on**May 1, 2004.**

ARTICLE 2. AMENDMENT TO THE OBLIGATIONS OF THE PARTIES

Section 2.01 ***Modification to Article 2, Definitions***

The following provisions amend and supplement the definitions set forth in Article 2, Definitions, as follows:

Court-ordered Commitment means a commitment of a STAR Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C, or a placement in a state-operated facility as a condition of probation, as authorized by the Texas Family Code.

Health-related Materials are materials that are developed by the HMO or obtained from a third party relating to the diagnosis or treatment of medical conditions.

Section 2.02 ***Modification to Article 3, Plan Administrative and Human Resources Requirements***

Article 3, Plan Administrative and Human Resources Requirements, is amended by modifying Sections 3.4.1 through 3.4.4, as follows:

3.4.1 Prior to distribution to (1) Members, (2) prospective Members, (3) providers within HMO's network, or (4) potential providers whom HMO intends to recruit as network providers, and with the exception of Health-related Materials, HMO must receive written approval from HHSC for all written materials produced or authorized by HMO containing information about the STAR Program. Health-related Materials do not need to be submitted for review and approval. Per HHSC request, and on an ad-hoc basis, HMOs will be required to submit a list of Health-related Materials currently being used, or used previously; HHSC may request the review of selected materials from that list. HHSC will provide HMO a reasonable amount of time to respond to such requests, generally no less than 10 business days.

3.4.2 Member materials must meet cultural and linguistic requirements, as stated in Article 8. Unless otherwise required, Member materials must be written at a 4th - 6th grade reading comprehension level, and translated into the language of any major population group, except when HHSC requires HMO to use statutory language (i.e., advance directives, medical necessity, etc.).

3.4.3 With the exception of Health-related Materials, all plan materials regarding the STAR Program, including Member education materials, must be submitted to HHSC for approval prior to distribution. HHSC has fifteen (15) working days to review the materials and recommend any suggestions or required changes. If HHSC has not responded to HMO by the fifteenth (15th) day, HMO may print and distribute these materials. HHSC reserves the right to request HMO to modify plan materials that are deemed approved and have been printed or distributed. These modifications can be made at the next printing unless substantial non-compliance exists, as determined by HHSC. An exception to the fifteen (15) working day timeframe may be requested in writing by HMO for written provider materials that require a quick turn-around time (e.g., letters). HHSC will review such requests within a reasonable amount of time, generally within 5 working days. HHSC reserves the right to require revisions to materials if inaccuracies are discovered or if changes are required by changes in policy or law. These changes can be made at the next printing unless substantial non-compliance exists, as determined by HHSC.

3.4.4 With the exception of Health-related Materials, HMO must send HHSC-approved English versions of HMO's Member Handbook, Member Provider Directory, newsletters, individual Member letters, and any written information that applies to Medicaid-specific services to TDHS for TDHS to translate into Spanish. TDHS must provide the written and approved translation into Spanish to HMO no later than 15 working days after receipt of the English version by HHSC. HMO must

incorporate the approved translation into their materials. If TDHS has not responded to HMO by the fifteenth day, HMO may print and distribute these materials. HHSC reserves the right to require revisions to materials if inaccuracies are discovered or if changes are required by changes in policy or law. These changes can be made at the next printing, unless substantial non-compliance exists, as determined by HHSC. HMO has the option to use the TDHS translation unit or their own translators for health education materials not containing Medicaid-specific information and for other marketing materials such as billboards, radio spots, and television and newspaper advertisements.

Section 2.03 ***Modification to Article 4, Fiscal, Financial, Claims, and Insurance Requirements***

Article 4, Fiscal, Financial, Claims, and Insurance Requirements, is amended by modifying Sections 4.10.3 and 4.10.6, respectively, as follows:

4.10.3 HMO and claims processing subcontractors must comply with HHSC's Texas Medicaid Managed Care Claims Manual (Claims Manual), as amended or modified. The Claims Manual is incorporated herein by reference and contains HHSC's claims processing and reporting requirements. HHSC will provide the HMO reasonable notice of changes to the Claims Manual. For purposes of this section only, "reasonable notice" will generally mean 60 days advance written notice of systems changes and 30 days advance written notice of other changes, unless in HHSC's sole discretion, changes in federal or state laws, rules, regulations, or policies warrant a shorter time period for notice.

4.10.6 All provider clean claims must be adjudicated (finalized as paid or denied adjudicated) within 30 days from the date the claim is received by HMO. HMO must pay providers interest on a claim that is not adjudicated within 30 days from either: (1) the date the HMO receives the clean claim, or (2) the date the claim becomes clean. HMO must pay providers interest at an 18% annual rate, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. HMO must comply with the Texas Medicaid Managed Care Claims Manual to determine the principal amount for the interest payment computation. HMO will be held to a minimum performance level of 90% of all clean claims paid or denied within 30 days of receipt and 99% of all clean claims paid or denied within 90 days of receipt. Failure to meet these performance levels is a default under this contract and could lead to damages or sanctions as outlined in Article 17. The performance levels are subject to changes, if required to comply with federal and state laws or regulations.

Section 2.04 ***Modification to Article 5, Statutory, Regulatory, and Compliance Requirements***

Effective February 15, 2004, Article 5, Statutory, Regulatory, and Compliance Requirements, is amended by adding new Section 5.1.4, and by modifying Sections 5.6.1 and 5.6.2, respectively, as set forth below. The attached HUB monthly reporting form replaces the quarterly reporting form included in Attachment B to the Agreement :

5.1.4 In accordance with Texas Government Code §2262.003, HMO understands that acceptance of funds under this contract acts as

acceptance of the authority of the State Auditor's Office, or any successor agency, to conduct an audit or investigation in connection with those funds. HMO further agrees to cooperate fully with the State Auditor's Office or its successor in the conduct of the audit or investigation, including providing all records requested. HMO will ensure that this clause concerning the authority to audit funds received indirectly by subcontractors through HMO and the requirement to cooperate is included in any subcontract it awards.

5.6 HISTORICALLY UNDERUTILIZED BUSINESS

5.6.1 In accordance with Texas Government Code Chapter 2161 and 1 TAC §111.11 et seq. and §392.100 state agencies are required to make a good faith effort to assist Historically Underutilized Businesses (HUBs) in receiving contract awards issued by the State. The goal of this program is to promote full and equal business opportunity for all businesses in contracting with the state. It is HHSC's intent that all contractors make a good faith effort to subcontract with HUBs during the performance of their contracts.

Important Note: The Health and Human Services Commission has concluded that HUB subcontracting opportunities may exist in connection with this contract. See Appendix B to the Agreement for the following instructions and form: "Grant/Subcontract Applications Client Services HUB Subcontracting Plan Instructions" (C-IGA) and "Determination of Good Faith Effort for Grant Contracts" (C-DGFE). If an approved HUB Subcontracting Plan is not already on file with HHSC, the HMO shall submit a completed C-DGFE with the signed contract or renewal.

5.6.2 In accordance with Article 12.11, HMO is required to submit HUB monthly reports in the format set forth in Appendix B to the Agreement. CONTRACTOR must submit retroactive monthly reports for months, beginning December 2003.

If HMO decides after the award to subcontract any part of the contracted work, the HMO shall notify HHSC Health Plan Manager prior to entering into any subcontract. The HMO shall comply with the good faith effort requirements relating to developing and submitting a modified HUB Subcontracting Plan.

Section 2.05 ***Modification of Article 6, Scope of Services***

Article 6, Scope of Services, is amended by modifying Section 6.6.11, as follows:

6.6 BEHAVIORAL HEALTH CARE SERVICES – SPECIFIC REQUIREMENTS

6.6.11 HMO must provide inpatient psychiatric Covered Services to Members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Title VII, Subtitle C of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, or a placement in a state-operated facility as a condition of probation, as authorized by the Texas Family Code.

Section 2.06 ***Modification of Article 7, Provider Network Requirements***

Article 7, Provider Network Requirements, is amended by modifying Section 7.2.8.10, as follows:

7.2.8.10 All provider clean claims must be adjudicated (finalized as paid or denied adjudicated) within 30 days from the date the claim is received by HMO. HMO must agree to pay the provider interest, in accordance with Section 4.10.6 for clean claims that are not adjudicated within 30 days.

Section 2.07 ***Modification of Article 12, Reporting Requirements***

Effective February 15, 2004, Article 12, Reporting Requirements, is amended by modifying Sections 12.2.9, and 12.11, as follows:

12.2.9 Claims Reports. HMO must comply with Claims Reports submission requirements specified in HHSC's Texas Medicaid Managed Care Claims Manual. The reports must be submitted to HHSC in a format specified within the Texas Medicaid Managed Care Claims Manual and/or report templates provided by HHSC.

12.11 HMO must submit monthly reports documenting HMO's HUB program efforts and accomplishments in a format provided by HHSC.

Section 2.08 ***Modification of Article 13, Payment Provisions***

Article 13, Payment Provisions, is amended by modifying Section 13.1.2. Section 13.2.4 is deleted in its entirety, and new Section 13.2.6 is added, as follows:

13.1.2 The monthly capitation amounts and the Delivery Supplemental Payment (DSP) amount, effective as of September 1, 2003, are listed below.

SDA Risk Group	Monthly Capitation Amounts
TANF Children (> 1 year of age)	**$ 90.20**
TANF Adults	**$ 183.46**
Pregnant Women	**$ 274.23**
Newborns* (up to 12 Months of Age)	**$ 369.15**
Expansion Children (> 1 year of Age)	**$ 77.35**
Federal Mandate Children	**$ 53.78**
Disabled/Blind Administration	**$ 14.00**

* The category, "Newborns" includes the following groups of children: 1) TP 45s (see Article 2, Definitions of STAR contract), 2) Expansion Children who are less than or equal to 1 year of age, and 3) TANF children who are less than or equal to 1 year of age).

Delivery Supplemental Payment. A one-time per pregnancy supplemental payment for each delivery shall be paid to HMO as provided below in the following amount: **$2992.02**.

13.2 EXPERIENCE REBATE TO STATE

13.2.4 [deleted]

13.2.6 Interest on any experience rebate owed to HHSC shall be charged beginning on the date that the first and/or second settlements are overdue to the date of the respective payment. In addition, if any adjusted amount is owed to HHSC at the final settlement date, then interest is charged on the adjusted amount owed beginning on the second settlement date to the date of the final settlement payment. Interest charged shall be calculated on an annual and simple basis using the current Prime Rate(s) established by the federal government.

ARTICLE 3. REPRESENTATIONS AND AGREEMENT OF THE PARTIES

The Parties contract and agree that the terms of the Agreement will remain in effect and continue to govern except to the extent modified in this Amendment.

By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made a part of the Agreement as though it were set out word for word in the Agreement.

IN WITNESS HEREOF, HHSC and the CONTRACTOR have each caused this Amendment to be signed and delivered by its duly authorized representative.

SUPERIOR HEALTH PLAN, INC.	**HEALTH & HUMAN SERVICES COMMISSION**
By: _____	By: _____
Christopher Bowers **President and CEO**	**Albert Hawkins** **Executive Commissioner**
Date: _____	Date: _____

STATE OF TEXAS

COUNTY OF TRAVIS

AMENDMENT 15
TO THE AGREEMENT BETWEEN THE
HEALTH & HUMAN SERVICES COMMISSION
AND
SUPERIOR HEALTH PLAN, INC.
FOR HEALTH SERVICES
TO THE
MEDICAID STAR PROGRAM
IN THE
TRAVIS SERVICE DELIVERY AREA

THIS CONTRACT AMENDMENT (the "Amendment") is entered into between the HEALTH & HUMAN SERVICES COMMISSION ("HHSC"), an administrative agency within the executive department of the State of Texas, and **Superior Health Plan, Inc.** ("HMO"), a health maintenance organization organized under the laws of the State of Texas, possessing a certificate of authority issued by the Texas Department of Insurance to operate as a health maintenance organization, and having its principal office at **2100 S. IH 35, Suite 202, Austin, Texas 78704** HHSC and CONTRACTOR may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their Agreement as set forth in Article 2 of this Amendment.

ARTICLE 1. PURPOSE.

Section 1.01 ***Authorization.***

This Amendment is executed by the Parties in accordance with Article 15.2 of the Agreement.

Section 1.02 ***Effective date.***

The effective date of this amendment is **March 1, 2004.**

ARTICLE 2. AMENDMENT TO THE OBLIGATIONS OF THE PARTIES

Section 2.01 ***Modification of Appendix C, Value-added Services***

Appendix C of the Contract is modified to revise the value-added services provided by the HMO on or after March 1, 2004 as follows:

1. In the "Physical Health Value-added Services" category, replace the "Prenatal Program with Gifts," benefit description with the language in the revised Appendix C, attached.
2. In the "Physical Health Value-added Services" category, replace the "Additional Vision Benefits" benefit description with the language in the revised Appendix C, attached."

The revised Appendix C is attached to this amendment and incorporated by reference into the Contract.

ARTICLE 3. REPRESENTATIONS AND AGREEMENT OF THE PARTIES

The Parties contract and agree that the terms of the Agreement will remain in effect and continue to govern except to the extent modified in this Amendment.

By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made a part of the Agreement as though it were set out word for word in the Agreement.

IN WITNESS HEREOF, HHSC and the CONTRACTOR have each caused this Amendment to be signed and delivered by its duly authorized representative.

SUPERIOR HEALTH PLAN, INC.

By: _____

Christopher Bowers
President and CEO

Date: _____

HEALTH & HUMAN SERVICES COMMISSION

By: _____

Albert Hawkins
Executive Commissioner

Date: _____

STATE OF TEXAS

COUNTY OF TRAVIS

AMENDMENT 16
TO THE AGREEMENT BETWEEN THE
HEALTH & HUMAN SERVICES COMMISSION
AND
SUPERIOR HEALTH PLAN, INC.
FOR HEALTH SERVICES
TO THE
MEDICAID STAR PROGRAM
IN THE
TRAVIS SERVICE DELIVERY AREA

THIS CONTRACT AMENDMENT (the "Amendment") is entered into between the HEALTH & HUMAN SERVICES COMMISSION ("HHSC"), an administrative agency within the executive department of the State of Texas, and **Superior Health Plan, Inc.** ("HMO"), a health maintenance organization organized under the laws of the State of Texas, possessing a certificate of authority issued by the Texas Department of Insurance to operate as a health maintenance organization, and having its principal office at **2100 S. IH 35, Suite 202, Austin, Texas 78704** HHSC and CONTRACTOR may be referred to within this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their Agreement as set forth herein.

ARTICLE 1. PURPOSE.

Section 1.01 ***Authorization.***

This Amendment is executed by the Parties in accordance with Article 15.2 of the Agreement.

Section 1.02 ***Effective Date.***

Except as otherwise provided in this Amendment, the provisions of this Amendment are effective on **May 1, 2004.**

ARTICLE 2. AMENDMENT TO THE OBLIGATIONS OF THE PARTIES

Section 2.01 ***Modification to Article 2, Definitions***

The following provisions amend and supplement the definitions set forth in Article 2, Definitions, as follows:

Court-ordered Commitment means a commitment of a STAR Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C, or a placement in a state-operated facility as a condition of probation, as authorized by the Texas Family Code.

Health-related Materials are materials that are developed by the HMO or obtained from a third party relating to the diagnosis or treatment of medical conditions.

Section 2.02 ***Modification to Article 3, Plan Administrative and Human Resources Requirements***

Article 3, Plan Administrative and Human Resources Requirements, is amended by modifying Sections 3.4.1 through 3.4.4, as follows:

3.4.1 Prior to distribution to (1) Members, (2) prospective Members, (3) providers within HMO's network, or (4) potential providers whom HMO intends to recruit as network providers, and with the exception of Health-related Materials, HMO must receive written approval from HHSC for all written materials produced or authorized by HMO containing information about the STAR Program. Health-related Materials do not need to be submitted for review and approval. Per HHSC request, and on an ad-hoc basis, HMOs will be required to submit a list of Health-related Materials currently being used, or used previously; HHSC may request the review of selected materials from that list. HHSC will provide HMO a reasonable amount of time to respond to such requests, generally no less than 10 business days.

3.4.2 Member materials must meet cultural and linguistic requirements, as stated in Article 8. Unless otherwise required, Member materials must be written at a 4th - 6th grade reading comprehension level, and translated into the language of any major population group, except when HHSC requires HMO to use statutory language (i.e., advance directives, medical necessity, etc.).

3.4.3 With the exception of Health-related Materials, all plan materials regarding the STAR Program, including Member education materials, must be submitted to HHSC for approval prior to distribution. HHSC has fifteen (15) working days to review the materials and recommend any suggestions or required changes. If HHSC has not responded to HMO by the fifteenth (15th) day, HMO may print and distribute these materials. HHSC reserves the right to request HMO to modify plan materials that are deemed approved and have been printed or distributed. These modifications can be made at the next printing unless substantial non-compliance exists, as determined by HHSC. An exception to the fifteen (15) working day timeframe may be requested in writing by HMO for written provider materials that require a quick turn-around time (e.g., letters). HHSC will review such requests within a reasonable amount of time, generally within 5 working days. HHSC reserves the right to require revisions to materials if inaccuracies are discovered or if changes are required by changes in policy or law. These changes can be made at the next printing unless substantial non-compliance exists, as determined by HHSC.

3.4.4 With the exception of Health-related Materials, HMO must send HHSC-approved English versions of HMO's Member Handbook, Member Provider Directory, newsletters, individual Member letters, and any written information that applies to Medicaid-specific services to TDHS for TDHS to translate into Spanish. TDHS must provide the written and approved translation into Spanish to HMO no later than 15 working days after receipt of the English version by HHSC. HMO must

incorporate the approved translation into their materials. If TDHS has not responded to HMO by the fifteenth day, HMO may print and distribute these materials. HHSC reserves the right to require revisions to materials if inaccuracies are discovered or if changes are required by changes in policy or law. These changes can be made at the next printing, unless substantial non-compliance exists, as determined by HHSC. HMO has the option to use the TDHS translation unit or their own translators for health education materials not containing Medicaid-specific information and for other marketing materials such as billboards, radio spots, and television and newspaper advertisements.

Section 2.03 ***Modification to Article 4, Fiscal, Financial, Claims, and Insurance Requirements***

Article 4, Fiscal, Financial, Claims, and Insurance Requirements, is amended by modifying Sections 4.10.3 and 4.10.6, respectively, as follows:

4.10.3 HMO and claims processing subcontractors must comply with HHSC's Texas Medicaid Managed Care Claims Manual (Claims Manual), as amended or modified. The Claims Manual is incorporated herein by reference and contains HHSC's claims processing and reporting requirements. HHSC will provide the HMO reasonable notice of changes to the Claims Manual. For purposes of this section only, "reasonable notice" will generally mean 60 days advance written notice of systems changes and 30 days advance written notice of other changes, unless in HHSC's sole discretion, changes in federal or state laws, rules, regulations, or policies warrant a shorter time period for notice.

4.10.6 All provider clean claims must be adjudicated (finalized as paid or denied adjudicated) within 30 days from the date the claim is received by HMO. HMO must pay providers interest on a claim that is not adjudicated within 30 days from either: (1) the date the HMO receives the clean claim, or (2) the date the claim becomes clean. HMO must pay providers interest at an 18% annual rate, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. HMO must comply with the Texas Medicaid Managed Care Claims Manual to determine the principal amount for the interest payment computation. HMO will be held to a minimum performance level of 90% of all clean claims paid or denied within 30 days of receipt and 99% of all clean claims paid or denied within 90 days of receipt. Failure to meet these performance levels is a default under this contract and could lead to damages or sanctions as outlined in Article 17. The performance levels are subject to changes, if required to comply with federal and state laws or regulations.

Section 2.04 ***Modification to Article 5, Statutory, Regulatory, and Compliance Requirements***

Effective February 15, 2004, Article 5, Statutory, Regulatory, and Compliance Requirements, is amended by adding new Section 5.1.4, and by modifying Sections 5.6.1 and 5.6.2, respectively, as set forth below. The attached HUB monthly reporting form replaces the quarterly reporting form included in Attachment B to the Agreement :

5.1.4 In accordance with Texas Government Code §2262.003, HMO understands that acceptance of funds under this contract acts as

acceptance of the authority of the State Auditor's Office, or any successor agency, to conduct an audit or investigation in connection with those funds. HMO further agrees to cooperate fully with the State Auditor's Office or its successor in the conduct of the audit or investigation, including providing all records requested. HMO will ensure that this clause concerning the authority to audit funds received indirectly by subcontractors through HMO and the requirement to cooperate is included in any subcontract it awards.

5.6 HISTORICALLY UNDERUTILIZED BUSINESS

5.6.1 In accordance with Texas Government Code Chapter 2161 and 1 TAC §111.11 et seq. and §392.100 state agencies are required to make a good faith effort to assist Historically Underutilized Businesses (HUBs) in receiving contract awards issued by the State. The goal of this program is to promote full and equal business opportunity for all businesses in contracting with the state. It is HHSC's intent that all contractors make a good faith effort to subcontract with HUBs during the performance of their contracts.

Important Note: The Health and Human Services Commission has concluded that HUB subcontracting opportunities may exist in connection with this contract. See Appendix B to the Agreement for the following instructions and form: "Grant/Subcontract Applications Client Services HUB Subcontracting Plan Instructions" (C-IGA) and "Determination of Good Faith Effort for Grant Contracts" (C-DGFE). If an approved HUB Subcontracting Plan is not already on file with HHSC, the HMO shall submit a completed C-DGFE with the signed contract or renewal.

5.6.2 In accordance with Article 12.11, HMO is required to submit HUB monthly reports in the format set forth in Appendix B to the Agreement. CONTRACTOR must submit retroactive monthly reports for months, beginning December 2003.

If HMO decides after the award to subcontract any part of the contracted work, the HMO shall notify HHSC Health Plan Manager prior to entering into any subcontract. The HMO shall comply with the good faith effort requirements relating to developing and submitting a modified HUB Subcontracting Plan.

Section 2.05 ***Modification of Article 6, Scope of Services***

Article 6, Scope of Services, is amended by modifying Section 6.6.11, as follows:

6.6 BEHAVIORAL HEALTH CARE SERVICES – SPECIFIC REQUIREMENTS

6.6.11 HMO must provide inpatient psychiatric Covered Services to Members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Title VII, Subtitle C of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, or a placement in a state-operated facility as a condition of probation, as authorized by the Texas Family Code.

Section 2.06 ***Modification of Article 7, Provider Network Requirements***

Article 7, Provider Network Requirements, is amended by modifying Section 7.2.8.10, as follows:

7.2.8.10 All provider clean claims must be adjudicated (finalized as paid or denied adjudicated) within 30 days from the date the claim is received by HMO. HMO must agree to pay the provider interest, in accordance with Section 4.10.6 for clean claims that are not adjudicated within 30 days.

Section 2.07 ***Modification of Article 12, Reporting Requirements***

Effective February 15, 2004, Article 12, Reporting Requirements, is amended by modifying Sections 12.2.9, and 12.11, as follows:

12.2.9 Claims Reports. HMO must comply with Claims Reports submission requirements specified in HHSC's Texas Medicaid Managed Care Claims Manual. The reports must be submitted to HHSC in a format specified within the Texas Medicaid Managed Care Claims Manual and/or report templates provided by HHSC.

12.11 HMO must submit monthly reports documenting HMO's HUB program efforts and accomplishments in a format provided by HHSC.

Section 2.08 ***Modification of Article 13, Payment Provisions***

Article 13, Payment Provisions, is amended by modifying Section 13.1.2. Section 13.2.4 is deleted in its entirety, and new Section 13.2.6 is added, as follows:

13.1.2 The monthly capitation amounts and the Delivery Supplemental Payment (DSP) amount, effective as of September 1, 2003, are listed below.

SDA Risk Group	Monthly Capitation Amounts
TANF Children (> 1 year of age)	**$ 82.80**
TANF Adults	**$ 174.43**
Pregnant Women	**$ 344.50**
Newborns* (up to 12 Months of Age)	**$ 349.61**
Expansion Children (> 1 year of Age)	**$ 82.18**
Federal Mandate Children	**$ 68.23**
Disabled/Blind Administration	**$ 14.00**

* The category, "Newborns" includes the following groups of children: 1) TP 45s (see Article 2, Definitions of STAR contract), 2) Expansion Children who are less than or equal to 1 year of age, and 3) TANF children who are less than or equal to 1 year of age).

Delivery Supplemental Payment. A one-time per pregnancy supplemental payment for each delivery shall be paid to HMO as provided below in the following amount: **$2817.00**.

13.2 EXPERIENCE REBATE TO STATE

13.2.4 [deleted]

13.2.6 Interest on any experience rebate owed to HHSC shall be charged beginning on the date that the first and/or second settlements are overdue to the date of the respective payment. In addition, if any adjusted amount is owed to HHSC at the final settlement date, then interest is charged on the adjusted amount owed beginning on the second settlement date to the date of the final settlement payment. Interest charged shall be calculated on an annual and simple basis using the current Prime Rate(s) established by the federal government.

ARTICLE 3. REPRESENTATIONS AND AGREEMENT OF THE PARTIES

The Parties contract and agree that the terms of the Agreement will remain in effect and continue to govern except to the extent modified in this Amendment.

By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made a part of the Agreement as though it were set out word for word in the Agreement.

IN WITNESS HEREOF, HHSC and the CONTRACTOR have each caused this Amendment to be signed and delivered by its duly authorized representative.

SUPERIOR HEALTH PLAN, INC.	**HEALTH & HUMAN SERVICES COMMISSION**
By: _____	By: _____
Christopher Bowers **President and CEO**	**Albert Hawkins** **Executive Commissioner**
Date: _____	Date: _____

STATE OF TEXAS

COUNTY OF TRAVIS

AMENDMENT 15
TO THE AGREEMENT BETWEEN THE
HEALTH & HUMAN SERVICES COMMISSION
AND
SUPERIOR HEALTH PLAN, INC.
FOR HEALTH SERVICES
TO THE
MEDICAID STAR PROGRAM
IN THE
BEXAR SERVICE DELIVERY AREA

THIS CONTRACT AMENDMENT (the "Amendment") is entered into between the HEALTH & HUMAN SERVICES COMMISSION ("HHSC"), an administrative agency within the executive department of the State of Texas, and **Superior Health Plan, Inc.** ("HMO"), a health maintenance organization organized under the laws of the State of Texas, possessing a certificate of authority issued by the Texas Department of Insurance to operate as a health maintenance organization, and having its principal office at **2100 S. IH 35, Suite 202, Austin, Texas 78704** HHSC and CONTRACTOR may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their Agreement as set forth in Article 2 of this Amendment.

ARTICLE 1. PURPOSE.

Section 1.01 ***Authorization.***

This Amendment is executed by the Parties in accordance with Article 15.2 of the Agreement.

Section 1.02 ***Effective date.***

The effective date of this amendment is **March 1, 2004.**

ARTICLE 2. AMENDMENT TO THE OBLIGATIONS OF THE PARTIES

Section 2.01 ***Modification of Appendix C, Value-added Services***

Appendix C of the Contract is modified to revise the value-added services provided by the HMO on or after March 1, 2004 as follows:

1. In the "Physical Health Value-added Services" category, replace the "Prenatal Program with Gifts," benefit description with the language in the revised Appendix C, attached.
2. In the "Physical Health Value-added Services" category, replace the "Additional Vision Benefits" benefit description with the language in the revised Appendix C, attached."

The revised Appendix C is attached to this amendment and incorporated by reference into the Contract.

ARTICLE 3. REPRESENTATIONS AND AGREEMENT OF THE PARTIES

The Parties contract and agree that the terms of the Agreement will remain in effect and continue to govern except to the extent modified in this Amendment.

By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made a part of the Agreement as though it were set out word for word in the Agreement.

IN WITNESS HEREOF, HHSC and the CONTRACTOR have each caused this Amendment to be signed and delivered by its duly authorized representative.

SUPERIOR HEALTH PLAN, INC.	**HEALTH & HUMAN SERVICES COMMISSION**
By: _____	By: _____
Christopher Bowers President and CEO	Albert Hawkins Executive Commissioner
Date: _____	Date: _____

Exhibit 10.3

HHSC Contract No. 529-03-042-P

STATE OF TEXAS

COUNTY OF TRAVIS

AMENDMENT 16
TO THE AGREEMENT BETWEEN THE
HEALTH & HUMAN SERVICES COMMISSION
AND
SUPERIOR HEALTH PLAN, INC.
FOR HEALTH SERVICES
TO THE
MEDICAID STAR PROGRAM
IN THE
BEXAR SERVICE DELIVERY AREA

THIS CONTRACT AMENDMENT (the "Amendment") is entered into between the HEALTH & HUMAN SERVICES COMMISSION ("HHSC"), an administrative agency within the executive department of the State of Texas, and **Superior Health Plan, Inc.** ("HMO"), a health maintenance organization organized under the laws of the State of Texas, possessing a certificate of authority issued by the Texas Department of Insurance to operate as a health maintenance organization, and having its principal office at **2100 S. IH 35, Suite 202, Austin, Texas 78704.**HHSC and CONTRACTOR may be referred to within this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their Agreement as set forth herein.

ARTICLE 1. PURPOSE.

Section 1.01 ***Authorization.***

This Amendment is executed by the Parties in accordance with Article 15.2 of the Agreement.

Section 1.02 ***Effective Date.***

Except as otherwise provided in this Amendment, the provisions of this Amendment are effective on**May 1, 2004.**

ARTICLE 2. AMENDMENT TO THE OBLIGATIONS OF THE PARTIES

Section 2.01 ***Modification to Article 2, Definitions***

The following provisions amend and supplement the definitions set forth in Article 2, Definitions, as follows:

Court-ordered Commitment means a commitment of a STAR Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C, or a placement in a state-operated facility as a condition of probation, as authorized by the Texas Family Code.

Health-related Materials are materials that are developed by the HMO or obtained from a third party relating to the diagnosis or treatment of medical conditions.

Section 2.02 ***Modification to Article 3, Plan Administrative and Human Resources Requirements***

Article 3, Plan Administrative and Human Resources Requirements, is amended by modifying Sections 3.4.1 through 3.4.4, as follows:

3.4.1 Prior to distribution to (1) Members, (2) prospective Members, (3) providers within HMO's network, or (4) potential providers whom HMO intends to recruit as network providers, and with the exception of Health-related Materials, HMO must receive written approval from HHSC for all written materials produced or authorized by HMO containing information about the STAR Program. Health-related Materials do not need to be submitted for review and approval. Per HHSC request, and on an ad-hoc basis, HMOs will be required to submit a list of Health-related Materials currently being used, or used previously; HHSC may request the review of selected materials from that list. HHSC will provide HMO a reasonable amount of time to respond to such requests, generally no less than 10 business days.

3.4.2 Member materials must meet cultural and linguistic requirements, as stated in Article 8. Unless otherwise required, Member materials must be written at a 4th - 6th grade reading comprehension level, and translated into the language of any major population group, except when HHSC requires HMO to use statutory language (i.e., advance directives, medical necessity, etc.).

3.4.3 With the exception of Health-related Materials, all plan materials regarding the STAR Program, including Member education materials, must be submitted to HHSC for approval prior to distribution. HHSC has fifteen (15) working days to review the materials and recommend any suggestions or required changes. If HHSC has not responded to HMO by the fifteenth (15th) day, HMO may print and distribute these materials. HHSC reserves the right to request HMO to modify plan materials that are deemed approved and have been printed or distributed. These modifications can be made at the next printing unless substantial non-compliance exists, as determined by HHSC. An exception to the fifteen (15) working day timeframe may be requested in writing by HMO for written provider materials that require a quick turn-around time (e.g., letters). HHSC will review such requests within a reasonable amount of time, generally within 5 working days. HHSC reserves the right to require revisions to materials if inaccuracies are discovered or if changes are required by changes in policy or law. These changes can be made at the next printing unless substantial non-compliance exists, as determined by HHSC.

3.4.4 With the exception of Health-related Materials, HMO must send HHSC-approved English versions of HMO's Member Handbook, Member Provider Directory, newsletters, individual Member letters, and any written information that applies to Medicaid-specific services to TDHS for TDHS to translate into Spanish. TDHS must provide the written and approved translation into Spanish to HMO no later than 15 working days after receipt of the English version by HHSC. HMO must

incorporate the approved translation into their materials. If TDHS has not responded to HMO by the fifteenth day, HMO may print and distribute these materials. HHSC reserves the right to require revisions to materials if inaccuracies are discovered or if changes are required by changes in policy or law. These changes can be made at the next printing, unless substantial non-compliance exists, as determined by HHSC. HMO has the option to use the TDHS translation unit or their own translators for health education materials not containing Medicaid-specific information and for other marketing materials such as billboards, radio spots, and television and newspaper advertisements.

Section 2.03 ***Modification to Article 4, Fiscal, Financial, Claims, and Insurance Requirements***

Article 4, Fiscal, Financial, Claims, and Insurance Requirements, is amended by modifying Sections 4.10.3 and 4.10.6, respectively, as follows:

4.10.3 HMO and claims processing subcontractors must comply with HHSC's Texas Medicaid Managed Care Claims Manual (Claims Manual), as amended or modified. The Claims Manual is incorporated herein by reference and contains HHSC's claims processing and reporting requirements. HHSC will provide the HMO reasonable notice of changes to the Claims Manual. For purposes of this section only, "reasonable notice" will generally mean 60 days advance written notice of systems changes and 30 days advance written notice of other changes, unless in HHSC's sole discretion, changes in federal or state laws, rules, regulations, or policies warrant a shorter time period for notice.

4.10.6 All provider clean claims must be adjudicated (finalized as paid or denied adjudicated) within 30 days from the date the claim is received by HMO. HMO must pay providers interest on a claim that is not adjudicated within 30 days from either: (1) the date the HMO receives the clean claim, or (2) the date the claim becomes clean. HMO must pay providers interest at an 18% annual rate, calculated daily for the full period in which the clean claim remains unadjudicated beyond the 30-day claims processing deadline. HMO must comply with the Texas Medicaid Managed Care Claims Manual to determine the principal amount for the interest payment computation. HMO will be held to a minimum performance level of 90% of all clean claims paid or denied within 30 days of receipt and 99% of all clean claims paid or denied within 90 days of receipt. Failure to meet these performance levels is a default under this contract and could lead to damages or sanctions as outlined in Article 17. The performance levels are subject to changes, if required to comply with federal and state laws or regulations.

Section 2.04 ***Modification to Article 5, Statutory, Regulatory, and Compliance Requirements***

Effective February 15, 2004, Article 5, Statutory, Regulatory, and Compliance Requirements, is amended by adding new Section 5.1.4, and by modifying Sections 5.6.1 and 5.6.2, respectively, as set forth below. The attached HUB monthly reporting form replaces the quarterly reporting form included in Attachment B to the Agreement :

5.1.4 In accordance with Texas Government Code §2262.003, HMO understands that acceptance of funds under this contract acts as

acceptance of the authority of the State Auditor's Office, or any successor agency, to conduct an audit or investigation in connection with those funds. HMO further agrees to cooperate fully with the State Auditor's Office or its successor in the conduct of the audit or investigation, including providing all records requested. HMO will ensure that this clause concerning the authority to audit funds received indirectly by subcontractors through HMO and the requirement to cooperate is included in any subcontract it awards.

5.6 HISTORICALLY UNDERUTILIZED BUSINESS

5.6.1 In accordance with Texas Government Code Chapter 2161 and 1 TAC §111.11 et seq. and §392.100 state agencies are required to make a good faith effort to assist Historically Underutilized Businesses (HUBs) in receiving contract awards issued by the State. The goal of this program is to promote full and equal business opportunity for all businesses in contracting with the state. It is HHSC's intent that all contractors make a good faith effort to subcontract with HUBs during the performance of their contracts.

Important Note: The Health and Human Services Commission has concluded that HUB subcontracting opportunities may exist in connection with this contract. See Appendix B to the Agreement for the following instructions and form: "Grant/Subcontract Applications Client Services HUB Subcontracting Plan Instructions" (C-IGA) and "Determination of Good Faith Effort for Grant Contracts" (C-DGFE). If an approved HUB Subcontracting Plan is not already on file with HHSC, the HMO shall submit a completed C-DGFE with the signed contract or renewal.

5.6.2 In accordance with Article 12.11, HMO is required to submit HUB monthly reports in the format set forth in Appendix B to the Agreement. CONTRACTOR must submit retroactive monthly reports for months, beginning December 2003.

If HMO decides after the award to subcontract any part of the contracted work, the HMO shall notify HHSC Health Plan Manager prior to entering into any subcontract. The HMO shall comply with the good faith effort requirements relating to developing and submitting a modified HUB Subcontracting Plan.

Section 2.05 ***Modification of Article 6, Scope of Services***

Article 6, Scope of Services, is amended by modifying Section 6.6.11, as follows:

6.6 BEHAVIORAL HEALTH CARE SERVICES – SPECIFIC REQUIREMENTS

6.6.11 HMO must provide inpatient psychiatric Covered Services to Members under the age of 21 who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Title VII, Subtitle C of the Texas Health and Safety Code, relating to court-ordered commitments to psychiatric facilities, or a placement in a state-operated facility as a condition of probation, as authorized by the Texas Family Code.

Section 2.06 ***Modification of Article 7, Provider Network Requirements***

Article 7, Provider Network Requirements, is amended by modifying Section 7.2.8.10, as follows:

7.2.8.10 All provider clean claims must be adjudicated (finalized as paid or denied adjudicated) within 30 days from the date the claim is received by HMO. HMO must agree to pay the provider interest, in accordance with Section 4.10.6 for clean claims that are not adjudicated within 30 days.

Section 2.07 ***Modification of Article 12, Reporting Requirements***

Effective February 15, 2004, Article 12, Reporting Requirements, is amended by modifying Sections 12.2.9, and 12.11, as follows:

12.2.9 Claims Reports. HMO must comply with Claims Reports submission requirements specified in HHSC's Texas Medicaid Managed Care Claims Manual. The reports must be submitted to HHSC in a format specified within the Texas Medicaid Managed Care Claims Manual and/or report templates provided by HHSC.

12.11 HMO must submit monthly reports documenting HMO's HUB program efforts and accomplishments in a format provided by HHSC.

Section 2.08 ***Modification of Article 13, Payment Provisions***

Article 13, Payment Provisions, is amended by modifying Section 13.1.2. Section 13.2.4 is deleted in its entirety, and new Section 13.2.6 is added, as follows:

13.1.2 The monthly capitation amounts and the Delivery Supplemental Payment (DSP) amount, effective as of September 1, 2003, are listed below.

SDA Risk Group	Monthly Capitation Amounts
TANF Children (> 1 year of age)	**$ 71.40**
TANF Adults	**$ 192.95**
Pregnant Women	**$ 337.33**
Newborns* (up to 12 Months of Age)	**$ 408.23**
Expansion Children (> 1 year of Age)	**$ 73.46**
Federal Mandate Children	**$ 64.53**
Disabled/Blind Administration	**$ 14.00**

* The category, "Newborns" includes the following groups of children: 1) TP 45s (see Article 2, Definitions of STAR contract), 2) Expansion Children who are less than or equal to 1 year of age, and 3) TANF children who are less than or equal to 1 year of age).

Delivery Supplemental Payment. A one-time per pregnancy supplemental payment for each delivery shall be paid to HMO as provided below in the following amount: **$2,834.10**.

13.2 EXPERIENCE REBATE TO STATE

13.2.4 [deleted]

13.2.6 Interest on any experience rebate owed to HHSC shall be charged beginning on the date that the first and/or second settlements are overdue to the date of the respective payment. In addition, if any adjusted amount is owed to HHSC at the final settlement date, then interest is charged on the adjusted amount owed beginning on the second settlement date to the date of the final settlement payment. Interest charged shall be calculated on an annual and simple basis using the current Prime Rate(s) established by the federal government.

ARTICLE 3. REPRESENTATIONS AND AGREEMENT OF THE PARTIES

The Parties contract and agree that the terms of the Agreement will remain in effect and continue to govern except to the extent modified in this Amendment.

By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made a part of the Agreement as though it were set out word for word in the Agreement.

IN WITNESS HEREOF, HHSC and the CONTRACTOR have each caused this Amendment to be signed and delivered by its duly authorized representative.

SUPERIOR HEALTH PLAN, INC.	**HEALTH & HUMAN SERVICES COMMISSION**
By: _____	By: _____
Christopher Bowers **President and CEO**	**Albert Hawkins** **Executive Commissioner**
Date: _____	Date: _____

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)) 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 annual report is being prepared;
   (b) [Paragraph omitted in accordance with SEC transition instructions contained in SEC Release 34-47986];
   (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 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 function):
   (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: April 26, 2004

/s/ MICHAEL F. NEIDORFF

Michael F. Neidorff
President and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, Karey L. Witty 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 Rules13a-15(e) and 15d-15(e)) 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 annual report is being prepared;
   (b) [Paragraph omitted in accordance with SEC transition instructions contained in SEC Release34-47986];
   (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 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 function):
   (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: April 26, 2004

/s/ KAREY L. WITTY

Karey L. Witty
Senior Vice President, Chief Financial Officer, Secretary and Treasurer
(principal financial and accounting 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 March 31, 2004, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Michael F. Neidorff, 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 and 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.

/s/ MICHAEL F. NEIDORFF

Michael F. Neidorff
President and Chief Executive Officer
(principal executive officer)

Dated: April 26, 2004

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 March 31, 2004, as filed with the Securities and Exchange Commission on the date hereof (the "Report"), the undersigned, Karey L. Witty, Senior Vice President, Chief Executive Officer and Treasurer 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 and 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.

/s/ KAREY L. WITTY

Karey L. Witty
Senior Vice President, Chief Financial Officer, Secretary and Treasurer
(principal financial and accounting officer)

Dated: April 26, 2004