UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549

Form 10-K

(Mark One)

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

For the fiscal year ended December 31, 2011

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation

(Exact name of registrant as specified in its charter)

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

Registrant's telephone number, including area code: (314) 725-4477

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

Common Stock, $0.001 Par Value	**New York Stock Exchange**
Title of Each Class	**Name of Each Exchange on Which Registered**

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

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

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

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 T No £

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

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

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2011, was $1.7 billion.

As of February 3, 2012, the registrant had 50,916,959 shares of common stock issued and outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2012 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

All statements, other than statements of current or historical fact, contained in this filing are forward-looking statements. We have attempted to identify these statements by terminology including “believe,” “anticipate,” “plan,” “expect,” “estimate,” “intend,” “seek,” “target,” “goal,” “may,” “will,” “should,” “can,” “continue” and other similar words or expressions in connection with, among other things, any discussion of future operating or financial performance. In particular, these statements include statements about our market opportunity, our growth strategy, competition, expected activities and future acquisitions, investments and the adequacy of our available cash resources. These statements may be found in the various sections of this filing, including those entitled “Management’s Discussion and Analysis of Financial Condition and Results of Operations,” Part I, Item 1A. “Risk Factors,” and Part I, Item 3 “Legal Proceedings.” Readers are cautioned that matters subject to forward-looking statements involve known and unknown risks and uncertainties, including economic, regulatory, competitive and other factors that may cause our or our industry’s actual results, levels of activity, performance or achievements to be materially different from any future results, levels of activity, performance or achievements expressed or implied by these forward-looking statements. These statements are not guarantees of future performance and are subject to risks, uncertainties and assumptions.

All forward-looking statements included in this filing are based on information available to us on the date of this filing. Actual results may differ from projections or estimates due to a variety of important factors, including:

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

Item 1A “Risk Factors” of Part I of this filing contains a further discussion of these and other important factors that could cause actual results to differ from expectations. We disclaim any current intention or obligation to update or revise any forward-looking statements, whether as a result of new information, future events or otherwise. Due to these important factors and risks, we cannot give assurances with respect to our future premium levels or our ability to control our future medical costs.

PART I

Item 1. ***Business***

OVERVIEW

We are a diversified, multi-line healthcare enterprise that provides programs and services to the rising number of under-insured and uninsured individuals. We provide member-focused services through locally based staff by assisting in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services. We believe our local approach to managing our health plans, including member and provider services, enables us to provide accessible, quality, culturally-sensitive healthcare coverage to our communities. Our health management, educational and other initiatives are designed to help members best utilize the healthcare system to ensure they receive appropriate, medically necessary services and effective management of routine, severe and chronic health problems, resulting in better health outcomes. We combine our decentralized local approach for care with a centralized infrastructure of support functions such as finance, information systems and claims processing.

We operate in two segments: Medicaid Managed Care and Specialty Services. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. As of December 31, 2011, Medicaid accounted for 74% of our at-risk membership, while CHIP (also including Foster Care) and ABD (also including Medicare) accounted for 12% and 12%, respectively. Other state programs in Massachusetts represent the remaining 2% at-risk membership. Our Specialty Services segment offers products for behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, long-term care programs, managed vision, telehealth services, and pharmacy benefits management to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. Our health plans in Arizona, operated by our long-term care company, and Massachusetts, operated by our individual health insurance provider, are included in the Specialty Services segment.

Our at-risk managed care membership totaled 1.8 million as of December 31, 2011. For the year ended December 31, 2011, our revenues and net earnings from continuing operations were $5.3 billion and $108.4 million, respectively, and our total cash flow from operations was $261.7 million.

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7700 Forsyth Boulevard, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

INDUSTRY

We provide our services to the uninsured primarily through Medicaid, CHIP, Foster Care, ABD, Medicare and other state programs for the uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid and CHIP market was approximately $374 billion in 2009, and estimate the market will grow to $908 billion by 2020. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 7.3% in fiscal 2011 and states appropriated an increase of 2.2% for Medicaid in fiscal 2012 budgets.

Established in 1965, Medicaid is the largest publicly funded program in the United States, and provides health insurance to low-income families and individuals with disabilities. Authorized by Title XIX of the Social Security Act, Medicaid is an entitlement program funded jointly by the federal and state governments and administered by the states. The majority of funding is provided at the federal level. Each state establishes its own eligibility standards, benefit packages, payment rates and program administration within federal standards. As a result, there are 56 Medicaid programs— one for each U.S. state, each U.S. territory and the District of Columbia. Eligibility is based on a combination of household income and assets, often determined by an income level relative to the federal poverty level. Historically, children have represented the largest eligibility group. Many states have selected Medicaid managed care as a means of delivering quality healthcare and controlling costs, including states that automatically enroll Medicaid recipients who don't select a health plan. We refer to these states as mandated managed care states.

Established in 1972, and authorized by Title XVI of the Social Security Act, ABD covers low-income persons with chronic physical disabilities or behavioral health impairments. ABD beneficiaries represent a growing portion of all Medicaid recipients. In addition, ABD recipients typically utilize more services because of their critical health issues.

The Balanced Budget Act of 1997 created CHIP to help states expand coverage primarily to children whose families earned too much to qualify for Medicaid, yet not enough to afford private health insurance. Some states include the parents of these children in their CHIP programs. CHIP is the single largest expansion of health insurance coverage for children since the enactment of Medicaid. Costs related to the largest eligibility group, children, are primarily composed of pediatrics and family care. These costs tend to be more predictable than other healthcare issues which predominantly affect the adult population.

A portion of Medicaid beneficiaries are dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to the Kaiser Commission on Medicaid and the Uninsured, there were approximately 9 million dual eligible enrollees in 2011. These dual eligibles may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual eligibles also use more services due to their tendency to have more chronic health issues. We serve dual eligibles through our ABD and long-term care programs, and beginning in 2008, through Medicare Special Needs Plans.

While Medicaid programs have directed funds to many individuals who cannot afford or otherwise maintain health insurance coverage, they did not initially address the inefficient and costly manner in which the Medicaid population tends to access healthcare. Medicaid recipients in non-managed care programs typically have not sought preventive care or routine treatment for chronic conditions, such as asthma and diabetes. Rather, they have sought healthcare in hospital emergency rooms, which tends to be more expensive. As a result, many states have found that the costs of providing Medicaid benefits have increased while the medical outcomes for the recipients remained unsatisfactory.

Since the early 1980s, increasing healthcare costs, combined with significant growth in the number of Medicaid recipients, have led many states to establish Medicaid managed care initiatives. Additionally, a number of states are designing programs to cover the rising number of uninsured Americans. The Kaiser Commission on Medicaid and the Uninsured estimated there were over 49 million Americans in 2010 that lacked health insurance. We expect that continued pressure on states' Medicaid budgets will cause public policy to recognize the value of managed care as a means of delivering quality healthcare and effectively controlling costs. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, Foster Care and ABD populations. We believe our approach and strategy enable us to be a growing participant in this market.

OUR COMPETITIVE STRENGTHS

Our multi-line managed care approach is based on the following key attributes:

- *Strong Historic Operating Performance.* We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984 as a single health plan and have grown to 12 health plans with at-risk membership totaling 1.8 million in 2011. For the year ended December 31, 2011, we had premium and service revenues of $5.2 billion, representing a five year Compound Annual Growth Rate, of 23.7%, generated total cash flow from operations of $261.7 million and net earnings of $108.4 million.

- *Innovative Technology and Scalable Systems.* The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions. Our predictive modeling technology enables the medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members. Our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner.

- *Medicaid Expertise*. For more than 25 years, we have developed a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. We work with state agencies on redefining benefits and eligibility requirements in order to maximize the number of uninsured individuals covered through Medicaid, CHIP, Foster Care, ABD and other state sponsored programs and expand the types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

- *Diversified Business Lines.* We continue to broaden our service offerings to address areas that we believe have been traditionally underserved by Medicaid managed care organizations. In addition to our Medicaid and Medicaid-related managed care services, our service offerings include behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, long-term care programs, managed vision, telehealth services and pharmacy benefits management. Through the utilization of a multi-business line approach, we are able to improve the quality of care, improve outcomes, diversify our revenues and help control our medical costs.

- *Localized Approach with Centralized Support Infrastructure*. We take a localized approach to managing our subsidiaries, including provider and member services. This approach enables us to facilitate access by our members to high quality, culturally sensitive healthcare services. Our systems and procedures have been designed to address these community-specific challenges through outreach, education, transportation and other member support activities. For example, our community outreach programs work with our members and their communities to promote health and self-improvement through employment and education on how best to access care. We complement this localized approach with a centralized infrastructure of support functions such as finance, information systems and claims processing, which allows us to minimize general and administrative expenses and to integrate and realize synergies from acquisitions. We believe this combined approach allows us to efficiently integrate new business opportunities in both Medicaid and specialty services while maintaining our local accountability and improved access.

OUR BUSINESS STRATEGY

Our objective is to become the leading multi-line healthcare enterprise focusing on the uninsured and under-insured population and state funded healthcare initiatives. We intend to achieve this objective by implementing the following key components of our strategy:

- *Increase Penetration of Existing State Markets.* We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and implementation of community-specific products and acquisitions. For example, in 2010, we expanded our health plan in Florida into long-term care through the acquisition of Citrus Health Care, Inc. In 2011, we expanded our health plan in Texas under an additional STAR+PLUS ABD contract in the Dallas service area and will expand in 2012 under a new contract to serve additional members in several new service areas.

- *Diversify Business Lines.* We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in July 2008, we completed the acquisition of Celtic Insurance Company, a nationwide individual health insurance provider. In 2010, we acquired a controlling ownership interest in Casenet, LLC, or Casenet, a care management software provider. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

- *Address Emerging State Needs.* We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, and provider compensation. For example, in 2008, we began operating under a new statewide program providing managed care services to participants in the Texas Foster Care program; in April 2010, we began offering an individual insurance product for residents of Massachusetts who do not qualify for other state funded insurance programs; in November 2010, we began operating under a new contract to provide affordable health plans for Texas small businesses under the new Healthy Texas initiative; and, in January 2011, we began operating under a new contract with the state of Indiana to provide affordable health plans for uninsured Indiana individuals under the new Healthy Indiana Plan. By helping states structure an appropriate level and range of Medicaid, CHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

- *Develop and Acquire Additional State Markets.* We continue to leverage our experience to identify and develop new markets by seeking both to acquire existing business and to build our own operations. We expect to focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations because we believe member enrollment levels are more predictable in these states. In addition, we focus on states where managed care programs can help address states' financial needs. For example, in 2011, we began managing care for ABD members in Mississippi, began providing managed care services to older adults and adults with disabilities in Illinois, and began managing care for Medicaid, ABD and Foster Care members in Kentucky.

- *Leverage Established Infrastructure to Enhance Operating Efficiencies*. We intend to continue to invest in infrastructure to further drive efficiencies in operations and to add functionality to improve the service provided to members and other organizations at a low cost. Information technology, or IT, investments complement our overall efficiency goals by increasing the automated processing of transactions and growing the base of decision-making analytical tools. Our centralized functions and common systems enable us to add members and markets quickly and economically.

- *Maintain Operational Discipline*. We seek to operate in markets that allow us to meet our internal metrics including membership growth, plan size, market leadership and operating efficiency. We use multiple techniques to monitor and reduce our medical costs, including on-site hospital review by staff nurses and involvement of medical management in significant cases. Our executive dashboard is utilized to quickly identify cost drivers and medical trends. Our management team regularly evaluates the financial impact of proposed changes in provider relationships, contracts, changes in membership and mix of members, potential state rate changes and cost reduction initiatives. We may divest contracts or health plans in markets where the state's Medicaid environment, over a long-term basis, does not allow us to meet our targeted performance levels.

We have regulated subsidiaries offering healthcare services in each state we serve. The table below provides summary data for the state markets we currently serve:

State	Local Health Plan Name	First Year of Operations Under the Company	Counties Served at December 31, 2011	Market Share	At-risk Managed Care Membership at December 31, 2011
Arizona	Bridgeway Health Solutions [1]	2006	10	(2)	23,700
Florida	Sunshine State Health Plan	2009	24	17.1%[3]	198,300
Georgia	Peach State Health Plan	2006	90	26.5%	298,200
Illinois	IlliniCare Health Plan	2011	7	50.0%	16,300
Indiana	Managed Health Services	1995	92	28.2%	206,900
Kentucky	Kentucky Spirit Health Plan	2011	104	34.7%	180,700
Massachusetts	CeltiCare Health Plan	2009	14	(4)	35,700
Mississippi	Magnolia Health Plan	2011	82	33.3%	31,600
Ohio	Buckeye Community Health Plan	2004	43	9.7%	159,900
South Carolina	Absolute Total Care	2007	39	13.6%	82,900
Texas	Superior HealthPlan	1999	254	18.7%	503,800
Wisconsin	Managed Health Services	1984	41	11.1%	78,000
					1,816,000

(1) Represents the acute care, long-term care and Medicare businesses under Bridgeway Health Solutions.
(2) Bridgeway acute care has a market share of 1.5% and long-term care has a market share of 9.8%.
(3) Florida market share excludes long-term care.
(4) CeltiCare Health Plan manages members under the state Commonwealth Care Bridge program and Commonwealth Care program with market share of 100% and approximately 13.0%, respectively.

All of our revenue is derived from operations within the United States and its territories, and all of the Company's long lived assets are based in the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of the following year. Our managed care subsidiaries in Georgia, Ohio, and Texas had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2011.

MEDICAID MANAGED CARE

Benefits to States

Our ability to establish and maintain a leadership position in the markets we serve results primarily from our demonstrated success in providing quality care while reducing and managing costs, and from our specialized programs in working with state governments. Among the benefits we are able to provide to the states with which we contract are:

- *Significant cost savings and budget predictability compared to state paid reimbursement for services.* We bring bottom-line management experience to our health plans. On the administrative and management side, we bring experience including quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care. We receive a contracted premium on a per member basis and are responsible for the medical costs and as a result, provide budget predictability.

- *Data-driven approaches to balance cost and verify eligibility.* We seek to ensure effective outreach procedures for new members, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems. We utilize predictive modeling technology to proactively case and disease manage specific high risk members. In addition, we have developed Centelligence, our enterprise data warehouse system provides a seamless flow of data across our organization, enabling providers and case managers to access information, apply analytical insight and make informed decisions.

- *Establishment of realistic and meaningful expectations for quality deliverables.* We have collaborated with state agencies in redefining benefits, eligibility requirements and provider fee schedules with the goal of maximizing the number of individuals covered through Medicaid, CHIP, Foster Care and ABD programs.

- *Managed care expertise in government subsidized programs.* Our expertise in Medicaid has helped us establish and maintain strong relationships with our constituent communities of members, providers and state governments. We provide access to services through local providers and staff that focus on the cultural norms of their individual communities. To that end, systems and procedures have been designed to address community-specific challenges through outreach, education, transportation and other member support activities.

- *Improved medical outcomes.* We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illness.

- *Timely payment of provider claims.* We are committed to ensuring that our information systems and claims payment systems meet or exceed state requirements. We continuously endeavor to update our systems and processes to improve the timeliness of our provider payments.

- *Provider outreach and programs.* Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. We prepare provider comparisons on a severity adjusted basis. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.

- *Responsible collection and dissemination of utilization data.* We gather utilization data from multiple sources, allowing for an integrated view of our members' utilization of services. These sources include medical, vision and behavioral health claims and encounter data, pharmacy data, dental vendor claims and authorization data from the authorization and case management system utilized by us to coordinate care.

- *Timely and accurate reporting.* Our information systems have reporting capabilities which have been instrumental in identifying the need for new and/or improved healthcare and specialty programs. For state agencies, our reporting capability is important in demonstrating an auditable program.

- *Fraud and abuse prevention.* We have several systems in place to help identify, detect and investigate potential waste, abuse and fraud including pre and post payment software. We collaborate with state and federal agencies and assist with investigation requests. We use nationally recognized standards to benchmark our processes.

Member Programs and Services

We recognize the importance of member-focused delivery of quality managed care services. Our locally-based staff assists members in accessing care, coordinating referrals to related health and social services and addressing member concerns and questions. While covered healthcare benefits vary from state to state, our health plans generally provide the following services:

- primary and specialty physician care
- inpatient and outpatient hospital care
- emergency and urgent care
- prenatal care
- laboratory and x-ray services
- home health and durable medical equipment
- behavioral health and substance abuse services
- 24-hour nurse advice line
- transportation assistance
- vision care
- dental care
- immunizations
- prescriptions and limited over-the-counter drugs
- therapies
- social work services
- care coordination

We also provide the following education and outreach programs to inform, assist and incentivize members in accessing quality, appropriate healthcare services in an efficient manner:

- *Start Smart For Your Baby* is our award winning prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits. The program includes risk assessments, education through face-to-face meetings and materials, behavior modification plans, assistance in selecting a physician for the infant and scheduling newborn follow-up visits. These initiatives are supported by a statistically proven reduction in Neonatal Intensive Care Unit (NICU) days as well as increased gestational birth weights. The program includes a proprietary Notification of Pregnancy process to identify pregnant women more quickly and enables us to help them gain access to prenatal medical care, give them education on their healthcare needs, assist with social needs and concerns, and coordinate referrals to appropriate specialists and the obstetrics (OB) case management program as needed. The Notification of Pregnancy also identifies women eligible for our high risk OB management program, or 17P Program, which aims to reduce the rate of recurrent preterm delivery and neonatal intensive care admissions through the use of Progesterone. In addition, Start Smart has also co-written a book for the first year of life with the American Academy of Pediatrics. The results of this program have also been published in several peer reviewed articles. In 2010, Start Smart won the Platinum Award for Consumer Empowerment at the URAC Quality Summit. Start Smart also was awarded the 2010 URAC / GKEN International Health Promotion Award. The "Your Pregnancy Guide" developed by Start Smart was a 2010 Silver Medalist of the National Health Information Award. In 2011, Start Smart was recognized in NCQA Quality Profiles: Focus on Patient Engagement as a featured program.

- *Connections Plus* is a cell phone program developed for high-risk members who have limited or no access to a safe, reliable telephone. The program puts free, preprogrammed cell phones into the hands of eligible members. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth. Members are identified through case management activities or through a referral. Connections Plus is available to high-risk members in all Centene health plans. Originally designed for pregnant women and ABD populations, this program has now been expanded to service members with mental health issues, and specific diseases, including sickle cell. Connections Plus was recognized as a URAC Best Practice 2009 Silver Medalist.

- *AT&T / WellDoc Program* is a pilot program introduced in Ohio in 2011 through a partnership with AT&T. This program provides smart phones to a limited group of high-risk members with diabetes, giving them access to DiabetesManager, the enterprise mHealth solution from AT&T and WellDoc. DiabetesManager enables patients to manage their diabetes by offering real-time tips and advice based on their individual data. It not only tracks food consumption and blood sugar levels, but also allows members to take better control of self-management of their Type 2 diabetes to support them in establishing long-term healthy habits and improved quality of life. This highly-secure technology also empowers our nurse case managers to monitor patients virtually, so they can more efficiently intervene when necessary.

- *MemberConnections* is a community face-to-face outreach and education program designed to create a link between the member and the provider and help identify potential challenges or risk elements to a member's health, such as nutritional challenges and health education shortcomings. MemberConnections representatives contact new members by phone or mail to discuss managed care, the Medicaid program and our services. Our MemberConnections representatives make home visits, conduct educational programs and represent our health plans at community events such as health fairs.

- *Health Initiatives for Children* is aimed at educating child members on a variety of health topics. Our health plans are reaching out directly to children with newsletters, contests and a series of children's books that have been sponsored by the Company. These books have focused on managing asthma, obesity prevention and healthy eating. Obesity rates for children doubled in the past two decades and tripled for adolescents during the same period. Preventive obesity focuses on the childhood obesity epidemic with educational information encouraging proper eating and exercise habits. The books educate children on the importance of living an active and healthy life. During 2010, one of the books received the National Health Information Award Silver Medal.

- *Health Passport* is a leading-edge, patient-centric electronic community health record for foster care children. Health Passport collects patient demographic data, clinician visit records, dispensed medications, vital sign history, lab results, allergy charts, and immunization data. Providers can directly input additional or updated patient data and documentation into the Passport. All information is accessible anywhere, anytime to all authorized users, including health plan staff, greatly facilitating coordinated care among providers. In 2010, we expanded the Health Passport to our behavioral health program in Arizona.

- The *CentAccount Program* encourages healthy behaviors by offering members financial incentives for performing certain healthy behaviors. The incentives are delivered through a restricted-use MasterCard redeemable for health-related items only. This incentive-based approach effectively increases the utilization of preventive services while strengthening the relationships between members and their primary care providers.

- The *Asthma Management Program* integrates a hands-on approach with a flexible outreach methodology that can be customized to suit the different age groups and populations it serves that are affected by asthma. Working closely with Nurtur Health, Inc., a wholly-owned subsidiary of Centene that provides life, health and wellness programs, we provide proactive identification of members, stratification into appropriate levels of intervention including home visits, culturally sensitive education, and robust outcome reporting. The program also includes aggressive care coordination to ensure patients have basic services such as transportation to the doctor, electricity to power the nebulizer, and a clean, safe home environment. During 2011, the Asthma Management Program was the recipient of the EPA National Environmental Leadership Award in Asthma Management.

- *Fluvention* is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness. We use an integrated communications approach including direct mail, phone calls, providing information via health plan websites and posting information in provider offices. The health plans also conduct general community awareness through public service announcements on television and radio. Beginning in 2009, we targeted education efforts related to health hygiene, preventative care and the benefits of obtaining appropriate care for their condition, for groups that are at higher-risk for contracting the influenza viruses, including pregnant women, children from six months old up to 24-year-old adults, as well as adults with chronic health conditions.

- *EPSDT Case Management* is a preventive care program designed to educate our members on the benefits of Early and Periodic Screening, Diagnosis and Treatment, or EPSDT, services. We have a systematic program of communicating, tracking, outreach, reporting and follow-through that promotes state EPSDT programs.

- *Life and Health Management Programs* are designed to help members understand their disease and treatment plan and improve their wellness in a cost effective manner. These programs address medical conditions that are common within the Medicaid population such as asthma, diabetes and pregnancy. Our Specialty Services segment manages many of our life and health management programs. Our ABD program uses a proprietary assessment tool that effectively identifies barriers to care, unmet functional needs, available social supports and the existence of behavioral health conditions that impede a member's ability to maintain a proper health status. Care coordinators develop individual care plans with the member and healthcare providers ensuring the full integration of behavioral, social and acute care services. These care plans, while specific to an ABD member, incorporate "Condition Specific" practices in collaboration with physician partners and community resources.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. As of December 31, 2011, the health plans we currently operate contracted with the following number of physicians and hospitals:

	Primary Care Physicians	Specialty Care Physicians	Hospitals
Arizona	957	3,028	26
Florida	1,410	8,967	92
Georgia	4,834	9,651	116
Illinois	1,754	3,874	54
Indiana	1,168	7,037	111
Kentucky	2,283	4,897	75
Massachusetts	2,212	7,918	37
Mississippi	1,365	2,920	74
Ohio	2,530	10,061	148
South Carolina	1,729	4,664	29
Texas	9,775	25,966	409
Wisconsin	2,807	8,441	87
Total	32,824	97,424	1,258

Our network of primary care physicians is a critical component in care delivery, management of costs and the attraction and retention of new members. Primary care physicians include family and general practitioners, pediatricians, internal medicine physicians and obstetricians and gynecologists. Specialty care physicians provide medical care to members generally upon referral by the primary care physicians. Specialty care physicians include, but are not limited to, orthopedic surgeons, cardiologists and otolaryngologists. We also provide education and outreach programs to inform and assist members in accessing quality, appropriate healthcare services.

Our health plans facilitate access to healthcare services for our members primarily through contracts with our providers. Our contracts with primary and specialty care physicians and hospitals usually are for one to two-year periods and renew automatically for successive one-year terms, but generally are subject to termination by either party upon 90 to 120 days prior written notice. In the absence of a contract, we typically pay providers at state Medicaid reimbursement levels. We pay hospitals under a variety of methods, including fee-for-services, per diems, diagnostic related grouping and case rates. We pay physicians under a fee-for-service, capitation arrangement, or risk-sharing arrangement. In addition, we are governed by state prompt payment policies.

- Under our fee-for-service contracts with physicians, particularly specialty care physicians, we pay a negotiated fee for covered services. This model is characterized as having no financial risk for the physician. In addition, this model requires management oversight because our total cost may increase as the units of services increase or as more expensive services replace less expensive services. We have prior authorization procedures in place that are intended to make sure that certain high cost diagnostic and other services are medically appropriate.

- Under our capitated contracts, primary care physicians are paid a monthly fee for each of our members assigned to his or her practice for all ambulatory care. In return for this payment, these physicians provide all primary care and preventive services, including primary care office visits and EPSDT services, and are at risk for all costs associated with such services. If these physicians also provide non-capitated services to their assigned members, they may receive payment under fee-for-service arrangements at standard Medicaid rates.

- Under risk-sharing arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality factors.

We work with physicians to help them operate efficiently by providing financial and utilization information, physician and patient educational programs and disease and medical management programs. Our programs are also designed to help the physicians coordinate care outside of their offices.

We believe our collaborative approach with physicians gives us a competitive advantage in entering new markets. Our physicians serve on local committees that assist us in implementing preventive care programs, managing costs and improving the overall quality of care delivered to our members, while also simplifying the administrative burdens on our providers. This approach has enabled us to strengthen our provider networks through improved physician recruitment and retention that, in turn, have helped to increase our membership base. The following are among the services we provide to support physicians:

- *Customized Utilization Reports* provide certain of our contracted physicians with information that enables them to run their practices more efficiently and focuses them on specific patient needs. For example, quarterly detail reports update physicians on their status within their risk pools. Equivalency reports provide physicians with financial comparisons of capitated versus fee-for-service arrangements.

- *Case Management Support* helps the physician coordinate specialty care and ancillary services for patients with complex conditions and direct members to appropriate community resources to address both their health and socio-economic needs.

- *Web-based Claims and Eligibility Resources* have been implemented to provide physicians with on-line access to perform claims and eligibility inquiries.

Our contracted physicians also benefit from several of the services offered to our members, including the MemberConnections, EPSDT case management and health management programs. For example, the MemberConnections staff facilitates doctor/patient relationships by connecting members with physicians, the EPSDT programs encourage routine checkups for children with their physicians and the health management programs assist physicians in managing their patients with chronic disease.

Where appropriate, our health plans contract with our specialty services organizations to provide services and programs such as behavioral health, life and health management, managed vision, telehealth services and pharmacy benefits management. When necessary, we also contract with third-party providers on a negotiated fee arrangement for physical therapy, home healthcare, diagnostic laboratory tests, x-ray examinations, ambulance services and durable medical equipment. Additionally, we contract with dental vendors in markets where routine dental care is a covered benefit.

Quality Management

Our medical management programs focus on improving quality of care in areas that have the greatest impact on our members. We employ strategies, including health management and complex case management, that are adjusted for implementation in our individual markets by a system of physician committees chaired by local physician leaders. This process promotes physician participation and support, both critical factors in the success of any clinical quality improvement program.

We have implemented specialized information systems to support our medical quality management activities. Information is drawn from our data warehouse, clinical databases and our membership and claims processing system to identify opportunities to improve care and to track the outcomes of the interventions implemented to achieve those improvements. Some examples of these intervention programs include:

- appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria
- tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles
- emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs
- incorporation of disease management, which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma and diabetes
- Start Smart For Your Baby, a prenatal case management program aimed at helping women with high-risk pregnancies deliver full-term, healthy infants

We provide reporting on a regular basis using our data warehouse. State and Health Employer Data and Information Set, or HEDIS, reporting constitutes the core of the information base that drives our clinical quality performance efforts. This reporting is monitored by Plan Quality Improvement Committees and our corporate medical management team.

In an effort to ensure the quality of our provider networks, we undertake to verify the credentials and background of our providers using standards that are supported by the National Committee for Quality Assurance, or NCQA.

It is our objective to provide access to the highest quality of care for our members. As a validation of that objective, we often pursue accreditation by independent organizations that have been established to promote health care quality. The NCQA Health Plan Accreditation and URAC Health Plan Accreditation programs provide unbiased, third party reviews to verify and publicly report results on specific quality care metrics. While we have achieved or are pursuing accreditation for all of our plans, accreditation is only one measure of our ability to provide access to quality care for our members.

SPECIALTY SERVICES

Our specialty services are a key component of our healthcare enterprise and complement our core Medicaid Managed Care business. Specialty services diversify our revenue stream, provide higher quality health outcomes to our membership and others, and assist in controlling costs. Our specialty services are provided primarily through the following businesses:

- *Behavioral Health.* Cenpatico Behavioral Health, or Cenpatico, manages behavioral healthcare for members via a contracted network of providers. Cenpatico works with providers to determine the best services to help people overcome mental illness and lead productive lives. Our networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. In addition, we operate school-based programs in Arizona that focus on students with special needs and also provide speech and other therapy services.

- *Individual and State Sponsored Health Insurance Exchanges.* Celtic Insurance Company, or Celtic, is a nationwide healthcare provider licensed in 49 states offering high-quality, affordable health insurance to individual customers and their families. Sold online and through independent insurance agents nationwide, Celtic's portfolio of major medical plans is designed to meet the diverse needs of the uninsured at all budget and benefit levels. Celtic also offers a standalone guaranteed-issue medical conversion program to self-funded employer groups, stop-loss and fully-insured group carriers, managed care plans, and HMO reinsurers.

- *Life and Health Management.* Nurtur Health, Inc., or Nurtur, specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve workforce and societal productivity and reduce healthcare costs. Health risk appraisals, biometric screenings, online and telephonic wellness programs, disease management and work-life/employee assistance services are areas of focus. Nurtur uses telephonic health and work/life balance coaching, in-home and online interaction and informatics processes to deliver effective clinical outcomes, enhanced patient-provider satisfaction and overall healthcare cost.

- *Long-term Care and Acute Care.* Bridgeway Health Solutions, or Bridgeway, provides long-term care services to the elderly and people with disabilities that meet income and resources requirements who are at risk of being or are institutionalized. Bridgeway participates with community groups to address situations that might be barriers to quality care and independent living. Acute care services include emergency and physician and hospitalization services, limited dental and rehabilitative services and other maternal and child health services.

- *Managed Vision.* OptiCare administers routine and medical surgical eye care benefits via its own contracted national network of eye care providers. OptiCare clients include Medicaid, Medicare, and commercial health plans, as well as employer groups. OptiCare has been providing vision network services for over 25 years and offers a variety of plan designs to meet the individual needs of its clients and members.

- *Telehealth Services.* NurseWise and Nurse Response provide a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. Our members call one number and reach bilingual customer service representatives and nursing staff who provide health education, triage advice and offer continuous access to health plan functions. Additionally, our representatives verify eligibility, confirm primary care provider assignments and provide benefit and network referral coordination for members and providers after business hours. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments. Call volume is based on membership levels and seasonal variation.

- *Pharmacy Benefits Management.* US Script offers progressive pharmacy benefits management services that are specifically designed to improve quality of care while containing costs. This is achieved through a lowest net cost strategy that helps optimize clients' pharmacy benefit. Services include claims processing, pharmacy network management, benefit design consultation, drug utilization review, formulary and rebate management, specialty and mail order pharmacy services, and patient and physician intervention.

- *Care Management Software.* Casenet is a software provider of innovative care management solutions that automate the clinical, administrative and technical components of care management programs. We maintain a controlling ownership interest in Casenet and are currently implementing this new software platform which is available for sale to third parties.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program provides controls by which we further enhance operations, safeguard against fraud and abuse, improve access to quality care and help assure that our values are reflected in everything we do.

The two primary standards by which corporate compliance programs in the healthcare industry are measured are the Federal Organizational Sentencing Guidelines and Compliance Program Guidance series issued by the Department of Health and Human Services' Office of the Inspector General, or OIG. Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

- written standards of conduct
- designation of a corporate compliance officer and compliance committee
- effective training and education
- effective lines for reporting and communication
- enforcement of standards through disciplinary guidelines and actions
- internal monitoring and auditing
- prompt response to detected offenses and development of corrective action plans

The goal of the program is to build a culture of ethics and compliance, which is assessed yearly using a diagnostic survey to measure the integrity of the organization. Our internal Corporate Compliance intranet site, accessible to all employees, contains our Business Ethics and Conduct Policy, Compliance Program description and various resources for employees to report concerns or ask questions. If needed, employees have access to the contact information for the members of our Board of Directors' Audit Committee to report concerns. Our Ethics and Compliance Helpline is a toll-free number and web-based reporting tool operated by a third party independent of the Company to allow employees or other persons to report suspected incidents of fraud, abuse or other compliance violations. Furthermore, the Board of Directors reviews an ethics and compliance report on a quarterly basis.

COMPETITION

We continue to face varying and increasing levels of competition as we expand in our existing service areas or enter new markets, as federal regulations require at least two competitors in each service area. Healthcare reform may cause a number of commercial managed care organizations to decide to enter or exit the Medicaid market.

In our business, our principal competitors for state contracts, members and providers consist of the following types of organizations:

- *Medicaid Managed Care Organizations* focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as smaller organizations that operate in one city or state and are owned by providers, primarily hospitals.

- *National and Regional Commercial Managed Care Organizations* have Medicaid members in addition to members in private commercial plans. Some of these organizations offer a range of specialty services including pharmacy benefits management, behavioral health management, health management, and nurse triage call support centers.

- *Primary Care Case Management Programs* are programs established by the states through contracts with primary care providers. Under these programs, physicians provide primary care services to Medicaid recipients, as well as limited medical management oversight.

We compete with other managed care organizations and specialty companies for state contracts. In order to grant a contract, state governments consider many factors. These factors include quality of care, financial requirements, an ability to deliver services and establish provider networks and infrastructure. In addition, our specialty companies also compete with other providers, such as disease management companies, individual health insurance companies, and pharmacy benefits managers for non-governmental contracts.

We also compete to enroll new members and retain existing members. People who wish to enroll in a managed healthcare plan or to change healthcare plans typically choose a plan based on the quality of care and services offered, ease of access to services, a specific provider being part of the network and the availability of supplemental benefits.

We also compete with other managed care organizations to enter into contracts with physicians, physician groups and other providers. We believe the factors that providers consider in deciding whether to contract with us include existing and potential member volume, reimbursement rates, medical management programs, speed of reimbursement and administrative service capabilities. See "Risk Factors — Competition may limit our ability to increase penetration of the markets that we serve."

REGULATION

Our Medicaid, Medicare and Specialty operations are regulated at both state and federal levels. Government regulation of the provision of healthcare products and services is a changing area of law that varies from jurisdiction to jurisdiction. Regulatory agencies generally have discretion to issue regulations and interpret and enforce laws and rules. Changes in applicable laws and rules also may occur periodically.

Our regulated subsidiaries are licensed to operate as health maintenance organizations, third party administrators, utilization review and/or insurance companies in their respective states. In each of the jurisdictions in which we operate, we are regulated by the relevant health, insurance and/or human services departments that oversee the activities of managed care organizations providing or arranging to provide services to Medicaid or Medicare enrollees.

The process for obtaining authorization to operate as a managed care organization is complex and requires us to demonstrate to the regulators the adequacy of the health plan's organizational structure, financial resources, utilization review, quality assurance programs, complaint procedures, provider network and procedures for covering emergency medical conditions. Under both state managed care organization statutes and insurance laws, our health plan subsidiaries, as well as our applicable specialty companies, must comply with minimum statutory capital and other financial requirements, such as deposit and reserve requirements. Insurance regulations may also require prior state approval of acquisitions of other managed care organization businesses and the payment of dividends, as well as notice for loans or the transfer of funds. Our subsidiaries are also subject to periodic state and federal reporting requirements. In addition, each health plan and individual health insurance provider must meet criteria to secure the approval of state regulatory authorities before implementing operational changes, including the development of new product offerings and, in some states, the expansion of service areas.

States have adopted a number of regulations that may affect our business and results of operations. These regulations in certain states include:

- premium taxes or similar assessments
- stringent prompt-pay laws
- disclosure requirements regarding provider fee schedules and coding procedures
- programs to monitor and supervise the activities and financial solvency of provider groups

We are regulated as an insurance holding company and are subject to the insurance holding company acts of the states in which our insurance company and HMO subsidiaries are domiciled. These acts contain certain reporting requirements as well as restrictions on transactions between an insurer or HMO and its affiliates. These holding company laws and regulations generally require insurance companies and HMOs within an insurance holding company system to register with the insurance department of each state where they are domiciled and to file with those states' insurance departments reports describing capital structure, ownership, financial condition, intercompany transactions and general business operations. In addition, depending on the size and nature of the transaction, there are various notice and reporting requirements that generally apply to transactions between insurance companies and HMOs and their affiliates within an insurance holding company structure. Some insurance holding company laws and regulations require prior regulatory approval or, in certain circumstances, prior notice of certain material intercompany transfers of assets as well as certain transactions between insurance companies, HMOs, their parent holding companies and affiliates. Among other provisions, state insurance and HMO laws may restrict the ability of our regulated subsidiaries to pay dividends.

Additionally, the holding company acts of the states in which our subsidiaries are domiciled restrict the ability of any person to obtain control of an insurance company or HMO without prior regulatory approval. Under those statutes, without such approval (or an exemption), no person may acquire any voting security of an insurance holding company, which controls an insurance company or HMO, or merge with such a holding company, if as a result of such transaction such person would "control" the insurance holding company. "Control" is generally defined as the direct or indirect power to direct or cause the direction of the management and policies of a person and is presumed to exist if a person directly or indirectly owns or controls 10% or more of the voting securities of another person.

State Contracts

In addition to being a licensed health maintenance organization, in order to be a Medicaid Managed Care organization in each of the states in which we operate, we must operate under a contract with the state's Medicaid agency. States generally use either a formal proposal process, reviewing a number of bidders, or award individual contracts to qualified applicants that apply for entry to the program. We receive monthly payments based on specified capitation rates determined on an actuarial basis. These rates differ by membership category and by state depending on the specific benefits and policies adopted by each state.

Our state contracts and the regulatory provisions applicable to us generally set forth the requirements for operating in the Medicaid sector, including provisions relating to:

- Ÿ eligibility, enrollment and disenrollment processes
- Ÿ covered services
- Ÿ eligible providers
- Ÿ subcontractors
- Ÿ record-keeping and record retention
- Ÿ periodic financial and informational reporting
- Ÿ quality assurance
- Ÿ accreditation
- Ÿ health education and wellness and prevention programs
- Ÿ timeliness of claims payment
- Ÿ financial standards
- Ÿ safeguarding of member information
- Ÿ fraud and abuse detection and reporting
- Ÿ grievance procedures
- Ÿ organization and administrative systems

A health plan or individual health insurance provider's compliance with these requirements is subject to monitoring by state regulators and by CMS. A health plan is also subject to periodic comprehensive quality assurance evaluations by a third-party reviewing organization and generally by the insurance department of the jurisdiction that licenses the health plan. A health plan or individual health insurance provider must also submit reports to various regulatory agencies, including quarterly and annual statutory financial statements and utilization reports.

The table below sets forth the terms of our state contracts and provides details regarding related renewal or extension and termination provisions. The contracts are subject to termination by the state for cause, an event of default or lack of funding.

State Contract	Expiration Date	Renewal or Extension by the State
Arizona – Acute Care	September 30, 2012	May be extended for up to one additional one-year term.
Arizona – Behavioral Health	June 30, 2013	Renewable for two additional one-year terms.
Arizona – Long-term Care	September 30, 2014	May be extended for up to two additional one-year terms.
Arizona – Special Needs Plan (Medicare)	December 31, 2012	Renewable annually for successive 12-month periods.
Florida – Medicaid & ABD	August 31, 2012	Renewable through the state's recertification process.
Florida – Long-term Care	August 31, 2012	Renewable through the state's recertification process.
Georgia – Medicaid & CHIP	June 30, 2012	Renewable for two additional one-year terms.
Georgia – Special Needs Plan (Medicare)	December 31, 2012	Renewable annually for successive 12-month periods.
Illinois – ABD	April 30, 2016	May be extended for up to five additional years.
Indiana – Medicaid, CHIP & Hybrid (Healthy Indiana Plan)	December 31, 2014	Renewable for two additional one-year terms.
Kansas – Behavioral Health	September 30, 2012	Renewable through the state's reprocurement process.
Kentucky – Medicaid, Foster Care, & ABD	June 30, 2014	Renewable for four additional one-year terms.
Louisiana – Medicaid, CHIP & ABD	January 31, 2015	Renewable for an additional 2-year period through the state's recertification process.
Massachusetts – Hybrid (Commonwealth Care)	June 30, 2012	Renewable through the state's recertification process.
Massachusetts – Hybrid (Commonwealth Care Bridge)	February 29, 2012	Program ends February 29, 2012.
Mississippi – ABD & Foster Care	December 31, 2013	Renewable through the state's recertification process.
Ohio – Medicaid, CHIP & ABD	June 30, 2012	Renewable annually for successive 12-month periods.
Ohio – Special Needs Plan (Medicare)	December 31, 2012	Renewable annually for successive 12-month periods.
South Carolina – Medicaid, CHIP & ABD	March 31, 2012	May be extended for up to one additional year and subsequently renewable through the state's recertification process.
Texas – Medicaid, CHIP & ABD[1]	August 31, 2015	May be extended for up to four and a half additional years.
Texas – ABD Dallas Expansion	August 31, 2013	May be extended for up to five additional years.
Texas – CHIP Rural Service Area	August 31, 2013	May be extended for up to five additional years.
Texas – Foster Care	August 31, 2012	May be extended for up to three and a half additional years.
Texas – Hybrid (Healthy Texas)	August 31, 2013	Renewable for two additional two-year terms.
Texas – Special Needs Plan (Medicare)	December 31, 2012	Renewable annually for successive 12-month periods.
Wisconsin – Medicaid, CHIP & ABD	February 29, 2012	Renewable through the state's recertification process.
Wisconsin – Network Health Plan Subcontract	December 31, 2016	Renews automatically for successive five-year terms.
Wisconsin – Special Needs Plan (Medicare)	December 31, 2012	Renewable annually for successive 12-month periods.

[1] The current Texas Medicaid, CHIP and ABD contract expires on February 29, 2012. The new Texas Medicaid, CHIP & ABD contract with expanded service areas commences March 1, 2012.

HIPAA and HITECH

In 1996, Congress enacted the Health Insurance Portability and Accountability Act, or HIPAA. HIPAA is designed to improve the portability and continuity of health insurance coverage, simplify the administration of health insurance transactions and ensure the privacy and security of individual's information. Among the main requirements of HIPAA are the Administrative Simplification provisions which include: standards for processing health insurance claims and related transactions (Transactions Standards); requirements for protecting the privacy and limiting the disclosre of medical records and other personal health information (Privacy Rule); and standards and specifications for safeguarding personal health information which is maintained, stored or transmitted in electronic format (Security Rule). The Health Information Technology for Economic and Clinical Health (HITECH) Act, which was enacted as part of the American Reinvestment and Recovery Act of 2009, amended certain provisions of HIPAA and introduced new data security obligations for covered entities and their business associates. HITECH also mandated individual notification in instances of a data breach, provided enhanced penalties for HIPAA violations, and granted enforcement authority to states' Attorneys General in addition to the HHS Office of Civil Rights.

The Privacy and Security Rules and HITECH enhancements establish requirements to protect the privacy of medical records and safeguard personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates. Other requirements of the privacy regulations include:

- limit certain uses and disclosures of health information, and require individual authorizations for some uses and disclosures of protected health information
- guarantee patients the right to access their health information and to know who else has accessed it
- limit most disclosure of health information to the minimum needed for the intended purpose
- establish procedures to ensure the protection of health information
- authorize access to records by researchers and others under certain circumstances
- establish requirements for breach notification
- impose criminal and civil sanctions for improper uses or disclosures of health information

The Security Rule requires healthcare providers, health plans, healthcare clearinghouses, and their business associates to implement administrative, physical and technical safeguards to ensure the privacy and confidentiality of health information when it is electronically stored, maintained or transmitted. The HITECH Act established a federal requirement for notification when the security of protected health information is breached. In addition, there is a patchwork of state laws that have been adopted to provide for, among other things, private rights of action for breaches of data security and mandatory notification to persons whose identifiable information is obtained without authorization.

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements. The transaction standards are being modified to version 5010 to prepare for the implementation of the ICD10 coding system. We are planning for an expected transition to ICD10 in October 2013.

The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements. In addition, the Secretary of HHS may grant exceptions allowing state laws contrary to HIPAA to prevail if the Secretary determines that:

- the state law is necessary to prevent fraud and abuse associated with the provision of and payment for healthcare
- the state law is necessary to ensure appropriate state regulation of insurance and health plans
- the state law is necessary for state reporting on healthcare delivery or costs
- the state law addresses controlled substances

We have implemented processes, policies and procedures to comply with both HIPAA and HITECH, including administrative, technical and physical safeguards to prevent against electronic data breach. We provide education and training for employees specifically designed to help prevent any unauthorized use or access to health information and enhance the reporting of suspected breaches. In addition, our corporate privacy officer and health plan privacy officials handle privacy complaints and serve as resources to employees to address questions or concerns they may have.

Other Fraud and Abuse Laws

Investigating and prosecuting healthcare fraud and abuse continues to be a top priority for state and federal law enforcement entities. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicare and Medicaid. The laws and regulations relating to fraud and abuse and the contractual requirements applicable to health plans participating in these programs are complex, changing and may require substantial resources. We are constantly looking for ways to improve our waste, fraud and abuse detection methods. While we have both prospective and retrospective processes to identify abusive patterns and fraudulent billing, we have increased our capabilities to proactively detect inappropriate billing prior to payment.

EMPLOYEES

As of December 31, 2011, we had approximately 5,300 employees. None of our employees are represented by a union. We believe our relationships with our employees are good.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at February 10, 2012:

Name	Age	Position
Michael F. Neidorff	69	Chairman and Chief Executive Officer
Karen A. Bedell	52	Senior Vice President, New Business Integration & Development
Mark W. Eggert	50	Executive Vice President, Health Plan Business Unit
Carol E. Goldman	54	Executive Vice President and Chief Administrative Officer
Jason M. Harrold	42	Senior Vice President, Specialty Business Unit
Jesse N. Hunter	36	Executive Vice President, Corporate Development
Donald G. Imholz	59	Executive Vice President and Chief Information Officer
Edmund E. Kroll	52	Senior Vice President, Finance and Investor Relations
Mary V. Mason	43	Senior Vice President and Chief Medical Officer
William N. Scheffel	58	Executive Vice President, Chief Financial Officer and Treasurer
Jeffrey A. Schwaneke	36	Senior Vice President, Corporate Controller and Chief Accounting Officer
Keith H. Williamson	59	Senior Vice President, Secretary and General Counsel

Michael F. Neidorff. Mr. Neidorff has served as our Chairman and Chief Executive Officer since May 2004. From May 1996 to May 2004, Mr. Neidorff served as President, Chief Executive Officer and as a member of our Board of Directors. From 1995 to 1996, Mr. Neidorff served as a Regional Vice President of Coventry Corporation, a publicly-traded managed care organization, and as the President and Chief Executive Officer of one of its subsidiaries, Group Health Plan, Inc. From 1985 to 1995, Mr. Neidorff served as the President and Chief Executive Officer of Physicians Health Plan of Greater St. Louis, a subsidiary of United Healthcare Corp., a publicly-traded managed care organization now known as UnitedHealth Group Incorporated. Mr. Neidorff also serves as a director of Brown Shoe Company, Inc., a publicly-traded footwear company with global operations.

Karen A. Bedell. Ms. Bedell has served as our Senior Vice President, New Business Integration & Development since May 2010. From 2007 to 2009, Ms. Bedell served as Vice President and General Manager for DRS Marlo Coil, a manufacturer of heat transfer systems. From 2003 to 2007, Ms. Bedell served as Senior Vice President, Marketing and Strategic Planning for Engineered Support Systems, Inc.

Mark W. Eggert. Mr. Eggert has served as our Executive Vice President, Health Plan Business Unit since November 2007. From January 1999 to November 2007, Mr. Eggert served as the Associate Vice Chancellor and Deputy General Counsel at Washington University, where he oversaw the legal affairs of the School of Medicine.

Carol E. Goldman. Ms. Goldman has served as Executive Vice President and Chief Administrative Officer since June 2007. From July 2002 to June 2007, she served as our Senior Vice President, Chief Administrative Officer. From September 2001 to July 2002, Ms. Goldman served as our Plan Director of Human Resources. From 1998 to August 2001, Ms. Goldman was Human Resources Manager at Mallinckrodt Inc., a medical device and pharmaceutical company.

Jason M. Harrold. Mr. Harrold has served as our Senior Vice President, Specialty Business Unit since August 2009. He served as President of OptiCare from July 2000 to August 2009. From July 1996 to July 2000, Mr. Harrold held various positions of increasing responsibility at OptiCare including Vice President of Operations and Chief Operating Officer.

Jesse N. Hunter. Mr. Hunter has served as our Executive Vice President, Corporate Development since April 2008. He served as our Senior Vice President, Corporate Development from April 2007 to April 2008. He served as our Vice President, Corporate Development from December 2006 to April 2007. From October 2004 to December 2006, he served as our Vice President, Mergers & Acquisitions. From July 2003 until October 2004, he served as the Director of Mergers & Acquisitions and from February 2002 until July 2003, he served as the Manager of Mergers & Acquisitions.

Donald G. Imholz. Mr. Imholz has served as our Executive Vice President and Chief Information Officer since December 2009. Mr. Imholz served as our Senior Vice President and Chief Information Officer from September 2008 to December 2009. From January 2008 to September 2008, Mr. Imholz was an independent consultant working for clients across a variety of industries. From January 1975 to January 2008, Mr. Imholz was with The Boeing Company and served as Vice President of Information Technology from 2002 to January 2008. In that role, Mr. Imholz was responsible for all application development and support worldwide.

Edmund E. Kroll. Mr. Kroll has served as our Senior Vice President, Finance and Investor Relations since May 2007. From June 1997 to November 2006, Mr. Kroll served as Managing Director at Cowen and Company LLC, where his research coverage focused on the managed care industry, including the Company.

Dr. Mary V. Mason. Dr. Mason has served as our Senior Vice President and Chief Medical Officer since March 2007. From April 2006 to February 2007, she served as our Vice President, Medical Affairs – Health Plans. From January 2006 to April 2006 she served as our National Medical Director.

William N. Scheffel. Mr. Scheffel has served as our Executive Vice President, Chief Financial Officer and Treasurer since May 2009. He served as our Executive Vice President, Specialty Business Unit from June 2007 to May 2009. From May 2005 to June 2007, he served as our Senior Vice President, Specialty Business Unit. From December 2003 until May 2005, he served as our Senior Vice President and Controller. From July 2002 to October 2003, Mr. Scheffel was a partner with Ernst & Young LLP. From 1975 to July 2002, Mr. Scheffel was with Arthur Andersen LLP.

Jeffrey A. Schwaneke. Mr. Schwaneke has served as our Senior Vice President, Corporate Controller since December 2011 and our Chief Accounting Officer since September 2008. He served as our Vice President, Corporate Controller from July 2008 to December 2011. He previously served as Vice President, Controller and Chief Accounting Officer at Novelis Inc. from October 2007 to July 2008, and Assistant Corporate Controller from May 2006 to September 2007. Mr. Schwaneke served as Segment Controller for SPX Corporation from January 2005 to April 2006. Mr. Schwaneke served as Corporate Controller at Marley Cooling Technologies, a segment of SPX Corporation, from March 2004 to December 2004 and Director of Financial Reporting from November 2002 to February 2004.

Keith H. Williamson. Mr. Williamson has served as our Senior Vice President, General Counsel since November 2006 and as our Secretary since February 2007. From 1988 until November 2006, he served at Pitney Bowes Inc. in various legal and executive roles, the last seven years as a Division President. Mr. Williamson also serves as a director of PPL Corporation, a publicly-traded energy and utility holding company.

Available Information

We are subject to the reporting and information requirements of the Securities Exchange Act of 1934, as amended (Exchange Act) and, as a result, we file periodic reports and other information with the Securities and Exchange Commission, or SEC. We make these filings available on our website free of charge, the URL of which is http://www.centene.com, as soon as reasonably practicable after we electronically file such material with, or furnish it to, the SEC. The SEC maintains a website (http://www.sec.gov) that contains our annual, quarterly and current reports and other information we file electronically with the SEC. You can read and copy any materials we file with the SEC at the SEC's Public Reference Room at 100 F Street, N.E., Room 1850, Washington, D.C. 20549. You may obtain information on the operation of the Public Reference Room by calling the SEC at 1-800-SEC-0330. Information on our website does not constitute part of this Annual Report on Form 10-K.

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

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

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

Risks Related to Being a Regulated Entity

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

Most of our revenues come from Medicaid, CHIP and ABD premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, CHIP and ABD funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Although they were not included in the final budget, there were budget proposals for 2012 that included federal cuts to Medicaid funding (i.e. through block grants and other means) by as much as $1 trillion over 10 years.

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

In litigation that is pending before the U.S. Supreme Court, providers and beneficiaries have sued the state of California over reductions in reimbursement to the California Medicaid program known as Medi-Cal. While we do not operate a health plan in California, we cannot predict how the Supreme Court will rule in this case and the outcome of this litigation could have an impact on the amount of flexibility states have in reducing reimbursement.

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

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

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

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

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

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

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

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

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

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, CHIP and ABD. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire or renew between February 29, 2012 and December 31, 2016. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on April 12, 2010, the Wisconsin Department of Health Services notified us that our Wisconsin subsidiary was not awarded a Southeast Wisconsin BadgerCare Plus Managed Care contract. While we will continue to serve other regions of the state, we transitioned the affected members to other plans by November 1, 2010. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed, renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

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

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and generally are intended to benefit and protect the financial interests of health plan providers and members rather than investors. The enactment of new laws and rules or changes to existing laws and rules or the interpretation of such laws and rules could, among other things:

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

Regulations may decrease the profitability of our health plans.

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

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

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

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

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

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

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

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

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

Changes in healthcare law and benefits may reduce our profitability.

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

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

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

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

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

In addition, there have been a number of lawsuits filed that challenge all or part of the health care reform law. A number of the lawsuits have been ruled on by federal appeals courts and those rulings were not consistent. Several parties including the current administration have appealed to the U.S. Supreme Court. The Supreme Court has agreed to hear these cases, but we cannot predict how it will rule. Various Congressional leaders have indicated a desire to revisit some or all of the health care reform law. While the U.S. House of Representatives voted to repeal the whole health care reform law, the U.S. Senate voted against such a repeal, and there have separately been a number of bills introduced that would repeal, change or defund certain provisions of the law. The 2011 budget eliminates two programs funded under the health care reform law – the Consumer Operated and Oriented Plan (CO-OP) and the Free Choice Voucher programs. Further, a number of states have passed legislation intended to block various requirements of the health care reform law. Because of these challenges, we cannot predict whether any or all of the legislation will be implemented as enacted, overturned, repealed or modified.

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

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

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

Changes in federal funding mechanisms may reduce our profitability.

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

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

Medicaid spending by the federal government could be decreased as part of the spending cuts associated with the recent increase of the debt ceiling.

In August 2011, the Budget Control Act of 2011 was enacted into law in order to increase the federal debt ceiling. The law included spending cuts of nearly $1 trillion over 10 years, but did not include any cuts to Medicaid. The law further created a Congressional committee that was tasked with recommending a plan that would reduce the federal deficit by another $1.5 trillion over 10 years. The committee was required to recommend a plan to Congress by the end of November 2011. The committee was not able to come to agreement and recommend a plan to Congress. Therefore, automatic spending cuts will become effective. While changes to Medicaid could have been considered by the committee, Medicaid is not subject to the automatic spending cuts.

We cannot predict whether Congress will take any action to change the automatic spending cuts. Further, we cannot predict how states will react to any changes that occur at the federal level.

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

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

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

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

Risks Related to Our Business

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

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

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

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

While we utilize our predictive modeling technology and our executive dashboard, we still cannot be sure that our medical claims liability estimates are adequate or that adjustments to those estimates will not unfavorably impact our results of operations. For example, in the three months ended June 30, 2006 we adjusted medical expense by $9.7 million for adverse medical costs development from the first quarter of 2006.

Additionally, when we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. For example, we commenced operations in Florida in February 2009, in Massachusetts in July 2009, in Mississippi in January 2011, in Illinois in May 2011, in Kentucky in November 2011, and expect to commence operations in Louisiana in the first quarter of 2012. For a period of time after the inception of business in these states, we base our estimates on state-provided historical actuarial data and limited actual incurred and received claims. The addition of new categories of individuals who are eligible for Medicaid under new legislation may pose the same difficulty in estimating our medical claims liability and utilization patterns.

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

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

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

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

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

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

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

As of December 31, 2011, we had $704.2 million in cash, cash equivalents and short-term investments and $533.0 million of long-term investments and restricted deposits. We maintain an investment portfolio of cash equivalents and short-term and long-term investments in a variety of securities which may include asset backed securities, bank deposits, commercial paper, certificates of deposit, money market funds, municipal bonds, corporate bonds, instruments of the U.S. Treasury and other government corporations and agencies, insurance contracts and equity securities. These investments are subject to general credit, liquidity, market and interest rate risks. Substantially all of these securities are subject to interest rate and credit risk and will decline in value if interest rates increase or one of the issuers' credit ratings is reduced. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition. For example, in the third quarter of 2008, we recorded a loss on investments of approximately $4.5 million due to a loss in a money market fund.

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

As of December 31, 2011, we had $537.9 million of investments in state, municipal and corporate securities. These securities are not guaranteed by the United States government. State and municipal securities are subject to additional credit risk based upon each local municipality's tax revenues and financial stability. As a result, we may experience a reduction in value or loss of liquidity of our investments, which may have a negative adverse effect on our results of operations, liquidity and financial condition.

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

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

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

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

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

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

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

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

Additionally, our growth strategy includes start-up operations in new markets or new products in existing markets. We may incur significant expenses prior to commencement of operations and the receipt of revenue. As a result, these start-up operations may decrease our profitability. We also face the risk that we will not be able to integrate start-up operations into our existing operations effectively without substantial expense, delay or other operational or financial problems. In the event we pursue any opportunity to diversify our business internationally, we would become subject to additional risks, including, but not limited to, political risk, an unfamiliar regulatory regime, currency exchange risk and exchange controls, cultural and language differences, foreign tax issues, and different labor laws and practices.

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

Acquisitions of unfamiliar new businesses could negatively impact our business.

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

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

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

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

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

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

The securities and credit markets have been experiencing extreme volatility and disruption over the past several years. The availability of credit, from virtually all types of lenders, has been restricted. Such conditions may persist during 2012 and beyond. In the event we need access to additional capital to pay our operating expenses, make payments on our indebtedness, pay capital expenditures, or fund acquisitions, our ability to obtain such capital may be limited and the cost of any such capital may be significant, particularly if we are unable to access our existing credit facility.

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

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

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

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

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

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

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

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

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

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

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

We may be unable to attract and retain key personnel.

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

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

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

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

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

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

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

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

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

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

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

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

Our operations depend significantly on effective information systems. The information gathered and processed by our information systems assists us in, among other things, monitoring utilization and other cost factors, processing provider claims, and providing data to our regulators. Our providers also depend upon our information systems for membership verifications, claims status and other information.

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

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

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

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

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

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

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

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

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

Item 1B. ***Unresolved Staff Comments***

None.

Item 2. ***Properties***

We own our corporate office headquarters buildings located in St. Louis, Missouri. During 2009 through 2011, our capital expenditures included costs for the construction of a new real estate development on our property, which has accommodated our growing business. During 2011, our capital expenditures also included costs for the construction of a new datacenter.

We generally lease space in the states where our health plans, specialty companies and claims processing facilities operate. We are required by various insurance and regulatory authorities to have offices in the service areas where we provide benefits. We believe our current facilities are adequate to meet our operational needs for the foreseeable future.

Item 3. ***Legal Proceedings***

The Internal Revenue Service (IRS) performed an examination of the Company's 2006 and 2007 tax returns and initially denied a tax benefit related to the abandonment of the FirstGuard stock in 2007. In 2011, the Company agreed to a settlement for the open tax years of 2006 and 2007. The settlement did not have a material impact on the consolidated financial statements.

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

PART II

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

Market for Common Stock; Dividends

Our common stock has been traded and quoted on the New York Stock Exchange under the symbol "CNC" since October 16, 2003. The high and low prices, as reported by the NYSE, are set forth below for the periods indicated.

	2012 Stock Price (through February 15, 2012)		2011 Stock Price		2010 Stock Price	
	High	Low	High	Low	High	Low
First Quarter	$ 50.00	$ 38.97	$ 32.99	$ 25.08	$ 25.03	$ 17.60
Second Quarter			39.25	31.34	25.95	20.51
Third Quarter			39.35	25.64	23.65	20.00
Fourth Quarter			40.81	25.28	26.43	21.19

As of February 3, 2012, there were 54 holders of record of our common stock.

We have never declared any cash dividends on our capital stock and currently anticipate that we will retain any future earnings for the development, operation and expansion of our business.

Issuer Purchases of Equity Securities

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2011, we did not repurchase any shares through this publicly announced program.

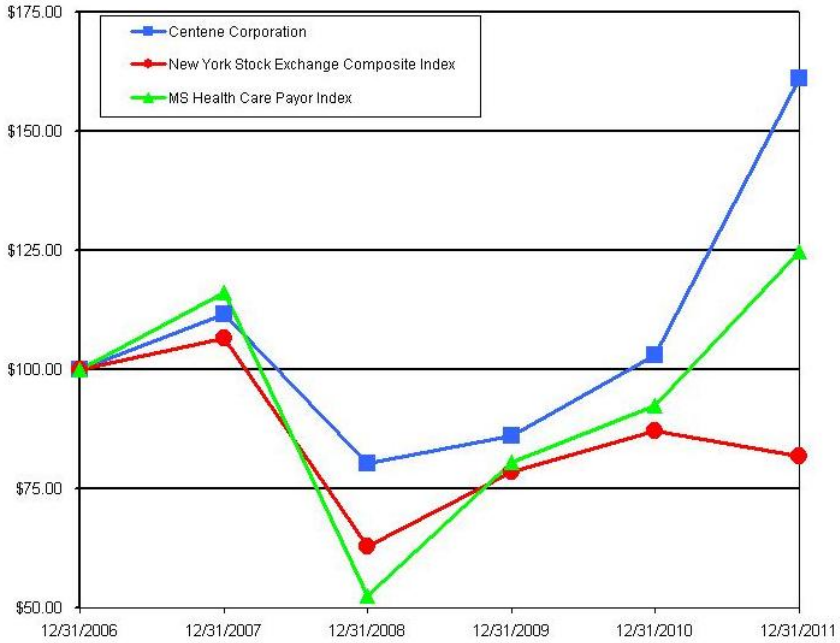
Issuer Purchases of Equity Securities
Fourth Quarter 2011

Period	Total Number of Shares Purchased[1]	Average Price Per Share	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
October 1 – October 31, 2011	7,535	$ 31.02	—	1,667,724
November 1 – November 30, 2011	6,892	35.30	—	1,667,724
December 1 – December 31, 2011	164,200	36.86	—	1,667,724
TOTAL	178,627	$ 36.55	—	1,667,724

[1] Shares acquired represent shares relinquished to the Company by certain employees for payment of taxes upon vesting of restricted stock units.

Stock Performance Graph

The graph below compares the cumulative total stockholder return on our common stock for the period from December 31, 2006 to December 31, 2011 with the cumulative total return of the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index over the same period. The graph assumes an investment of $100 on December 31, 2006 in our common stock (at the last reported sale price on such day), the New York Stock Exchange Composite Index and the Morgan Stanley Health Care Payor Index and assumes the reinvestment of any dividends.



	12/31/2006	12/31/2007	12/31/2008	12/31/2009	12/31/2010	12/31/2011
Centene Corporation	$ 100.00	$ 111.68	$ 80.22	$ 86.16	$ 103.13	$ 161.13
New York Stock Exchange Composite Index	$ 100.00	$ 106.58	$ 62.99	$ 78.62	$ 87.14	$ 81.81
MS Health Care Payor Index	$ 100.00	$ 116.19	$ 52.51	$ 80.55	$ 92.53	$ 124.77

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

The following selected consolidated financial data should be read in conjunction with the consolidated financial statements and related notes and "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations" included in our Annual Report on Form 10-K. The assets, liabilities and results of operations of FirstGuard and University Health Plans have been classified as discontinued operations for all periods presented. The data for the years ended December 31, 2011, 2010 and 2009 and as of December 31, 2011 and 2010 are derived from consolidated financial statements included elsewhere in this filing. The data for the years ended December 31, 2008 and 2007 and as of December 31, 2009, 2008 and 2007 are derived from consolidated financial statements not included in this filing.

	Year Ended December 31,				
	2011	2010	2009	2008	2007
	(In thousands, except share data)				
Revenues:					
Premium	$ 5,077,242	$ 4,192,172	$ 3,786,525	$ 3,199,360	$ 2,611,953
Service	103,765	91,661	91,758	74,953	80,508
Premium and service revenues	5,181,007	4,283,833	3,878,283	3,274,313	2,692,461
Premium tax	159,575	164,490	224,581	90,202	76,567
Total revenues	5,340,582	4,448,323	4,102,864	3,364,515	2,769,028
Expenses:					
Medical costs	4,324,746	3,584,452	3,230,131	2,704,647	2,242,982
Cost of services	78,114	63,919	60,789	56,920	61,348
General and administrative expenses	587,004	477,765	447,921	380,421	332,886
Premium tax expense	160,394	165,118	225,888	90,966	76,567
Total operating expenses	5,150,258	4,291,254	3,964,729	3,232,954	2,713,783
Earnings from operations	190,324	157,069	138,135	131,561	55,245
Other income (expense):					
Investment and other income	13,369	15,205	15,691	21,728	24,452
Debt extinguishment costs	(8,488)	—	—	—	—
Interest expense	(20,320)	(17,992)	(16,318)	(16,673)	(15,626)
Earnings from continuing operations, before income tax expense	174,885	154,282	137,508	136,616	64,071
Income tax expense	66,522	59,900	48,841	52,435	23,031
Earnings from continuing operations, net of income tax expense	108,363	94,382	88,667	84,181	41,040
Discontinued operations, net of income tax expense (benefit) of $0, $4,388, $(1,204), $(281), and $(31,563), respectively	—	3,889	(2,422)	(684)	32,362
Net earnings	108,363	98,271	86,245	83,497	73,402
Noncontrolling interest	(2,855)	3,435	2,574	—	—
Net earnings attributable to Centene Corporation	$ 111,218	$ 94,836	$ 83,671	$ 83,497	$ 73,402
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 111,218	$ 90,947	$ 86,093	$ 84,181	$ 41,040
Discontinued operations, net of income tax expense (benefit)	—	3,889	(2,422)	(684)	32,362
Net earnings	$ 111,218	$ 94,836	$ 83,671	$ 83,497	$ 73,402
Net earnings (loss) per common share attributable to Centene Corporation:					
Basic:					
Continuing operations	$ 2.22	$ 1.87	$ 2.00	$ 1.95	$ 0.95
Discontinued operations	—	0.08	(0.06)	(0.02)	0.74
Basic earnings per common share	$ 2.22	$ 1.95	$ 1.94	$ 1.93	$ 1.69
Diluted:					
Continuing operations	$ 2.12	$ 1.80	$ 1.94	$ 1.90	$ 0.92
Discontinued operations	—	0.08	(0.05)	(0.02)	0.72
Diluted earnings per common share	$ 2.12	$ 1.88	$ 1.89	$ 1.88	$ 1.64
Weighted average number of common shares outstanding:					
Basic	50,198,954	48,754,947	43,034,791	43,275,187	43,539,950
Diluted	52,474,238	50,447,888	44,316,467	44,398,955	44,823,082

	December 31,				
	2011	2010	2009	2008	2007
			(In thousands)		
Consolidated Balance Sheet Data:					
Cash and cash equivalents	$ 573,698	$ 434,166	$ 400,951	$ 370,999	$ 267,305
Investments and restricted deposits	663,457	639,983	585,183	451,058	369,545
Total assets	2,190,336	1,943,882	1,702,364	1,451,152	1,121,824
Medical claims liability	607,985	456,765	470,932	384,360	323,741
Long-term debt	348,344	327,824	307,085	264,637	206,406
Total stockholders' equity	936,419	797,055	619,427	501,272	415,047

Item 7. ***Management's Discussion and Analysis of Financial Condition and Results of Operations***

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

OVERVIEW

Our financial performance for 2011 is summarized as follows:

- Year-end at-risk managed care membership of 1,816,000, an increase of 282,500 members, or 18.4% year over year.
- Premium and service revenues from continuing operations of $5.2 billion, representing 20.9% growth year over year.
- Health Benefits Ratio from continuing operations of 85.2%, compared to 85.5% in 2010.
- General and Administrative expense ratio of 11.3%, compared to 11.2% in 2010.
- Diluted net earnings per share from continuing operations of $2.12, including $(0.10) of debt extinguishment costs.
- Total operating cash flows of $261.7 million, or 2.4 times net earnings.

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

- *Arizona.* In December 2010, Cenpatico Behavioral Health of Arizona began operating under an expanded contract to manage behavioral healthcare services for an additional four counties. In October 2011, Bridgeway Health Solutions, began operating under an expanded contract to deliver long-term care services in three geographic service areas of Arizona.

- *Florida*. In December 2010, we completed the conversion of non-risk managed care membership from Access Health Solutions LLC to our subsidiary, Sunshine State Health Plan. Additionally, in December 2010, we completed the acquisition of Citrus Health Care, Inc., a Medicaid and long-term care health plan.

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

- *Kentucky.* In November 2011, our subsidiary, Kentucky Spirit Health Plan, began providing managed care services under a three-year contract with the Kentucky Finance and Administration Cabinet to serve Medicaid beneficiaries.

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

- *Mississippi.* In January 2011, we began operating through the Mississippi Coordinated Access Network program to serve Medicaid beneficiaries.

- *Ohio.* In October 2011, Buckeye Community Health Plan began operating under an amended contract with the Ohio Department of Job and Family Services which includes the management of the pharmacy benefit for Buckeye's members.

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

- *Texas.* In February 2011, we began operating under an additional STAR+PLUS ABD contract in the Dallas service area and in September 2011, added additional membership through the contiguous county expansion.

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

- In July 2011, Louisiana Healthcare Connections, our joint venture subsidiary, was selected to contract with the Louisiana Department of Health and Hospitals to provide healthcare services to Medicaid enrollees participating in the Bayou Health Program in all three of the state's geographical services areas. Services for these members commenced in February 2012, with a three-phase membership roll-out ending in the second quarter of 2012.

- In August 2011, we were awarded renewed and expanded contracts by the Texas Health and Human Services Commission. The contracts expand Superior's STAR, STAR+PLUS and CHIP product offerings to include the new 10 county Hidalgo Service Area (STAR and STAR+PLUS), Medicaid RSA West Texas, Medicaid RSA Central Texas, Medicaid RSA North-East Texas and Lubbock (STAR+PLUS). All of the service areas and products will now include the management of the pharmacy benefit for Superior's members. In addition, the state has added inpatient facility services to the managed care structure for the STAR+PLUS program. Operations in the expanded areas are expected to commence late in the first quarter of 2012.

- In 2012, we expect to realize the full year benefit of business commenced during 2011 in Arizona, Illinois, Kentucky, Ohio and Texas, as discussed above.

- In 2012, we announced that we were selected to contract with the Washington Health Care Authority to serve Medicaid beneficiaries in the state. Operations are expected to commence in the third quarter of 2012.

In 2010, we filed a legal challenge to the state of Wisconsin's decision on the southeast region reprocurement. In September 2011, the Wisconsin Court of Appeals denied our appeal.

As part of an RFP process, the state of Texas added a second vendor to the rural CHIP product in September 2010, which we previously managed under an exclusive contract. As a result, our December 31, 2010 membership in this product decreased by approximately 50,000 as compared to the prior year.

In March 2010, the Patient Protection and Affordable Care Act and the accompanying Health Care and Education Affordability Reconciliation Act, or the Acts, were enacted in the United States. The Acts contain provisions we expect will have a significant effect on our business in coming years including expanding Medicaid eligibility beginning in 2014 to recipients with incomes below 133% of the federal poverty level, retaining the CHIP program in its current form, and requiring state-based exchanges similar to our experience in Massachusetts in the future. The Acts allow states to receive the same level of rebates from pharmaceutical companies for their Medicaid programs, whether or not the states participate in managed care. The Acts also impose an excise tax on health insurers beginning in 2014 based upon relative market share. Effective in 2011, minimum health benefit cost ratios became mandated for commercial, fully-insured major medical health plans in the individual market, such as our Celtic subsidiary. The minimum health benefit cost ratio for these commercial plans will be set at 80% of premium revenue, adjusted for certain taxes, fees, assessments, risk premium and a credibility factor based upon both the number of covered life years and an average plan cost sharing adjustment calculated for each state. Certain states have filed and been granted waivers allowing for minimum heath benefit cost ratios at levels below 80%. If the actual health benefit cost ratios do not meet the minimum calculated for any state, rebates will be paid to those policyholders. Celtic expects to pay minimal rebates based on its 2011 results. Due to its complexity and lack of comprehensive interpretive guidance and implementation regulations, the ultimate impact of the Acts on Celtic is not yet fully known. The health benefit cost ratio minimum does not apply to other Centene subsidiaries.

MEMBERSHIP

From December 31, 2009 to December 31, 2011, we increased our at-risk managed care membership by 24.5%. The following table sets forth our membership by state for our managed care organizations:

	December 31,		
	2011	2010	2009
Arizona	23,700	22,400	20,700
Florida	198,300	194,900	102,600
Georgia	298,200	305,800	309,700
Illinois	16,300	—	—
Indiana	206,900	215,800	208,100
Kentucky	180,700	—	—
Massachusetts	35,700	36,200	27,800
Mississippi	31,600	—	—
Ohio	159,900	160,100	150,800
South Carolina	82,900	90,300	48,600
Texas	503,800	433,100	455,100
Wisconsin	78,000	74,900	134,800
Total at-risk membership	1,816,000	1,533,500	1,458,200
Non-risk membership	4,900	4,200	63,700
Total	1,820,900	1,537,700	1,521,900

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

	December 31,		
	2011	2010	2009
Medicaid	1,336,800	1,177,100	1,081,400
CHIP & Foster Care	213,900	210,500	263,600
ABD & Medicare	218,000	104,600	82,800
Hybrid Programs	40,500	36,200	27,800
Long-term Care	6,800	5,100	2,600
Total at-risk membership	1,816,000	1,533,500	1,458,200
Non-risk membership	4,900	4,200	63,700
Total	1,820,900	1,537,700	1,521,900

The following table provides information for other membership categories:

	December 31,		
	2011	2010	2009
Cenpatico Behavioral Health:			
Arizona	168,900	174,600	120,100
Kansas	46,200	39,200	41,400

From December 31, 2010 to December 31, 2011 our membership increased as a result of:

- operations commenced in Illinois, Kentucky and Mississippi
- contract awards and geographic expansion in Texas
- expanded contract awards in Arizona

From December 31, 2009 to December 31, 2010 our membership changed as a result of:

- acquisitions in Florida and South Carolina
- continued conversion of non-risk membership from Access to at-risk under Sunshine State Health Plan in Florida
- decreased membership in Texas and Wisconsin resulting from reprocurements

RESULTS OF CONTINUING OPERATIONS

The following discussion and analysis is based on our consolidated statements of operations, which reflect our results of operations for the years ended December 31, 2011, 2010 and 2009, as prepared in accordance with generally accepted accounting principles in the United States.

Summarized comparative financial data for 2011, 2010 and 2009 are as follows ($ in millions):

	2011	2010	2009	% Change 2010 - 2011	% Change 2009 - 2010
Premium	$ 5,077.2	$ 4,192.2	$ 3,786.5	21.1%	10.7%
Service	103.8	91.6	91.8	13.2%	(0.1)%
Premium and service revenues	5,181.0	4,283.8	3,878.3	20.9%	10.5%
Premium tax	159.6	164.5	224.6	(3.0)%	(26.8)%
Total revenues	5,340.6	4,448.3	4,102.9	20.1%	8.4%
Medical costs	4,324.8	3,584.5	3,230.1	20.7%	11.0%
Cost of services	78.1	63.9	60.8	22.2%	5.1%
General and administrative expenses	587.0	477.7	448.0	22.9%	6.7%
Premium tax expense	160.4	165.1	225.9	(2.9)%	(26.9)%
Earnings from operations	190.3	157.1	138.1	21.2%	13.7%
Investment and other income, net	(15.4)	(2.8)	(0.6)	454.0%	344.5%
Earnings from continuing operations, before income tax expense	174.9	154.3	137.5	13.4%	12.2%
Income tax expense	66.5	59.9	48.8	11.1%	22.6%
Earnings from continuing operations, net of income tax expense	108.4	94.4	88.7	14.8%	6.4%
Discontinued operations, net of income tax expense (benefit) of $0, $4.4, and $(1.2) respectively	—	3.9	(2.4)	(100.0)%	(260.6)%
Net earnings	108.4	98.3	86.3	10.3%	13.9%
Noncontrolling interest	(2.8)	3.5	2.6	(183.1)%	33.4%
Net earnings attributable to Centene Corporation	$ 111.2	$ 94.8	$ 83.7	17.3%	13.3%
Amounts attributable to Centene Corporation common shareholders:					
Earnings from continuing operations, net of income tax expense	$ 111.2	$ 90.9	$ 86.1	22.3%	5.6%
Discontinued operations, net of income tax expense (benefit)	—	3.9	(2.4)	(100.0)%	(260.6)%
Net earnings	$ 111.2	$ 94.8	$ 83.7	17.3%	13.3%
Diluted earnings (loss) per common share attributable to Centene Corporation:					
Continuing operations	$ 2.12	$ 1.80	$ 1.94	17.8%	(7.2)%
Discontinued operations	—	0.08	(0.05)	(100.0)%	(260.0)%
Total diluted earnings per common share	$ 2.12	$ 1.88	$ 1.89	12.8%	(0.5)%

Overview

Revenues and Revenue Recognition

Our health plans generate revenues primarily from premiums we receive from the states in which we operate. We receive a fixed premium per member per month pursuant to our state contracts. We generally receive premium payments and recognize premium revenue during the month in which we are obligated to provide services to our members. In some instances, our base premiums are subject to an adjustment, or risk score, based on the acuity of our membership. Generally, the risk score is determined by the state analyzing submissions of processed claims data to determine the acuity of our membership relative to the entire state's membership. Some contracts allow for additional premium associated with certain supplemental services provided such as maternity deliveries.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are reflected in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

Our specialty services generate revenues under contracts with state programs, healthcare organizations, and other commercial organizations, as well as from our own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of services.

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts, we do not recognize revenue subject to refund until data is sufficient to measure performance. Premium and service revenues due to us are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and our management's judgment on the collectibility of these accounts. As we generally receive payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of our financial condition or results of operations.

Some states enact premium taxes, similar assessments and provider and hospital pass-through payments, collectively, premium taxes, and these taxes are recorded as a component of revenues as well as operating expenses. We exclude premium taxes from our key ratios as we believe the premium tax is a pass-through of costs and not indicative of our operating performance.

The Centers for Medicare and Medicaid Services (CMS) deploys a risk adjustment model that retroactively apportions Medicare premiums paid according to health severity and certain demographic factors. The model pays more for members whose medical history indicates they have certain medical conditions. Under this risk adjustment methodology, CMS calculates the risk adjusted premium payment using diagnosis data from hospital inpatient, hospital outpatient, physician treatment settings as well as prescription drug events. The Company estimates the amount of risk adjustment based upon the diagnosis and pharmacy data submitted and expected to be submitted to CMS and records revenues on a risk adjusted basis.

Operating Expenses

Medical Costs

Medical costs include payments to physicians, hospitals, and other providers for healthcare and specialty services 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. We use our judgment to determine the assumptions to be used in the calculation of the required IBNR estimate. The assumptions we consider include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to Medicaid fee schedules, and the incidence of high dollar or catastrophic claims.

Our development of the IBNR estimate is a continuous process which we monitor and refine on a monthly basis as claims receipts and payment information becomes available. As more complete information becomes available, we adjust the amount of the estimate, and include the changes in estimates in medical expense in the period in which the changes are identified.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for medical costs.

While we believe our IBNR estimate is appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. Accordingly, we cannot assure you that healthcare claim costs will not materially differ from our estimates.

Results of operations depend on our ability to manage expenses associated with health benefits and to accurately predict costs incurred. The health benefits ratio, or HBR, represents medical costs as a percentage of premium revenues (excluding premium taxes) and reflects the direct relationship between the premium received and the medical services provided.

During 2011, we reclassified certain Medical Costs and General & Administrative Expenses to more closely align with the new National Association of Insurance Commissioners (NAIC) definitions of medical costs. We have reclassified all periods presented to conform to the new presentation. The table below presents the impact of the reclassification on consolidated Medical Costs and HBR for the years ended December 31, 2011, 2010 and 2009.

	2011		2010		2009	
	Medical Costs	HBR	Medical Costs	HBR	Medical Costs	HBR
Historical	$ 4,227,916	83.3%	$ 3,514,394	83.8%	$ 3,163,523	83.5%
Reclassification impact	96,830	1.9	70,058	1.7	66,608	1.8
Revised	$ 4,324,746	85.2%	$ 3,584,452	85.5%	$ 3,230,131	85.3%

Cost of Services

Cost of services expense includes the pharmaceutical costs associated with our pharmacy benefit manager's external revenues and certain direct costs to support the functions responsible for generation of our services revenues. These expenses consist of the salaries and wages of the professionals who provide the services and associated expenses.

General and Administrative Expenses

General and administrative expenses, or G&A, primarily reflect wages and benefits, including stock compensation expense, and other administrative costs associated with our health plans, specialty companies and centralized functions that support all of our business units. Our major centralized functions are finance, information systems and claims processing. G&A expenses also include business expansion costs, such as wages and benefits for administrative personnel, contracting costs, and information technology buildouts, incurred prior to the commencement of a new contract or health plan.

The G&A expense ratio represents G&A expenses as a percentage of premium and service revenues, and reflects the relationship between revenues earned and the costs necessary to earn those revenues.

As mentioned above, during 2011, we reclassified certain Medical Costs and G&A Expenses to more closely align with the new NAIC definitions. We have reclassified all periods presented to conform to the new presentation of medical costs. The table below presents the impact of the reclassification on consolidated G&A Expense and the G&A expense ratio for the years ended December 31, 2011, 2010 and 2009.

	2011		2010		2009	
	G&A Expense	G&A Ratio	G&A Expense	G&A Ratio	G&A Expense	G&A Ratio
Historical	$ 683,834	13.2%	$ 547,823	12.8%	$ 514,529	13.3%
Reclassification impact	(96,830)	(1.9)	(70,058)	(1.6)	(66,608)	(1.7)
Revised	$ 587,004	11.3%	$ 477,765	11.2%	$ 447,921	11.6%

Other Income (Expense)

Other income (expense) consists principally of investment income from cash and investments, earnings in equity method investments, and interest expense on debt.

Discontinued Operations

In November 2008, we announced our intention to sell certain assets of UHP, our New Jersey health plan. Accordingly, the results of operations for UHP are reported as discontinued operations for all periods presented. We completed the sale in the first quarter of 2010.

Year Ended December 31, 2011 Compared to Year Ended December 31, 2010

Revenues

Premium and service revenues increased 20.9% in 2011 over 2010 as a result of membership growth discussed under the heading "Membership". The premium rates specified in our state contracts are generally updated on an annual basis through contract amendments. In 2011, we received premium rate adjustments which yielded a net 0.9% composite decrease across all of our markets.

Operating Expenses

Medical Costs

The table below depicts the HBR for our external membership by member category:

	Year Ended December 31,	
	2011	2010
Medicaid and CHIP	82.4%	85.0%
ABD and Medicare	89.8	87.1
Specialty Services	89.1	86.2
Total	85.2	85.5

The consolidated HBR of 85.2% for 2011 represented a 0.3% decrease from the 2010 consolidated HBR of 85.5%. The decrease is primarily due to lower levels of utilization and contract enhancements.

General and Administrative Expenses

The consolidated G&A expense ratio for the years ended December 31, 2011 and 2010 was 11.3% and 11.2%, respectively. The increase in the ratio in 2011 primarily reflects increased business expansion costs to support new business in Illinois, Kentucky, Louisiana and Texas, partially offset by the leveraging of our expenses over higher revenues.

Investment and Other Income, Net

The following table summarizes the components of investment and other income, net ($ in millions):

	Year Ended December 31,	
	2011	2010
Investment income	$ 13.1	$ 14.9
Net gain on sale of investments	0.3	2.5
Impairment of investment	—	(5.5)
Gain on Reserve Primary Fund distributions	—	3.3
Debt extinguishment costs	(8.5)	—
Interest expense	(20.3)	(18.0)
Investment and other income, net	$ (15.4)	$ (2.8)

Investment income. The decrease in investment income in 2011 reflects the continued low market interest rates, partially offset by an increase in investment balances.

Net gain on sale of investments. As a result of tightening our investment criteria for municipal securities, we sold municipal securities resulting in net gains of $2.5 million during 2010.

Impairment of investment. During 2010, we determined we had an other-than-temporary impairment of our cost method investment in Casenet, LLC, and recorded an impairment charge of $5.5 million.

Gain on Reserve Primary Fund distributions. In 2010, we received distributions from the Reserve Primary Fund of $5.7 million resulting in a gain of $3.3 million recorded for the distributions received in excess of our adjusted basis.

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

Interest expense. Interest expense for 2011 increased by $2.3 million from 2010 primarily due to borrowings on the mortgage loan associated with the real estate development including our corporate headquarters. The real estate development was placed in service in the third quarter of 2010 and, accordingly, we ceased capitalizing interest on the project. The increase in interest expense was partially offset by reduced interest expense reflecting the refinancing our Senior Notes and lower interest rate as a result of the execution of the associated interest rate swap agreements in 2011.

Income Tax Expense

Excluding the amounts attributable to noncontrolling interest, our effective tax rate in 2011 was 37.4% compared to 39.7% in 2010. The decrease in the effective tax rate was driven by a higher rate in 2010 resulting from legislation enacted in May 2010 in the state of Georgia which replaced the state income tax with a premium tax for Medicaid managed care organizations effective July 1, 2010. Accordingly, a deferred tax asset of $1.7 million related to Georgia state net operating loss carry forwards was written off during 2010. Additionally, the higher effective tax rate in 2010 was also related to a decrease in tax exempt interest and an increase in state income taxes.

Segment Results

The following table summarizes our operating results by segment ($ in millions):

	2011	2010	% Change 2010-2011
Premium and Service Revenues			
Medicaid Managed Care	$ 4,515.5	$ 3,740.5	20.7%
Specialty Services	1,484.3	1,112.1	33.5%
Eliminations	(818.8)	(568.8)	44.0%
Consolidated Total	$ 5,181.0	$ 4,283.8	20.9%
Earnings from Operations			
Medicaid Managed Care	$ 153.0	$ 117.1	30.6%
Specialty Services	37.3	40.0	(6.6) %
Consolidated Total	$ 190.3	$ 157.1	21.1%

Medicaid Managed Care

Premium and service revenues increased 20.7% in 2011 due to the addition of the Mississippi, Illinois and Kentucky contracts, the Texas market expansion, and overall membership growth. Earnings from operations increased 30.6% in 2011 reflecting overall growth in our membership, reduced HBR and leveraging of our general and administrative expenses.

Specialty Services

Premium and service revenues increased 33.5% in 2011 primarily due to the growth in our Medicaid segment and the associated specialty services provided to this increased membership. Earnings from operations decreased 6.6% in 2011 reflecting the addition of the care management software business which operates at a loss and lower earnings in our individual health insurance business.

Year Ended December 31, 2010 Compared to Year Ended December 31, 2009

Revenues

Premium and service revenues increased 10.5% in 2010 over 2009 as a result of membership growth discussed under the heading “Membership”, and net premium rate increases in 2010. In 2010, we received premium rate adjustments in certain markets which yielded a net 2.3% composite increase across all of our markets. The increase in premium and service revenues was moderated by the removal of pharmacy services in two states in 2010. These pharmacy carve outs had the effect of reducing revenue by approximately $185.0 million during 2010.

Operating Expenses

Medical Costs

The table below depicts the HBR for our external membership by member category:

	Year Ended December 31,	
	2010	2009
Medicaid and CHIP	85.0%	86.1%
ABD and Medicare	87.1	83.5
Specialty Services	86.2	83.1
Total	85.5	85.3

The consolidated HBR of 85.5% for 2010 represented a 0.2% increase from the 2009 consolidated HBR of 85.3%. The increase is mainly due to a member mix shift to less favorable HBR categories, partially offset by provider network and utilization management initiatives.

General and Administrative Expenses

The consolidated G&A expense ratio for the years ended December 31, 2010 and 2009 was 11.2% and 11.5%, respectively. The decrease in the ratio in 2010 primarily reflects the leveraging of our expenses over higher revenues.

Investment and Other Income, Net

The following table summarizes the components of investment and other income, net ($ in millions):

	Year Ended December 31,	
	2010	2009
Investment income	$ 14.9	$ 15.6
Net gain on sale of investments	2.5	0.1
Impairment of investment	(5.5)	—
Gain on Reserve Primary Fund distributions	3.3	—
Interest expense	(18.0)	(16.3)
Investment and other income, net	$ (2.8)	$ (0.6)

Investment income. The decrease in investment income in 2010 reflects the decline in market interest rates.

Net gain on sale of investments. As a result of tightening our investment criteria for municipal securities, we sold municipal securities resulting in net gains of $2.5 million during 2010.

Impairment of investment. During 2010, we determined we had an other-than-temporary impairment of our cost method investment in Casenet, LLC, and recorded an impairment charge of $5.5 million, including $3.5 million of convertible promissory notes.

Gain on Reserve Primary Fund distributions. In 2010, we received distributions from the Reserve Primary Fund of $5.7 million resulting in a gain of $3.3 million recorded for the distributions received in excess of our adjusted basis.

Interest expense. Interest expense increased reflecting the borrowings on the loans associated with the construction of our corporate headquarters. The real estate development was placed in service in the third quarter 2010 and accordingly we ceased capitalizing interest on the project. The increase was partially offset by the reduction in debt outstanding under our revolving credit agreement as a result of the equity offering completed during the first quarter of 2010.

Income Tax Expense

Excluding the amounts attributable to noncontrolling interest, our effective tax rate in 2010 was 39.7% compared to 36.2% in 2009. The increase in 2010 was primarily driven by legislation enacted in May 2010 in the state of Georgia which replaced the state income tax with a premium tax for Medicaid managed care organizations effective July 1, 2010. Accordingly, a deferred tax asset of $1.7 million related to Georgia state net operating loss carry forwards was written off during 2010. Additionally, the increase in the effective tax rate in 2010 was also related to a decrease in tax exempt interest and an increase in state income taxes.

Discontinued Operations

Pre-tax earnings related to discontinued operations (consisting solely of the New Jersey health plan operations) were $8.3 million in 2010 compared to a pre-tax loss of $3.6 million in 2009. As a result of the sale of certain assets of the New Jersey operations in March 2010, we recognized a pre-tax gain of $8.2 million, which was $3.9 million after tax, or $0.08 per diluted share. Additionally, we recognized $1.2 million of restructuring costs associated with the exit primarily due to lease termination costs and employee retention programs. The total revenue associated with UHP included in results from discontinued operations was $21.8 million and $145.1 million for 2010 and 2009, respectively.

Segment Results

The following table summarizes our operating results by segment ($ in millions):

	2010	2009	% Change 2009-2010
Premium and Service Revenues			
Medicaid Managed Care	$ 3,740.5	$ 3,464.8	8.0%
Specialty Services	1,112.1	1,049.5	6.0%
Eliminations	(568.8)	(636.0)	(10.6) %
Consolidated Total	$ 4,283.8	$ 3,878.3	10.5%
Earnings from Operations			
Medicaid Managed Care	$ 117.1	$ 99.3	17.9%
Specialty Services	40.0	38.8	2.9%
Consolidated Total	$ 157.1	$ 138.1	13.7%

Medicaid Managed Care

Premium and service revenues increased 8.0% in 2010 due to membership growth and net premium rate increases in 2010. Earnings from operations increased 17.9% in 2010 reflecting overall growth in our membership and leveraging of our general and administrative expenses.

Specialty Services

Premium and service revenues increased 6.0% in 2010 primarily due to growth of our operations in Massachusetts, as well as membership growth in our Medicaid segment and the associated specialty services provided to this increased membership. Earnings from operations increased 2.9% in 2010 reflecting the growth in service revenue for lower margin services, higher HBR in 2010, and the effect of pharmacy carve outs in two states.

LIQUIDITY AND CAPITAL RESOURCES

Shown below is a condensed schedule of cash flows for the years ended December 31, 2011, 2010 and 2009, that we use throughout our discussion of liquidity and capital resources ($ in millions).

	Year Ended December 31,		
	2011	2010	2009
Net cash provided by operating activities	$ 261.7	$ 168.9	$ 248.2
Net cash used in investing activities	(129.1)	(210.6)	(270.1)
Net cash provided by financing activities	6.9	72.1	46.6
Net increase in cash and cash equivalents	$ 139.5	$ 30.4	$ 24.7

Cash Flows Provided by Operating Activities

Normal operations are funded primarily through operating cash flows and borrowings under our revolving credit facility. Operating activities provided cash of $261.7 million in 2011, compared to $168.9 million in 2010 and $248.2 million in 2009.

Cash flows from operations in each year were impacted by the timing of payments we receive from our states. States may prepay the following month premium payment which we record as unearned revenue, or they may delay our premium payment by several days until the following month which we record as a receivable.

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

	Year Ended December 31,		
	2011	2010	2009
Premium and related receivables	$ (11.3)	$ (23.4)	$ 2.4
Unearned revenue	(109.1)	25.7	78.3
Net (decrease) increase in operating cash flow	$ (120.4)	$ 2.3	$ 80.7

Net cash provided by operating activities in 2011 was negatively impacted by the timing of payments from our states by $120.4 million. As of December 31, 2011, we had received all December 2011 capitation payments from our states and had not received any prepayments of January 2012 capitation. This was offset by an increase in medical claims liabilities related to the start up of our Mississippi, Illinois and Kentucky health plans, as well as expansion of our Texas health plan in 2011.

Net cash provided by operating activities benefited in 2010 and 2009 as a result of prepayments from several of our states. Cash flows from operations in 2010 also reflected an increase in premium and related receivables and medical claims liability primarily due to increased business in Florida, Massachusetts and South Carolina.

Cash Flows Used in Investing Activities

Investing activities used cash of $129.1 million in 2011, $210.6 million in 2010 and $270.1 million in 2009. Cash flows for each year primarily consisted of additions to the investment portfolio of our regulated subsidiaries, including transfers from cash and cash equivalents to long-term investments, and capital expenditures. In 2009, cash flows from investing activities also included membership conversion fees in Florida and acquisitions in Florida and South Carolina.

Our investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets within our guidelines. Net cash provided by and used in investing activities will fluctuate from year to year due to the timing of investment purchases, sales and maturities. As of December 31, 2011, our investment portfolio consisted primarily of fixed-income securities with an average duration of 2.0 years. These securities generally are actively traded in secondary markets and the reported fair market value is determined based on recent trading activity, recent trading activity in similar securities and other observable inputs. Our investment guidelines comply with the regulatory restrictions enacted in each state.

The following table summarizes our cash and investment balances as of December 31, ($ in millions):

	2011	2010
Cash, cash equivalents and short-term investments	$ 704.2	$ 455.2
Long-term investments	506.1	595.9
Restricted deposits	26.8	22.8
Total cash, investments and restricted deposits	$ 1,237.1	$ 1,073.9
Regulated cash, investments and restricted deposits	$ 1,198.9	$ 1,043.0
Unregulated cash and investments	38.2	30.9
Consolidated Total	$ 1,237.1	$ 1,073.9

We spent $64.4 million, $31.7 million and $23.2 million in 2011, 2010 and 2009 respectively, on capital expenditures for system enhancements, a new datacenter and market expansions. We also spent $4.6 million, $31.6 million, and $0.5 million in 2011, 2010 and 2009, respectively, for costs associated with our headquarters development including land, tenant improvements and furniture. We anticipate spending approximately $55 million on capital expenditures in 2012 primarily associated with system enhancements and market expansions.

During 2009, we executed an agreement as a joint venture partner in Centene Center LLC that began construction of a real estate development that included the Company's corporate headquarters. During 2010, the development was placed in service and we acquired the remaining ownership interest in Centene Center LLC. For the years ended December 31, 2011, 2010 and 2009, Centene Center LLC had capital expenditures of $4.7 million, $55.3 million and $59.4 million, respectively, for costs associated with the real estate development. We anticipate spending approximately $3 million on capital expenditures in 2012 associated with the real estate development.

Cash Flows Provided by Financing Activities

Our financing activities provided cash of $6.9 million in 2011, $72.1 million in 2010 and $46.6 million in 2009. During 2011, our financing activities primarily related to repayments and proceeds of long term debt as discussed below. During 2010, our financing activities primarily related to proceeds from our stock offering and resulting payoff of our revolving credit facility discussed below, as well as borrowings for the construction of the real estate development discussed above. During 2009, our financing activities primarily related to proceeds from borrowings under our $300 million credit facility and construction financing of the real estate development discussed above.

In June 2009, Centene Center LLC executed a $95 million construction loan associated with the real estate development that included our corporate headquarters. In December 2010, we refinanced the $95 million construction loan with an $80 million 10 year mortgage note payable. The mortgage note is non-recourse to the Company, bears a 5.14% interest rate and has a financial covenant requiring a minimum debt service coverage ratio.

During the first quarter of 2010, we completed the sale of 5.75 million shares of common stock for $19.25 per share. Net proceeds from the sale of the shares were approximately $104.5 million. A portion of the net proceeds was used to repay the outstanding indebtedness under our $300 million revolving credit loan facility ($84.0 million as of December 31, 2009). The remaining net proceeds were used to fund our acquisition in South Carolina as well as capital expenditures.

In January 2011, we replaced our $300 million revolving credit agreement with a new $350 million revolving credit facility, or the revolver. The revolver is unsecured and has a five-year maturity with non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver will bear interest based upon LIBOR rates, the Federal funds rate, or the prime rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.25% to 0.50% depending on the total debt to EBITDA ratio. As of December 31, 2011, we had no borrowings outstanding under the agreement, leaving availability of $350.0 million. As of December 31, 2011, we were in compliance with all covenants.

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

In May 2011, pursuant to a shelf registration statement, we issued $250 million of non-callable 5.75% Senior Notes due June 1, 2017 ($250 million Notes) at a discount to yield 6%. The indenture governing the $250 million Notes contains non-financial and financial covenants, including requirements of a minimum fixed charge coverage ratio. Interest is paid semi-annually in June and December. We used a portion of the net proceeds from the offering to repay the $175 million Notes and call premium and to repay approximately $50 million outstanding on our revolving credit facility. The additional proceeds were used for general corporate purposes. In connection with the issuance, we entered into $250 million notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, we receive a fixed rate of 5.75% and pay a variable rate of LIBOR plus 3.5% adjusted quarterly, which allows us to adjust the $250 million Notes to a floating rate. We do not hold or issue any derivative instrument for trading or speculative purposes.

At December 31, 2011, we had working capital, defined as current assets less current liabilities, of $102.4 million, as compared to $(108.4) million at December 31, 2010. We manage our short-term and long-term investments with the goal of ensuring that a sufficient portion is held in investments that are highly liquid and can be sold to fund short-term requirements as needed. Our working capital is negative from time to time due to our efforts to increase investment returns through purchases of investments that have maturities of greater than one year and, therefore, are classified as long-term.

At December 31, 2011, our debt to capital ratio, defined as total debt divided by the sum of total debt and total equity, was 27.3%, compared to 29.3% at December 31, 2010. Excluding the $77.8 million Non-Recourse Mortgage Note, our debt to capital ratio is 22.6%. We utilize the debt to capital ratio as a measure, among others, of our leverage and financial flexibility.

We have a stock repurchase program authorizing us to repurchase up to four million shares of common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. We reserve the right to discontinue the repurchase program at any time. We did not make any repurchases under this plan during 2011 or 2010.

During the year ended December 31, 2011, 2010 and 2009, we received dividends of $69.1 million, $67.9 million, $19.1 million, respectively, from our regulated subsidiaries.

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

CONTRACTUAL OBLIGATIONS

The following table summarizes future contractual obligations. These obligations contain estimates and are subject to revision under a number of circumstances. Our debt consists of borrowings from our senior notes, credit facility, mortgages and capital leases. The purchase obligations consist primarily of software purchase and maintenance contracts. The contractual obligations and estimated period of payment over the next five years and beyond are as follows (in thousands):

	Payments Due by Period				
	Total	Less Than 1 Year	1-3 Years	3-5 Years	More Than 5 Years
Medical claims liability	$ 607,985	$ 607,985	$ —	$ —	$ —
Debt and interest	467,225	21,814	51,397	42,176	351,838
Operating lease obligations	96,002	21,187	33,307	24,504	17,004
Purchase obligations	36,271	17,086	15,546	3,439	200
Reserve for uncertain tax positions	9,601	—	8,034	1,567	—
Other long-term liabilities [1]	58,359	3,651	10,810	8,614	35,284
Total	$ 1,275,443	$ 671,723	$ 119,094	$ 80,300	$ 404,326

[1] Includes $7,868 separate account liabilities from third party reinsurance that will not be settled in cash.

REGULATORY CAPITAL AND DIVIDEND RESTRICTIONS

Our operations are conducted through our subsidiaries. As managed care organizations, these subsidiaries are subject to state regulations that, among other things, require the maintenance of minimum levels of statutory capital, as defined by each state, and restrict the timing, payment and amount of dividends and other distributions that may be paid to us. Generally, the amount of dividend distributions that may be paid by a regulated subsidiary without prior approval by state regulatory authorities is limited based on the entity's level of statutory net income and statutory capital and surplus.

Our subsidiaries are required to maintain minimum capital requirements prescribed by various regulatory authorities in each of the states in which we operate. As of December 31, 2011, our subsidiaries had aggregate statutory capital and surplus of $619.9 million, compared with the required minimum aggregate statutory capital and surplus requirements of $342.0 million and we estimate our Risk Based Capital, or RBC, percentage to be in excess of 350% of the Authorized Control Level.

The National Association of Insurance Commissioners has adopted rules which set minimum risk-based capital requirements for insurance companies, managed care organizations and other entities bearing risk for healthcare coverage. As of December 31, 2011, each of our health plans were in compliance with the risk-based capital requirements enacted in those states.

RECENT ACCOUNTING PRONOUNCEMENTS

For this information, refer to Note 2, *Summary of Significant Accounting Policies*, in the Notes to the Consolidated Financials Statements, included herein.

CRITICAL ACCOUNTING POLICIES AND ESTIMATES

Our discussion and analysis of our results of operations and liquidity and capital resources are based on our consolidated financial statements which have been prepared in accordance with GAAP. In connection with the preparation of our consolidated financial statements, we are required to make assumptions and estimates about future events, and apply judgments that affect the reported amounts of assets, liabilities, revenue, expenses, and the related disclosures. We base our assumptions, estimates and judgments on historical experience, current trends and other factors we believe to be relevant at the time we prepared our consolidated financial statements. On a regular basis, we review the accounting policies, assumptions, estimates and judgments to ensure that our consolidated financial statements are presented fairly and in accordance with GAAP. However, because future events and their effects cannot be determined with certainty, actual results could differ from our assumptions and estimates, and such differences could be material.

Our significant accounting policies are more fully described in Note 2, *Summary of Significant Accounting Policies*, to our consolidated financial statements included elsewhere herein. Our accounting policies regarding medical claims liability and intangible assets are particularly important to the portrayal of our financial position and results of operations and require the application of significant judgment by our management. As a result, they are subject to an inherent degree of uncertainty. We have reviewed these critical accounting policies and related disclosures with the Audit Committee of our Board of Directors.

Medical claims liability

Our medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. We estimate our medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. We include in our IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in our actuarial method of reserving.

We use our judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions we consider when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

We apply various estimation methods depending on the claim type and the period for which claims are being estimated. For more recent periods, incurred non-inpatient claims are estimated based on historical per member per month claims experience adjusted for known factors. Incurred hospital inpatient claims are estimated based on known inpatient utilization data and prior claims experience adjusted for known factors. For older periods, we utilize an estimated completion factor based on our historical experience to develop IBNR estimates. The completion factor is an actuarial estimate of the percentage of claims incurred during a given period that have been received or adjudicated as of the reporting period to the estimate of the total ultimate incurred costs. When we commence operations in a new state or region, we have limited information with which to estimate our medical claims liability. See "Risk Factors – Failure to accurately predict our medical expenses could negatively affect our financial position, results of operations or cash flows." These approaches are consistently applied to each period presented.

Additionally, we contract with independent actuaries to review our estimates on a quarterly basis. The independent actuaries provide us with a review letter that includes the results of their analysis of our medical claims liability. We do not solely rely on their report to adjust our claims liability. We utilize their calculation of our claims liability only as additional information, together with management's judgment, to determine the assumptions to be used in the calculation of our liability for claims.

Our development of the medical claims liability estimate is a continuous process which we monitor and refine on a monthly basis as additional claims receipts and payment information becomes available. As more complete claim information becomes available, we adjust the amount of the estimates, and include the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, our operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. We consistently apply our reserving methodology from period to period. As additional information becomes known to us, we adjust our actuarial models accordingly to establish medical claims liability estimates.

The paid and received completion factors, claims per member per month and per diem cost trend factors are the most significant factors affecting the IBNR estimate. The following table illustrates the sensitivity of these factors and the estimated potential impact on our operating results caused by changes in these factors based on December 31, 2011 data:

Completion Factors (1):		Cost Trend Factors (2):	
(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities	(Decrease) Increase in Factors	Increase (Decrease) in Medical Claims Liabilities
	(in thousands)		(in thousands)
(2.0)%	$ 67,000	(2.0)%	$ (16,600)
(1.5)	49,900	(1.5)	(12,600)
(1.0)	33,000	(1.0)	(8,400)
(0.5)	16,500	(0.5)	(4,200)
0.5	(16,400)	0.5	4,200
1.0	(32,400)	1.0	8,500
1.5	(48,500)	1.5	12,700
2.0	(64,300)	2.0	17,000

(1) Reflects estimated potential changes in medical claims liability caused by changes in completion factors.
(2) Reflects estimated potential changes in medical claims liability caused by changes in cost trend factors for the most recent periods.

While we believe our estimates are appropriate, it is possible future events could require us to make significant adjustments for revisions to these estimates. For example, a 1% increase or decrease in our estimated medical claims liability would have affected net earnings by $3.8 million for the year ended December 31, 2011. The estimates are based on our historical experience, terms of existing contracts, our observance of trends in the industry, information provided by our providers and information available from other outside sources.

The change in medical claims liability is summarized as follows (in thousands):

	Year Ended December 31,		
	2011	2010	2009
Balance, January 1	$ 456,765	$ 470,932	$ 384,360
Incurred related to:			
Current year	4,390,123	3,652,521	3,283,141
Prior years	(65,377)	(68,069)	(53,010)
Total incurred	4,324,746	3,584,452	3,230,131
Paid related to:			
Current year	3,788,808	3,203,585	2,819,591
Prior years	384,718	395,034	323,968
Total paid	4,173,526	3,598,619	3,143,559
Balance, December 31	$ 607,985	$ 456,765	$ 470,932
Claims inventory, December 31	495,500	434,900	423,400
Days in claims payable [1]	45.3	44.7	49.1

[1] Days in claims payable is a calculation of medical claims liability at the end of the period divided by average expense per calendar day for the fourth quarter of each year.

Medical claims are usually paid within a few months of the member receiving service from the physician or other healthcare provider. As a result, the liability generally is described as having a “short-tail,” which causes less than 5% of our medical claims liability as of the end of any given year to be outstanding the following year. We believe that substantially all the development of the estimate of medical claims liability as of December 31, 2011 will be known by the end of 2012.

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While we have evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by us. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member’s acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of our business, the number of states in which we operate, and the volume of claims that we process, we are unable to practically quantify the impact of these initiatives on our changes in estimates of IBNR.

The following medical management initiatives may have contributed to the favorable development through lower medical utilization and cost trends:

- Appropriate leveling of care for neonatal intensive care unit hospital admissions, other inpatient hospital admissions, and observation admissions, in accordance with Interqual criteria.
- Tightening of our pre-authorization list and more stringent review of durable medical equipment and injectibles.
- Emergency department, or ED, program designed to collaboratively work with hospitals to steer non-emergency care away from the costly ED setting (through patient education, on-site alternative urgent care settings, etc.)
- Increase emphasis on case management and clinical rounding where case managers are nurses or social workers who are employed by the health plan to assist selected patients with the coordination of healthcare services in order to meet a patient's specific healthcare needs.
- Incorporation of disease management which is a comprehensive, multidisciplinary, collaborative approach to chronic illnesses such as asthma.

Goodwill and Intangible Assets

We have made several acquisitions that have resulted in our recording of intangible assets. These intangible assets primarily consist of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. At December 31, 2011, we had $282.0 million of goodwill and $27.4 million of other intangible assets.

Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	7 – 10 years
Customer relationships	5 – 15 years
Trade names	7 – 20 years

Our management evaluates whether events or circumstances have occurred that may affect the estimated useful life or the recoverability of the remaining balance of goodwill and other identifiable intangible assets. If the events or circumstances indicate that the remaining balance of the intangible asset or goodwill may be impaired, the potential impairment will be measured based upon the difference between the carrying amount of the intangible asset or goodwill and the fair value of such asset. Our management must make assumptions and estimates, such as the discount factor, future utility and other internal and external factors, in determining the estimated fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results.

Goodwill is reviewed annually during the fourth quarter for impairment. In addition, an impairment analysis of intangible assets would be performed based on other factors. These factors include significant changes in membership, state funding, medical contracts and provider networks and contracts. The fair value of all reporting units with material amounts of goodwill was substantially in excess of the carrying value as of our annual impairment testing date.

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

INVESTMENTS

As of December 31, 2011, we had short-term investments of $130.5 million and long-term investments of $533.0 million, including restricted deposits of $26.8 million. The short-term investments generally consist of highly liquid securities with maturities between three and 12 months. The long-term investments consist of municipal, corporate and U.S. Treasury securities, government sponsored obligations, life insurance contracts, asset backed securities and equity securities and have maturities greater than one year. Restricted deposits consist of investments required by various state statutes to be deposited or pledged to state agencies. Due to the nature of the states' requirements, these investments are classified as long-term regardless of the contractual maturity date. Our available-for-sale investments are subject to interest rate risk and will decrease in value if market rates increase. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2011, the fair value of our fixed income investments would decrease by approximately $10.8 million. Declines in interest rates over time will reduce our investment income.

We entered into interest rate swap agreements with creditworthy financial institutions to manage the impact of market interest rates on interest expense. Our swap agreements convert a portion of our interest expense from fixed to variable rates to better match the impact of changes in market rates on our variable rate cash equivalent investments. As a result, the fair value of our $250 million Senior Note debt varies with market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at December 31, 2011, the fair value of our debt would decrease by approximately $12.3 million. An increase in interest rates decreases the fair value of the debt and conversely, a decrease in interest rates increases the value.

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

INFLATION

In 2011, the inflation rate for medical care costs was higher than the inflation rate for all items. We use various strategies to mitigate the negative effects of healthcare cost inflation. Specifically, our health plans try to control medical and hospital costs through our state savings initiatives and contracts with independent providers of healthcare services. Through these contracted care providers, our health plans emphasize preventive healthcare and appropriate use of specialty and hospital services. Additionally, our contracts with states require actuarially sound premiums that include health care cost trend.

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

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

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders
Centene Corporation:

We have audited the accompanying consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2011 and 2010, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2011. These consolidated financial statements are the responsibility of the Company's management. Our responsibility is to express an opinion on these consolidated financial statements based on our audits.

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

In our opinion, the consolidated financial statements referred to above present fairly, in all material respects, the financial position of Centene Corporation and subsidiaries as of December 31, 2011 and 2010, and the results of their operations and their cash flows for each of the years in the three-year period ended December 31, 2011, in conformity with U.S. generally accepted accounting principles.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), Centene Corporation's internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO), and our report dated February 20, 2012 expressed an unqualified opinion on the effectiveness of the Company's internal control over financial reporting.

/s/ KPMG LLP

St. Louis, Missouri
February 20, 2012

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	December 31, 2011	December 31, 2010
ASSETS		
Current assets:		
Cash and cash equivalents	$ 573,698	$ 434,166
Premium and related receivables, net of allowance for uncollectible accounts of $639 and $17, respectively	157,450	136,243
Short-term investments, at fair value (amortized cost $129,232 and $21,141, respectively)	130,499	21,346
Other current assets	78,363	65,066
Total current assets	940,010	656,821
Long-term investments, at fair value (amortized cost $497,805 and $585,862, respectively)	506,140	595,879
Restricted deposits, at fair value (amortized cost $26,751 and $22,755, respectively)	26,818	22,758
Property, software and equipment, net of accumulated depreciation of $177,294 and $138,629, respectively	349,622	326,341
Goodwill	281,981	278,051
Intangible assets, net	27,430	29,109
Other long-term assets	58,335	34,923
Total assets	$ 2,190,336	$ 1,943,882
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities:		
Medical claims liability	$ 607,985	$ 456,765
Accounts payable and accrued expenses	216,504	188,320
Unearned revenue	9,890	117,344
Current portion of long-term debt	3,234	2,817
Total current liabilities	837,613	765,246
Long-term debt	348,344	327,824
Other long-term liabilities	67,960	53,757
Total liabilities	1,253,917	1,146,827
Commitments and contingencies		
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 53,586,726 issued and 50,864,618 outstanding at December 31, 2011, and 52,172,037 issued and 49,616,824 outstanding at December 31, 2010	54	52
Additional paid-in capital	421,981	384,206
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	5,761	6,424
Retained earnings	564,961	453,743
Treasury stock, at cost (2,722,108 and 2,555,213 shares, respectively)	(57,123)	(50,486)
Total Centene stockholders' equity	935,634	793,939
Noncontrolling interest	785	3,116
Total stockholders' equity	936,419	797,055
Total liabilities and stockholders' equity	$ 2,190,336	$ 1,943,882

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

CENTENE CORPORATION AND SUBSIDIARIES

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

	Year Ended December 31,		
	2011	**2010**	**2009**
Revenues:			
Premium	$ 5,077,242	$ 4,192,172	$ 3,786,525
Service	103,765	91,661	91,758
Premium and service revenues	5,181,007	4,283,833	3,878,283
Premium tax	159,575	164,490	224,581
Total revenues	5,340,582	4,448,323	4,102,864
Expenses:			
Medical costs	4,324,746	3,584,452	3,230,131
Cost of services	78,114	63,919	60,789
General and administrative expenses	587,004	477,765	447,921
Premium tax expense	160,394	165,118	225,888
Total operating expenses	5,150,258	4,291,254	3,964,729
Earnings from operations	190,324	157,069	138,135
Other income (expense):			
Investment and other income	13,369	15,205	15,691
Debt extinguishment costs	(8,488)	—	—
Interest expense	(20,320)	(17,992)	(16,318)
Earnings from continuing operations, before income tax expense	174,885	154,282	137,508
Income tax expense	66,522	59,900	48,841
Earnings from continuing operations, net of income tax expense	108,363	94,382	88,667
Discontinued operations, net of income tax expense (benefit) of $0, $4,388 and $(1,204), respectively	—	3,889	(2,422)
Net earnings	108,363	98,271	86,245
Noncontrolling interest	(2,855)	3,435	2,574
Net earnings attributable to Centene Corporation	$ 111,218	$ 94,836	$ 83,671
Amounts attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of income tax expense	$ 111,218	$ 90,947	$ 86,093
Discontinued operations, net of income tax expense (benefit)	—	3,889	(2,422)
Net earnings	$ 111,218	$ 94,836	$ 83,671
Net earnings (loss) per common share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 2.22	$ 1.87	$ 2.00
Discontinued operations	—	0.08	(0.06)
Basic earnings per common share	$ 2.22	$ 1.95	$ 1.94
Diluted:			
Continuing operations	$ 2.12	$ 1.80	$ 1.94
Discontinued operations	—	0.08	(0.05)
Diluted earnings per common share	$ 2.12	$ 1.88	$ 1.89
Weighted average number of common shares outstanding:			
Basic	50,198,954	48,754,947	43,034,791
Diluted	52,474,238	50,447,888	44,316,467

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

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF STOCKHOLDERS' EQUITY
(In thousands, except share data)

	Centene Stockholders' Equity								
	Common Stock					Treasury Stock			
	$.001 Par Value Shares	Amt	Additional Paid-in Capital	Accumulated Other Comprehensive Income	Retained Earnings	$.001 Par Value Shares	Amt	Non controlling Interest	Total
Balance, December 31, 2008	45,071,179	$ 45	$ 263,835	$ 3,152	$ 275,236	2,083,415	$ (40,996)	$ —	$ 501,272
Consolidation of Access Health Solutions LLC	—	—	—	—	—	—	—	29,144	29,144
Consolidation of Centene Center LLC	—	—	—	—	—	—	—	17,400	17,400
Comprehensive Earnings:									
Net earnings	—	—	—	—	83,671	—	—	2,574	86,245
Change in unrealized investment gains, net of $2,663 tax	—	—	—	4,196	—	—	—	—	4,196
Total comprehensive earnings									90,441
Common stock issued for employee benefit plans	522,204	1	3,284	—	—		—	—	3,285
Common stock repurchases	—	—	—	—	—	332,595	(6,304)	—	(6,304)
Treasury stock issued for compensation	—	—	—	—	—	(2,000)	38	—	38
Stock compensation expense	—	—	14,634	—	—	—	—	—	14,634
Excess tax benefits from stock compensation	—	—	53	—	—	—	—	—	53
Conversion fee[1]	—	—	—	—	—	—	—	(27,366)	(27,366)
Distributions to noncontrolling interest	—	—	—	—	—	—	—	(3,170)	(3,170)
Balance, December 31, 2009	45,593,383	$ 46	$ 281,806	$ 7,348	$ 358,907	2,414,010	$ (47,262)	$ 18,582	$ 619,427
Consolidation of noncontrolling interest	—	—	—	—	—	—	—	3,104	3,104
Comprehensive Earnings:									
Net earnings	—	—	—	—	94,836	—	—	3,435	98,271
Change in unrealized investment gains, net of $(511) tax	—	—	—	(924)	—	—	—	—	(924)
Total comprehensive earnings									97,347
Common stock issued for stock offering	5,750,000	6	104,528	—	—	—	—	—	104,534
Common stock issued for employee benefit plans	828,654	—	4,254	—	—	—	—	—	4,254
Issuance of stock warrants	—	—	296	—	—	—	—	—	296
Common stock repurchases	—	—	—	—	—	141,203	(3,224)	—	(3,224)
Stock compensation expense	—	—	13,874	—	—	—	—	—	13,874
Excess tax benefits from stock compensation	—	—	868	—	—	—	—	—	868
Redemption / purchase of noncontrolling interest	—	—	(21,420)	—	—	—	—	(14,056)	(35,476)
Distributions to noncontrolling interest	—	—	—	—	—	—	—	(7,949)	(7,949)
Balance, December 31, 2010	52,172,037	$ 52	384,206	$ 6,424	$ 453,743	2,555,213	$ (50,486)	$ 3,116	$ 797,055
Comprehensive Earnings:									
Net earnings	—	—	—	—	111,218	—	—	(2,855)	108,363
Change in unrealized investment gain, net of $(334) tax	—	—	—	(663)	—	—	—	—	(663)
Total comprehensive earnings									107,700
Common stock issued for employee benefit plans	1,414,689	2	15,435	—	—	—	—	—	15,437
Exercise of stock warrants	—	—	—	—	—	(50,000)	1,172	—	1,172
Common stock repurchases	—	—	—	—	—	216,895	(7,809)	—	(7,809)
Stock compensation expense	—	—	18,171	—	—	—	—	—	18,171
Excess tax benefits from stock compensation	—	—	4,169	—	—	—	—	—	4,169
Contribution from Noncontrolling interest	—	—	—	—	—	—	—	813	813
Deconsolidation of Noncontrolling interest	—	—	—	—	—	—	—	(289)	(289)
Balance, December 31, 2011	53,586,726	$ 54	$ 421,981	$ 5,761	$ 564,961	2,722,108	$ (57,123)	$ 785	$ 936,419

1 Conversion fee represents additional purchase price to noncontrolling holders of Access Health Solutions LLC for the transfer of membership to the Company's wholly-owned subsidiary, Sunshine State Health Plan, Inc.

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

CENTENE CORPORATION AND SUBSIDIARIES

CONSOLIDATED STATEMENTS OF CASH FLOWS
(In thousands)

	Year Ended December 31,		
	2011	**2010**	**2009**
Cash flows from operating activities:			
Net earnings	$ 108,363	$ 98,271	$ 86,245
Adjustments to reconcile net earnings to net cash provided by operating activities:			
Depreciation and amortization	58,327	52,000	44,004
Stock compensation expense	18,171	13,874	14,634
Gain on sale of investments, net	(287)	(6,337)	(141)
Debt extinguishment costs	8,488	—	—
(Gain) on sale of UHP	—	(8,201)	—
Impairment loss on Casenet, LLC	—	5,531	—
Deferred income taxes	2,031	10,317	3,696
Changes in assets and liabilities:			
Premium and related receivables	(11,306)	(23,359)	2,379
Other current assets	(11,812)	(3,240)	(1,263)
Other assets	(2)	(2,028)	9
Medical claims liability	149,756	(30,421)	79,000
Unearned revenue	(109,082)	25,700	78,345
Accounts payable and accrued expenses	38,889	37,398	(60,915)
Other operating activities	10,160	(573)	2,202
Net cash provided by operating activities	261,696	168,932	248,195
Cash flows from investing activities:			
Capital expenditures	(68,993)	(63,304)	(23,721)
Capital expenditures of Centene Center LLC	(4,715)	(55,252)	(59,392)
Purchase of investments	(318,397)	(615,506)	(791,194)
Sales and maturities of investments	267,404	570,423	642,783
Proceeds from asset sales	—	13,420	—
Investments in acquisitions, net of cash acquired, and investment in equity method investee	(4,375)	(60,388)	(38,563)
Net cash used in investing activities	(129,076)	(210,607)	(270,087)
Cash flows from financing activities:			
Proceeds from exercise of stock options	15,815	3,419	2,365
Proceeds from borrowings	419,183	218,538	659,059
Proceeds from stock offering	—	104,534	—
Payment of long-term debt	(416,283)	(195,728)	(616,219)
Purchase of noncontrolling interest	—	(48,257)	—
Distributions from (to) noncontrolling interest	813	(7,387)	8,049
Excess tax benefits from stock compensation	4,435	963	53
Common stock repurchases	(7,809)	(3,224)	(6,304)
Debt issue costs	(9,242)	(769)	(458)
Net cash provided by financing activities	6,912	72,089	46,545
Net increase in cash and cash equivalents	139,532	30,414	24,653
Cash and cash equivalents, beginning of period	434,166	403,752	379,099
Cash and cash equivalents, end of period	$ 573,698	$ 434,166	$ 403,752
Supplemental disclosures of cash flow information:			
Interest paid	$ 27,383	$ 17,296	$ 15,428
Income taxes paid	$ 50,444	$ 53,938	$ 52,928
Supplemental disclosure of non-cash investing and financing activities:			
Contribution from noncontrolling interest	$ —	$ 306	$ 5,875
Capital expenditures	$ 6,591	$ 8,720	$ (1,476)

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

CENTENE CORPORATION AND SUBSIDIARIES

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

1. Organization and Operations

Centene Corporation, or the Company, is a diversified, multi-line healthcare enterprise operating in two segments: Medicaid Managed Care and Specialty Services. The Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. The Specialty Services segment offers products for behavioral health, care management software, health insurance exchanges, individual health insurance, life and health management, long-term care programs, managed vision, telehealth services, and pharmacy benefits management to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. The health plans in Arizona, operated by our long-term care company, and Massachusetts, operated by our individual health insurance provider, are included in the Specialty Services segment.

2. Summary of Significant Accounting Policies

Principles of Consolidation

The accompanying consolidated financial statements include the accounts of Centene Corporation and all majority owned subsidiaries and subsidiaries over which the Company exercises the power and control to direct activities significantly impacting financial performance. All material intercompany balances and transactions have been eliminated. The assets, liabilities and results of operations of University Health Plans, Inc. are classified as discontinued operations for all periods presented.

The Company uses the equity method to account for certain of its investment in entities that it does not control and for which it does not have the ability to exercise significant influence over operating and financial policies. These investments are recorded at the lower of their cost or fair value.

Use of Estimates

The preparation of financial statements in conformity with generally accepted accounting principles in the United States, or GAAP, requires management to make estimates and assumptions that affect the reported amounts of assets and liabilities and disclosure of contingent assets and liabilities at the date of the financial statements and the reported amounts of revenues and expenses during the reporting period. Future events and their effects cannot be predicted with certainty; accordingly, the accounting estimates require the exercise of judgment. The accounting estimates used in the preparation of the consolidated financial statements will change as new events occur, as more experience is acquired, as additional information is obtained and as the operating environment changes. The Company evaluates and updates its assumptions and estimates on an ongoing basis and may employ outside experts to assist in our evaluation, as considered necessary. Actual results could differ from those estimates.

Cash and Cash Equivalents

Investments with original maturities of three months or less are considered to be cash equivalents. Cash equivalents consist of commercial paper, money market funds, repurchase agreements and bank certificates of deposit and savings accounts.

The Company maintains amounts on deposit with various financial institutions, which may exceed federally insured limits. However, management periodically evaluates the credit-worthiness of those institutions, and the Company has not experienced any losses on such deposits.

Investments

Short-term investments include securities with maturities greater than three months to one year. Long-term investments include securities with maturities greater than one year.

Short-term and long-term investments are generally classified as available for sale and are carried at fair value. Certain equity investments are recorded using the cost or equity method. Unrealized gains and losses on investments available for sale are excluded from earnings and reported in accumulated other comprehensive income, a separate component of stockholders' equity, net of income tax effects. Premiums and discounts are amortized or accreted over the life of the related security using the effective interest method. The Company monitors the difference between the cost and fair value of investments. Investments that experience a decline in value that is judged to be other than temporary are written down to fair value and a realized loss is recorded in investment and other income. To calculate realized gains and losses on the sale of investments, the Company uses the specific amortized cost of each investment sold. Realized gains and losses are recorded in investment and other income.

Restricted Deposits

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. The Company is required to annually adjust the amount of the deposit pledged to certain states.

Fair Value Measurements

In the normal course of business, the Company invests in various financial assets and incurs various financial liabilities. Fair values are disclosed for all financial instruments, whether or not such values are recognized in the Consolidated Balance Sheets. Management obtains quoted market prices and other observable inputs for these disclosures. The carrying amounts reported in the Consolidated Balance Sheets for cash and cash equivalents, premium and related receivables, unearned revenue, accounts payable and accrued expenses, and certain other current liabilities are carried at cost, which approximates fair value because of their short-term nature.

The following methods and assumptions were used to estimate the fair value of each financial instrument:

- Available for sale investments and restricted deposits: The carrying amount is stated at fair value, based on quoted market prices, where available. For securities not actively traded, fair values were estimated using values obtained from independent pricing services or quoted market prices of comparable instruments.
- Senior unsecured notes: Estimated based on third-party quoted market prices for the same or similar issues.
- Variable rate debt: The carrying amount of our floating rate debt approximates fair value since the interest rates adjust based on market rate adjustments.
- Interest rate swap: Estimated based on third-party market prices based on the forward 3-month LIBOR curve.

Property, Software and Equipment

Property, software and equipment are stated at cost less accumulated depreciation. Capitalized software includes certain costs incurred in the development of internal-use software, including external direct costs of materials and services and payroll costs of employees devoted to specific software development. Depreciation is calculated principally by the straight-line method over estimated useful lives. Leasehold improvements are depreciated using the straight-line method over the shorter of the expected useful life or the remaining term of the lease. Property, software and equipment are depreciated over the following periods:

Fixed Asset	Depreciation Period
Buildings and land improvements	5 – 40 years
Computer hardware and software	3 – 10 years
Furniture and equipment	5 – 10 years
Leasehold improvements	1– 20 years

The carrying amounts of all long-lived assets are evaluated to determine if adjustment to the depreciation and amortization period or to the unamortized balance is warranted. Such evaluation is based principally on the expected utilization of the long-lived assets.

The Company retains fully depreciated assets in property and accumulated depreciation accounts until it removes them from service. In the case of sale, retirement, or disposal, the asset cost and related accumulated depreciation balance is removed from the respective account, and the resulting net amount, less any proceeds, is included as a component of earnings from operations in the consolidated statements of operations.

Goodwill and Intangible Assets

Intangible assets represent assets acquired in purchase transactions and consist primarily of customer relationships, purchased contract rights, provider contracts, trade names and goodwill. Intangible assets are amortized using the straight-line method over the following periods:

Intangible Asset	Amortization Period
Purchased contract rights	5 – 15 years
Provider contracts	7 – 10 years
Customer relationships	5 – 15 years
Trade names	7 – 20 years

The Company tests for impairment of intangible assets as well as long-lived assets whenever events or changes in circumstances indicate that the carrying value of an asset or asset group (hereinafter referred to as “asset group”) may not be recoverable by comparing the sum of the estimated undiscounted future cash flows expected to result from use of the asset group and its eventual disposition to the carrying value. Such factors include, but are not limited to, significant changes in membership, state funding, state contracts and provider networks and contracts. If the sum of the estimated undiscounted future cash flows is less than the carrying value, an impairment determination is required. The amount of impairment is calculated by subtracting the fair value of the asset group from the carrying value of the asset group. An impairment charge, if any, is recognized within earnings from operations.

The Company tests goodwill for impairment using a fair value approach. The Company is required to test for impairment at least annually, absent some triggering event including a significant decline in operating performance that would require an impairment assessment. Absent any impairment indicators, the Company performs its goodwill impairment testing during the fourth quarter of each year. The Company recognizes an impairment charge for any amount by which the carrying amount of goodwill exceeds its implied fair value.

During 2011, the Company early adopted updated guidance which simplifies how an entity is required to test goodwill for impairment. The Company first assesses qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. The Company does not calculate the fair value of a reporting unit unless it determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount.

If the two-step quantitative test is deemed necessary, the Company uses discounted cash flows to establish the fair value as of the testing date. The discounted cash flow approach includes many assumptions related to future growth rates, discount factors, future tax rates, etc. Changes in economic and operating conditions impacting these assumptions could result in goodwill impairment in future periods. When available and as appropriate, the Company uses comparative market multiples to corroborate discounted cash flow results.

Medical Claims Liability

Medical claims liability includes claims reported but not yet paid, or inventory, estimates for claims incurred but not reported, or IBNR, and estimates for the costs necessary to process unpaid claims at the end of each period. The Company estimates its medical claims liability using actuarial methods that are commonly used by health insurance actuaries and meet Actuarial Standards of Practice. These actuarial methods consider factors such as historical data for payment patterns, cost trends, product mix, seasonality, utilization of healthcare services and other relevant factors.

Actuarial Standards of Practice generally require that the medical claims liability estimates be adequate to cover obligations under moderately adverse conditions. Moderately adverse conditions are situations in which the actual claims are expected to be higher than the otherwise estimated value of such claims at the time of estimate. In many situations, the claims amounts ultimately settled will be different than the estimate that satisfies the Actuarial Standards of Practice. The Company includes in its IBNR an estimate for medical claims liability under moderately adverse conditions which represents the risk of adverse deviation of the estimates in its actuarial method of reserving.

The Company uses its judgment to determine the assumptions to be used in the calculation of the required estimates. The assumptions it considers when estimating IBNR include, without limitation, claims receipt and payment experience (and variations in that experience), changes in membership, provider billing practices, healthcare service utilization trends, cost trends, product mix, seasonality, prior authorization of medical services, benefit changes, known outbreaks of disease or increased incidence of illness such as influenza, provider contract changes, changes to fee schedules, and the incidence of high dollar or catastrophic claims.

The Company’s development of the medical claims liability estimate is a continuous process which it monitors and refines on a monthly basis as additional claims receipts and payment information becomes available. As more complete claim information becomes available, the Company adjusts the amount of the estimates, and includes the changes in estimates in medical costs in the period in which the changes are identified. In every reporting period, the operating results include the effects of more completely developed medical claims liability estimates associated with previously reported periods. The Company consistently applies its reserving methodology from period to period. As additional information becomes known, it adjusts the actuarial model accordingly to establish medical claims liability estimates.

The Company periodically reviews actual and anticipated experience compared to the assumptions used to establish medical costs. The Company establishes premium deficiency reserves if actual and anticipated experience indicates that existing policy liabilities together with the present value of future gross premiums will not be sufficient to cover the present value of future benefits, settlement and maintenance costs.

Revenue Recognition

The Company’s health plans generate revenues primarily from premiums received from the states in which it operates health plans. The Company receives a fixed premium per member per month pursuant to its state contracts. The Company generally receives premium payments during the month it provides services and recognizes premium revenue during the period in which it is obligated to provide services to its members. In some instances, the Company’s base premiums are subject to an adjustment, or risk score, based on the acuity of its membership. Generally, the risk score is determined by the State analyzing submissions of processed claims data to determine the acuity of the Company’s membership relative to the entire state’s Medicaid membership. Some states enact premium taxes, similar assessments and provider pass-through payments, collectively premium taxes, and these taxes are recorded as a separate component of both revenues and operating expenses. Some contracts allow for additional premium related to certain supplemental services provided such as maternity deliveries.

Revenues are recorded based on membership and eligibility data provided by the states, which is adjusted on a monthly basis by the states for retroactive additions or deletions to membership data. These eligibility adjustments are reflected in the period known. We continuously review and update those estimates as new information becomes available. It is possible that new information could require us to make additional adjustments, which could be significant, to these estimates.

The Company’s specialty companies generate revenues under contracts with state programs, individuals, healthcare organizations and other commercial organizations, as well as from the Company’s own subsidiaries. Revenues are recognized when the related services are provided or as ratably earned over the covered period of service.

Premium and Related Receivables and Unearned Revenue

Premium and service revenues collected in advance are recorded as unearned revenue. For performance-based contracts the Company does not recognize revenue subject to refund until data is sufficient to measure performance. Premiums and service revenues due to the Company are recorded as premium and related receivables and are recorded net of an allowance based on historical trends and management's judgment on the collectibility of these accounts. As the Company generally receives payments during the month in which services are provided, the allowance is typically not significant in comparison to total revenues and does not have a material impact on the presentation of the financial condition or results of operations. Activity in the allowance for uncollectible accounts for the years ended December 31, is summarized below:

	2011	2010	2009
Allowances, beginning of year	$ 17	$ 1,338	$ 1,304
Amounts charged to expense	865	(48)	285
Write-offs of uncollectible receivables	(243)	(1,273)	(251)
Allowances, end of year	$ 639	$ 17	$ 1,338

As of December 31, 2011, premium and related receivables included $20,742 of notes receivable.

Significant Customers

Centene receives the majority of its revenues under contracts or subcontracts with state Medicaid managed care programs. The current contracts expire on various dates between March 31, 2012 and December 31, 2016. States whose aggregate annual contract value exceeded 10% of annual revenues and the respective percentage of the Company's total revenues for the years ended December 31, are as follows:

2011		2010		2009	
Georgia	13%	Georgia	17%	Georgia	19%
Ohio	10%	Ohio	13%	Ohio	14%
Texas	26%	Texas	30%	Texas	30%

Reinsurance

Centene's subsidiaries report reinsurance premiums as medical costs, while related reinsurance recoveries are reported as deductions from medical costs. The Company limits its risk of certain catastrophic losses by maintaining high deductible reinsurance coverage.

Other Income (Expense)

Other income (expense) consists principally of investment income, interest expense and equity method earnings from investments. Investment income is derived from the Company's cash, cash equivalents, restricted deposits and investments. Interest expense relates to borrowings under the senior notes, interest rate swap, credit facilities, interest on capital leases and credit facility fees.

Income Taxes

Deferred tax assets and liabilities are recorded for the future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax bases. Deferred tax assets and liabilities are measured using enacted tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. The effect on deferred tax assets and liabilities of a change in tax law or tax rates is recognized in income in the period that includes the enactment date.

Valuation allowances are provided when it is considered more likely than not that deferred tax assets will not be realized. In determining if a deductible temporary difference or net operating loss can be realized, the Company considers future reversals of existing taxable temporary differences, future taxable income, taxable income in prior carryback periods and tax planning strategies.

Contingencies

The Company accrues for loss contingencies associated with outstanding litigation, claims and assessments for which it has determined it is probable that a loss contingency exists and the amount of loss can be reasonably estimated. The Company expenses professional fees associated with litigation claims and assessments as incurred.

Stock Based Compensation

The fair value of the Company's employee share options and similar instruments are estimated using the Black-Scholes option-pricing model. That cost is recognized over the period during which an employee is required to provide service in exchange for the award. Excess tax benefits related to stock compensation are presented as a cash inflow from financing activities.

Recent Accounting Pronouncements

In September 2011, the Financial Accounting Standards Board issued an Accounting Standards Update (ASU), which simplifies how an entity is required to test goodwill for impairment. The ASU allows an entity to first assess qualitative factors to determine whether it is necessary to perform the two-step quantitative goodwill impairment test. Under the ASU, an entity is not required to calculate the fair value of a reporting unit unless the entity determines, based on a qualitative assessment, that it is more likely than not that its fair value is less than its carrying amount. The amendments in the ASU are effective for annual and interim goodwill impairment tests performed for fiscal years beginning after December 15, 2011. Early adoption is permitted. The Company elected to adopt this guidance in the current fiscal year.

3. Reclassifications

During 2011, the National Association of Insurance Commissioners (NAIC) issued new definitions which clarified the classification of medical costs for statutory reporting. In light of these new definitions, the Company reclassified certain Medical Costs and General & Administrative Expenses beginning with its financial results for the year ended December 31, 2011 to more closely align to the new NAIC definition. The following costs were reclassified from General & Administrative Expense to Medical Costs:

- Case management, care coordination, medication & care compliance
- Nurse line triage services
- Disease management
- Cost of health risk assessments

In addition, the Company reclassified costs for provider network fees from Medical Costs to General & Administrative Expense.

Effective with the reporting of our financial results for the year ended December 31, 2011, the Company has reclassified the above mentioned expenses, as well as prior periods to conform to the current presentation. The reclassification had no impact on net earnings. For the years ended December 31, 2011, 2010 and 2009, the net impact of the reclassification increased Medical Costs and decreased General & Administrative Expense by $96,830, $70,058, and $66,608, respectively.

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

4. Acquisitions

2010 Acquisitions

- *Carolina Crescent Health Plan.* In June 2010, the Company acquired certain assets of Carolina Crescent Health Plan, a South Carolina Medicaid managed care organization for $17,993 in total consideration. The Company's allocation of fair value resulted in goodwill of $16,543 and other identifiable intangible assets of $1,450. The acquisition is recorded in the Medicaid Managed Care segment. All of the goodwill is deductible for income tax purposes.

- *NovaSys Health, LLC.* In July 2010, the Company acquired certain assets and liabilities of NovaSys Health, LLC, a third party administrator in Arkansas and paid $4,330 in cash. The Company's allocation of fair value resulted in goodwill of $1,444 and other identifiable intangible assets of $3,050 that were recorded in the Specialty Services segment. All of the goodwill is deductible for income tax purposes.

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

- *Access Health Solutions, LLC.* In December 2010, the Company exercised its right to obtain the remaining assets and ownership interest in Access Health Solutions, LLC, or Access, for zero dollars. Subsequent to the acquisition of the remaining interest, Access continues to be consolidated in the Company's Medicaid Managed Care segment results as a wholly owned subsidiary of the Company. During 2011, the Company made a conversion payment to the former owners of Access resulting in additional goodwill of $1,773. All of the goodwill is deductible for income tax purposes.

- *Centene Center LLC.* In December 2010, the Company acquired the remaining ownership interest in Centene Center LLC for $48,250. The excess purchase price over the noncontrolling interest was recorded to additional paid in capital, net of the related deferred tax asset of $12,779. Centene Center LLC is a real estate development entity created for the construction of a real estate development that includes the Company's corporate headquarters. The Company previously reported its investment in Centene Center as a consolidated VIE. Subsequent to the acquisition of the remaining interest, Centene Center LLC continues to be consolidated as a wholly owned subsidiary of the Company. The operating results of Centene Center LLC are included in general and administrative expense of the Company's Medicaid Managed Care segment.

- *Casenet, LLC.* In December 2010, the Company acquired an additional ownership interest in Casenet, LLC (Casenet) for total consideration of $6,619, bringing its ownership interest to 68%. Casenet is a provider of care management solutions that automate the clinical, administrative, and technical components of care management programs. The Company performed an initial allocation of total consideration to assets acquired and liabilities assumed based on its initial estimates of fair value using methodologies and assumptions that it believed were reasonable. The initial allocation resulted in goodwill of $1,752 and other identifiable intangible assets of $4,500 that were recorded in the Specialty Services segment. During 2011, the Company finalized the allocation of the fair value that resulted in goodwill of $8,975, other identifiable intangible assets of $3,561 and an increase in unearned revenue of $6,284. All of the goodwill is deductible for income tax purposes. During 2011, the Company increased its ownership interest in Casenet to 81%.

2009 Acquisitions

- *Access.* In July 2007, the Company acquired a 49% ownership interest in Access, a Medicaid managed care entity in Florida. The Company accounted for its investment in Access using the equity method of accounting through December 31, 2008. During the quarter ended March 31, 2009, the Company began presenting its investment in Access as a consolidated subsidiary in its financial statements. The consolidation of Access resulted in goodwill of approximately $43,400, and other identified intangible assets of approximately $5,400. In 2009, the Company paid an additional $33,927 conversion fee for the transfer of membership from Access to the Company's wholly-owned subsidiary, Sunshine State Health Plan, Inc.

- *Additional 2009 Acquisitions*. The Company acquired assets of the following entities: Pediatric Associates LLC, effective February 2009, Amerigroup Community Care of South Carolina, Inc., effective March 2009 and InSpeech, Inc., effective July 2009. The Company paid a total of approximately $12,500 in cash for these acquisitions. Goodwill of approximately $9,500 and other identifiable intangible assets of approximately $1,500 were included in the Medicaid Managed Care segment and other identifiable intangible assets of $1,700 were included in the Specialty Services segment, all of which is deductible for income tax purposes.

Pro forma disclosures related to these acquisitions have been excluded as immaterial.

5. Short-term and Long-term Investments and Restricted Deposits

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

	December 31, 2011				December 31, 2010			
	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value	Amortized Cost	Gross Unrealized Gains	Gross Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 29,014	$ 638	$ (13)	$ 29,639	$ 28,665	$ 510	$ (140)	$ 29,035
Corporate securities	186,018	3,762	(751)	189,029	197,577	3,124	(586)	200,115
Restricted certificates of deposit	5,890	—	—	5,890	6,814	—	—	6,814
Restricted cash equivalents	13,775	—	—	13,775	8,814	—	—	8,814
Municipal securities:								
General obligation	126,806	2,828	(26)	129,608	109,866	3,601	(6)	113,461
Pre-refunded	33,247	465	—	33,712	32,442	756	—	33,198
Revenue	118,507	2,387	(34)	120,860	100,198	2,781	(15)	102,964
Variable rate demand notes	64,658	—	—	64,658	106,540	—	—	106,540
Asset backed securities	51,779	430	(17)	52,192	17,391	243	(43)	17,591
Cost and equity method investments	9,395	—	—	9,395	7,060	—	—	7,060
Life insurance contracts	14,699	—	—	14,699	14,391	—	—	14,391
Total	$ 653,788	$ 10,510	$ (841)	$ 663,457	$ 629,758	$ 11,015	$ (790)	$ 639,983

The Company's investments are classified as available-for-sale with the exception of life insurance contracts and certain cost and equity method investments. The Company's investment policies are designed to provide liquidity, preserve capital and maximize total return on invested assets with the focus on high credit quality securities. The Company limits the size of investment in any single issuer other than U.S. treasury securities and obligations of U.S. government corporations and agencies. As of December 31, 2011, 38% of the Company's investments in securities recorded at fair value that carry a rating by Moody's or S&P were rated AAA, 76% were rated AA- or higher, and 99% were rated A- or higher. At December 31, 2011, the Company held certificates of deposit, life insurance contracts and cost and equity method invesments which did not carry a credit rating.

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

	December 31, 2011				December 31, 2010			
	Less Than 12 Months		12 Months or More		Less Than 12 Months		12 Months or More	
	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value	Unrealized Losses	Fair Value
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ (13)	$ 2,184	$ —	$ —	$ (140)	$ 9,246	$ —	$ —
Corporate securities	(751)	23,040	—	—	(586)	40,341	—	—
Municipal securities:								
General obligation	(26)	3,710	—	—	(6)	1,131	—	—
Revenue	(34)	12,597	—	—	(15)	2,419	—	—
Asset backed securities	(17)	20,417	—	—	(43)	5,276	—	—
Total	$ (841)	$ 61,948	$ —	$ —	$ (790)	$ 58,413	$ —	$ —

As of December 31, 2011, the gross unrealized losses were generated from 31 positions out of a total of 410 positions. The decline in fair value of fixed income securities is a result of movement in interest rates subsequent to the purchase of the security.

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

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

	December 31, 2011				December 31, 2010			
	Investments		Restricted Deposits		Investments		Restricted Deposits	
	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value	Amortized Cost	Fair Value
One year or less	$ 129,232	$ 130,499	$ 19,666	$ 19,666	$ 21,141	$ 21,346	$ 17,387	$ 17,392
One year through five years	406,140	413,953	7,085	7,152	464,270	474,255	5,368	5,366
Five years through ten years	34,945	34,961	—	—	39,732	39,731	—	—
Greater than ten years	56,720	57,226	—	—	81,860	81,893	—	—
Total	$ 627,037	$ 636,639	$ 26,751	$ 26,818	$ 607,003	$ 617,225	$ 22,755	$ 22,758

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

Realized gains and losses are determined on the basis of specific identification or a first-in, first-out methodology, if specific identification is not practicable. The Company's gross recorded realized gains and losses on investments for the years ended December 31, were as follows:

	2011	2010	2009
Gross realized gains	$ 314	$ 6,036	$ 1,252
Gross realized losses	(27)	(270)	(1,111)
Impairment of investment	—	(5,531)	—
Net realized gains (losses)	$ 287	$ 235	$ 141

The Company continuously monitors investments for other-than-temporary impairment. Certain investments have experienced a decline in fair value due to changes in credit quality, market interest rates and/or general economic conditions. The Company recognizes an impairment loss for cost and equity method investments when evidence demonstrates that it is other-than-temporarily impaired. Evidence of a loss in value that is other than temporary may include the absence of an ability to recover the carrying amount of the investment or the inability of the investee to sustain a level of earnings that would justify the carrying amount of the investment. During 2010, the Company determined it had an other-than-temporary impairment of its investment in Casenet, LLC. As a result, the Company recorded an impairment charge of $5,531, including $3,531 of convertible promissory notes. The impairment charge is included in investment and other income.

Investment and other income in 2010 included a net realized gain of $2,479 related to sales of fixed income investments and also included realized gains of $3,287 related to the Reserve Primary money market fund for distributions made during 2010. Investment amortization of $10,335, $10,750 and $7,209 was recorded in the years ended December 31, 2011, 2010 and 2009, respectively.

6. Fair Value Measurements

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

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

The following table summarizes fair value measurements by level at December 31, 2011, for assets and liabilities measured at fair value on a recurring basis:

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 573,698	$ —	$ —	$ 573,698
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 17,091	$ 5,395	$ —	$ 22,486
Corporate securities	—	189,029	—	189,029
Municipal securities:				
General obligation	—	129,608	—	129,608
Pre-refunded	—	33,712	—	33,712
Revenue	—	120,860	—	120,860
Variable rate demand notes	—	64,658	—	64,658
Asset backed securities	—	52,192	—	52,192
Total investments	$ 17,091	$ 595,454	$ —	$ 612,545
Restricted deposits available for sale:				
Cash and cash equivalents	$ 13,775	$ —	$ —	$ 13,775
Certificates of deposit	5,890	—	—	5,890
U.S. Treasury securities and obligations of U.S. government corporations and agencies	7,153	—	—	7,153
Total restricted deposits	$ 26,818	$ —	$ —	$ 26,818
Interest rate swap contract	$ —	$ 11,431	$ —	$ 11,431
Total assets at fair value	$ 617,607	$ 606,885	$ —	$ 1,224,492

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

	Level I	Level II	Level III	Total
Assets				
Cash and cash equivalents	$ 434,166	$ —	$ —	$ 434,166
Investments available for sale:				
U.S. Treasury securities and obligations of U.S. government corporations and agencies	$ 14,809	$ 7,096	$ —	$ 21,905
Corporate securities	—	200,115	—	200,115
Municipal securities:				
General obligation	—	113,461	—	113,461
Pre-refunded	—	33,198	—	33,198
Revenue	—	102,964	—	102,964
Variable rate demand notes	—	106,540	—	106,540
Asset backed securities	—	17,591	—	17,591
Total investments	$ 14,809	$ 580,965	$ —	$ 595,774
Restricted deposits available for sale:				
Cash and cash equivalents	$ 8,814	$ —	$ —	$ 8,814
Certificates of deposit	6,814	—	—	6,814
U.S. Treasury securities and obligations of U.S. government corporations and agencies	7,130	—	—	7,130
Total restricted deposits	$ 22,758	$ —	$ —	$ 22,758
Total assets at fair value	$ 471,733	$ 580,965	$ —	$ 1,052,698

The Company periodically transfers U.S. Treasury securities and obligations of U.S. government corporations and agencies between Level I and Level II fair value measurements dependent upon the level of trading activity for the specific securities at the measurement date. The Company utilizes matrix pricing services to estimate fair value for securities which are not actively traded on the measurement date. The Company designates these securities as Level II fair value measurements. The aggregate carrying amount of the Company's life insurance contracts and other non-majority owned investments, which approximates fair value, was $24,094 and $21,451 as of December 31, 2011 and December 31, 2010, respectively.

7. Property, Software and Equipment

Property, software and equipment consist of the following as of December 31:

	2011	2010
Computer software	$ 158,672	$ 141,918
Building	186,194	171,072
Land	47,614	44,282
Computer hardware	51,805	35,639
Furniture and office equipment	37,865	33,812
Leasehold improvements	44,766	38,247
	526,916	464,970
Less accumulated depreciation	(177,294)	(138,629)
Property, software and equipment, net	$ 349,622	$ 326,341

As of December 31, 2011 and 2010, the Company had assets acquired under capital leases of $6,316 and $6,339, net of accumulated amortization of $1,285 and $1,041, respectively. Amortization on assets under capital leases charged to expense is included in depreciation expense. Depreciation expense for the years ended December 31, 2011, 2010 and 2009 was $42,249, $37,131 and $33,103, respectively.

8. Goodwill and Intangible Assets

The following table summarizes the changes in goodwill by operating segment:

	Medicaid Managed Care	Specialty Services	Total
Balance as of December 31, 2009	$ 111,063	$ 113,524	$ 224,587
Acquisitions	43,633	9,831	53,464
Balance as of December 31, 2010	$ 154,696	$ 123,355	$ 278,051
Acquisitions	1,773	—	1,773
Other adjustments	(5,067)	7,224	2,157
Balance as of December 31, 2011	$ 151,402	$ 130,579	$ 281,981

Goodwill acquisitions and other adjustments were related to the acquisitions and finalization of fair value allocations discussed in Note 4, *Acquisitions*.

Intangible assets at December 31, consist of the following:

			Weighted Average Life in Years	
	2011	2010	2011	2010
Purchased contract rights	$ 21,988	$ 20,185	7.5	6.9
Provider contracts	2,737	2,578	9.8	10.0
Customer relationships	16,056	16,056	7.9	7.7
Trade names	6,495	5,595	16.3	18.9
Intangible assets	47,276	44,414	9.0	8.9
Less accumulated amortization:				
Purchased contract rights	(8,554)	(7,053)		
Provider contracts	(931)	(697)		
Customer relationships	(8,753)	(6,278)		
Trade names	(1,608)	(1,277)		
Total accumulated amortization	(19,846)	(15,305)		
Intangible assets, net	$ 27,430	$ 29,109		

Amortization expense was $5,561, $4,119 and $3,692 for the years ended December 31, 2011, 2010 and 2009, respectively.

Estimated total amortization expense related to intangible assets for each of the five succeeding fiscal years is as follows:

Year	Expense
2012	$ 5,200
2013	4,700
2014	4,300
2015	3,500
2016	3,000

9. Income Taxes

The consolidated income tax expense consists of the following for the years ended December 31:

	2011	2010	2009
Current provision:			
Federal	$ 59,641	$ 46,259	$ 41,310
State and local	5,186	6,868	5,578
Total current provision	64,827	53,127	46,888
Deferred provision	1,695	6,773	1,953
Total provision for income taxes	$ 66,522	$ 59,900	$ 48,841

The reconciliation of the tax provision at the U.S. Federal Statutory Rate to the provision for income taxes is as follows:

	2011	2010	2009
Earnings from continuing operations, before income tax expense	$ 174,885	$ 154,282	$ 137,508
Less noncontrolling interest	(2,855)	3,435	2,574
Earnings from continuing operations, less noncontrolling interest, before income tax expense	177,740	150,847	134,934
Tax provision at the U.S. federal statutory rate	62,209	52,797	47,227
State income taxes, net of federal income tax benefit	3,411	6,231	2,419
Other, net	902	872	(805)
Income tax expense	$ 66,522	$ 59,900	$ 48,841
Effective tax rate	*37.4%*	*39.7%*	*36.2%*

The tax effects of temporary differences which give rise to deferred tax assets and liabilities are presented below for the years ended December 31:

	2011	2010
Deferred tax assets:		
Current:		
Medical claims liability and other accruals	$ 39,864	$ 25,418
Unearned premium and other deferred revenue	985	8,934
Other	640	1,999
Current deferred tax assets	41,489	36,351
Valuation allowance	(2,896)	(741)
Net current deferred tax assets	$ 38,593	$ 35,610
Non-current deferred tax assets:		
State net operating loss carry forward	$ 8,761	$ 4,841
Purchase of noncontrolling interest	—	13,223
Stock compensation	13,234	13,676
Other	13,456	8,599
Non-current deferred tax assets	35,451	40,339
Valuation allowance	(5,625)	(4,400)
Net non-current deferred tax assets	$ 29,826	$ 35,939
Deferred tax liabilities:		
Current:		
Prepaid assets and other	$ 5,788	$ 4,350
Net current deferred tax liabilities	$ 5,788	$ 4,350
Non-current deferred tax liabilities:		
Intangible assets	$ 10,756	$ 11,519
Depreciation and amortization	31,398	34,743
Unrealized gain on investments	2,877	3,613
Other	2,620	2,777
Net non-current deferred tax liabilities	$ 47,651	$ 52,652
Net deferred tax assets	$ 14,980	$ 14,547

The Company's deferred tax assets include federal and state net operating losses, or NOLs, of which $1,373 were acquired in business combinations. Accordingly, the total and annual deduction for those NOLs is limited by tax law. The Company's federal NOLs expire between the years 2012 and 2023 and the state NOLs expire between the years 2012 and 2031. Valuation allowances are recorded for those NOLs the Company believes are more likely than not to expire unused. During 2011 and 2010, the Company recorded valuation allowance additions in the tax provision of $1,671 and $3,324, respectively. In 2011 and 2010, the Company recorded valuation allowance reductions of $528 and $323, respectively. The remaining valuation allowance additions of $2,038 were reported in discontinued operations in 2010.

The Company maintains a reserve for uncertain tax positions that may be challenged by a tax authority. A roll-forward of the reserve is as follows:

	2011	2010
Balance as January 1	$ 3,036	$ 5,465
Increase based on tax positions during the current year	10,863	231
Decreases based on tax positions taken in a prior period	(347)	(2,660)
Balance as of December 31	$ 13,552	$ 3,036

The December 31, 2011 reserve balance of $13,552 would decrease income tax expense, if recognized. The December 31, 2010 reserve balance of $3,036 would have decrease income tax expense, if recognized.

The Company recognizes interest accrued related to unrecognized tax benefits in the provision for income taxes. Interest accrued, net of federal benefit, was $1,157, $707 and $1,072 as of December 31, 2011, 2010 and 2009, respectively. No penalties have been accrued.

The federal income tax returns for 2008 through 2011 are open tax years. The Internal Revenue Service (IRS) performed an examination of the Company’s 2006 and 2007 tax returns and initially denied a tax benefit related to the abandonment of the FirstGuard stock in 2007. In 2011, the Company agreed to a settlement for the open tax years of 2006 and 2007. The settlement did not have a material impact on the consolidated financial statements.

The Company files in numerous state jurisdictions with varying statutes of limitation. The unrecognized state tax benefits are related to returns open from 2006 to 2011.

10. Medical Claims Liability

The change in medical claims liability is summarized as follows:

	Year Ended December 31,		
	2011	2010	2009
Balance, January 1,	$ 456,765	$ 470,932	$ 384,360
Incurred related to:			
Current year	4,390,123	3,652,521	3,283,141
Prior years	(65,377)	(68,069)	(53,010)
Total incurred	4,324,746	3,584,452	3,230,131
Paid related to:			
Current year	3,788,808	3,203,585	2,819,591
Prior years	384,718	395,034	323,968
Total paid	4,173,526	3,598,619	3,143,559
Balance, December 31,	$ 607,985	$ 456,765	$ 470,932

Changes in estimates of incurred claims for prior years are primarily attributable to reserving under moderately adverse conditions. In addition, claims processing initiatives yielded increased claim payment recoveries and coordination of benefits related to prior year dates of service. Changes in medical utilization and cost trends and the effect of medical management initiatives may also contribute to changes in medical claim liability estimates. While the Company has evidence that medical management initiatives are effective on a case by case basis, medical management initiatives primarily focus on events and behaviors prior to the incurrence of the medical event and generation of a claim. Accordingly, any change in behavior, leveling of care, or coordination of treatment occurs prior to claim generation and as a result, the costs prior to the medical management initiative are not known by the Company. Additionally, certain medical management initiatives are focused on member and provider education with the intent of influencing behavior to appropriately align the medical services provided with the member's acuity. In these cases, determining whether the medical management initiative changed the behavior cannot be determined. Because of the complexity of its business, the number of states in which it operates, and the volume of claims that it processes, the Company is unable to practically quantify the impact of these initiatives on its changes in estimates of IBNR.

The Company had reinsurance recoverables related to medical claims liability of $5,313 and $6,180 at December 31, 2011 and 2010, respectively, included in premium and related receivables.

11. Debt

Debt consists of the following at December 31:

	2011	2010
Senior notes, at par	$ 250,000	$ 175,000
Unamortized discount on Senior notes	(2,814)	—
Interest rate swap fair value	11,431	—
Senior notes, net	258,617	175,000
Revolving credit agreement	—	60,000
Mortgage notes payable	86,948	89,500
Capital leases and other	6,013	6,141
Total debt	351,578	330,641
Less current portion	(3,234)	(2,817)
Long-term debt	$ 348,344	$ 327,824

Senior Notes

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

In May 2011, pursuant to a shelf registration statement, the Company issued non-callable $250,000 5.75% Senior Notes due June 1, 2017 ($250,000 Notes) at a discount to yield 6%. At December 31, 2011, the unamortized debt discount was $2,814. The indenture governing the $250,000 Notes contains non-financial and financial covenants. Interest is paid semi-annually in June and December. In connection with the issuance, the Company entered into an interest rate swap as discussed below. Gains and losses due to changes in the fair value of the interest rate swap completely offset changes in the fair value of the hedged portion of the underlying debt and are recorded as an adjustment to the $250,000 Notes. At December 31, 2011, the fair value of the interest rate swap increased the fair value of the notes by $11,431.

Revolving Credit Agreement

In January 2011, the Company replaced its $300,000 revolving credit agreement with a new $350,000 revolving credit facility, or the revolver. The revolver is unsecured and has a five-year maturity with non-financial and financial covenants, including requirements of minimum fixed charge coverage ratios, maximum debt to EBITDA ratios and minimum net worth. Borrowings under the revolver bear interest based upon LIBOR rates, the Federal funds rate, or the prime rate. There is a commitment fee on the unused portion of the agreement that ranges from 0.25% to 0.50% depending on the total debt to EBITDA ratio, as defined. As of December 31, 2011, the Company had no borrowings outstanding under the agreement, leaving availability of $350,000.

The Company has outstanding letters of credit of $36,031 as of December 31, 2011, which are not part of the revolver. The letters of credit bore interest at 1.66%.

Mortgage Notes Payable

In December 2010, the Company refinanced a $95,000 construction loan with an $80,000 10 year mortgage note payable. The balance of the mortgage note payable was $77,847 at December 31, 2011. The mortgage note is non-recourse to the Company, bears a 5.14% interest rate and has a financial covenant requiring a minimum debt service coverage ratio. The collateralized property had a net book value of $165,106 at December 31, 2011.

The Company also has a mortgage note of $9,100 collateralized by another building and parking garage. The collateralized properties had a net book value of $23,898 at December 31, 2011. The mortgage is due August 31, 2014 and bears interest at the LIBOR rate plus 3% or the bank's certificate of deposit rate plus 2%. The mortgage includes a financial covenant requiring a minimum fixed charge coverage ratio. The weighted average interest rate of outstanding borrowings was 3.12% at December 31, 2011.

Aggregate maturities for the Company's debt are as follows:

2012	$ 3,212
2013	3,372
2014	11,343
2015	3,173
2016	3,337
Thereafter	318,524
Total	$ 342,961

The fair value of outstanding debt was approximately $351,578 and $336,766 at December 31, 2011 and 2010, respectively.

12. Interest Rate Swap

In May 2011, the Company entered into $250,000 notional amount of interest rate swap agreements (Swap Agreements) that are scheduled to expire June 1, 2017. Under the Swap Agreements, the Company receives a fixed rate of 5.75% and pays a variable rate of the three month LIBOR plus 3.5% adjusted quarterly, which allows the Company to adjust the $250,000 Notes to a floating rate. The Company does not hold or issue any derivative instrument for trading or speculative purposes. At December 31, 2011, the variable rate was 4.03%.

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

The fair value of the Swap Agreements as of December 31, 2011 was an asset of approximately $11,431, and is included in other long term assets in the Consolidated Balance Sheet. The fair value of the Swap Agreements excludes accrued interest and takes into consideration current interest rates and current likelihood of the swap counterparties' compliance with its contractual obligations.

13. Stockholders' Equity

The Company has 10,000,000 authorized shares of preferred stock at $.001 par value. At December 31, 2011, there were no preferred shares outstanding.

On October 26, 2009, the Company's Board of Directors extended the Company's stock repurchase program. The program authorizes the repurchase of up to 4,000,000 shares of the Company's common stock from time to time on the open market or through privately negotiated transactions. No duration has been placed on the repurchase program. The Company reserves the right to discontinue the repurchase program at any time. During the year ended December 31, 2011, the Company did not repurchase any shares through this publicly announced program.

As a component of the employee stock compensation plan, employees can use shares of stock which have vested to satisfy minimum statutory tax withholding obligations. During 2011, the Company repurchased 216,895 shares at an aggregate cost of $7,809. During 2010, the Company repurchased 141,073 shares at an aggregate cost of $3,224. These shares are included in the Company's treasury stock.

14. Statutory Capital Requirements and Dividend Restrictions

Various state laws require Centene's regulated subsidiaries to maintain minimum capital levels specified by each state and restrict the amount of dividends that may be paid without prior regulatory approval. At December 31, 2011 and 2010, Centene's subsidiaries, had aggregate statutory capital and surplus of $619,900 and $516,100, respectively, compared with the required minimum aggregate statutory capital and surplus of $342,000 and $308,000, respectively.

15. Stock Incentive Plans

The Company's stock incentive plans allow for the granting of restricted stock or restricted stock unit awards and options to purchase common stock. Both incentive stock options and nonqualified stock options can be awarded under the plans. No option will be exercisable for longer than ten years after the date of grant. The plans have 1,000,141 shares available for future awards. Compensation expense for stock options and restricted stock unit awards is recognized on a straight-line basis over the vesting period, generally three to five years for stock options and one to ten years for restricted stock or restricted stock unit awards. Certain restricted stock unit awards contain performance-based as well as service-based provisions. Certain awards provide for accelerated vesting if there is a change in control as defined in the plans. The total compensation cost that has been charged against income for the stock incentive plans was $18,171, $13,874 and $14,634 for the years ended December 31, 2011, 2010 and 2009, respectively. The total income tax benefit recognized in the income statement for stock-based compensation arrangements was $5,804, $4,713 and $3,945 for the years ended December 31, 2011, 2010 and 2009, respectively.

Option activity for the year ended December 31, 2011 is summarized below:

	Shares	Weighted Average Exercise Price	Aggregate Intrinsic Value	Weighted Average Remaining Contractual Term
Outstanding as of December 31, 2010	3,138,521	$ 20.71		
Granted	10,000	31.39		
Exercised	(914,859)	20.65		
Forfeited	(37,100)	23.73		
Outstanding as of December 31, 2011	2,196,562	$ 20.75	$ 41,393	3.9
Exercisable as of December 31, 2011	2,000,662	$ 20.68	$ 37,837	3.6

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

	Year Ended December 31,		
	2011	2010	2009
Expected life (in years)	5.2	5.8	5.8
Risk-free interest rate	0.9%	2.7%	2.2%
Expected volatility	49.9%	48.2%	50.9%
Expected dividend yield	0%	0%	0%

For the years ended December 31, 2011, 2010 and 2009, the Company used a projected expected life for each award granted based on historical experience of employees' exercise behavior. The expected volatility is primarily based on historical volatility levels along with the implied volatility of exchange traded options to purchase Centene common stock. The risk-free interest rates are based on the implied yield currently available on U.S. Treasury instruments with a remaining term equal to the expected life.

Other information pertaining to option activity is as follows:

	Year Ended December 31,		
	2011	2010	2009
Weighted-average fair value of options granted	$ 13.94	$ 11.60	$ 8.76
Total intrinsic value of stock options exercised	$ 11,744	$ 1,999	$ 2,192

A summary of the Company's non-vested restricted stock and restricted stock unit shares as of December 31, 2011, and changes during the year ended December 31, 2011, is presented below:

	Shares	Weighted Average Grant Date Fair Value
Non-vested balance as of December 31, 2010	1,868,035	$ 22.62
Granted	982,363	35.32
Vested	(698,110)	21.55
Forfeited	(33,685)	20.69
Non-vested balance as of December 31, 2011	2,118,603	$ 28.55

The total fair value of restricted stock and restricted stock units vested during the years ended December 31, 2011, 2010 and 2009, was $22,280, $13,012 and $17,213, respectively.

As of December 31, 2011, there was $53,072 of total unrecognized compensation cost related to non-vested share-based compensation arrangements granted under the plans; that cost is expected to be recognized over a weighted-average period of 1.8 years. The actual tax benefit realized for the tax deductions from stock option exercises totaled $955, $883 and $395 for the years ended December 31, 2011, 2010 and 2009, respectively.

The Company maintains an employee stock purchase plan and has issued 34,966 shares, 37,048 shares, and 34,306 shares in 2011, 2010 and 2009, respectively.

16. Retirement Plan

Centene has a defined contribution plan which covers substantially all employees who are at least twenty-one years of age. Under the plan, eligible employees may contribute a percentage of their base salary, subject to certain limitations. Centene may elect to match a portion of the employee's contribution. Company expense related to matching contributions to the plan was $5,146, $4,044 and $3,499 during the years ended December 31, 2011, 2010 and 2009, respectively.

17. Commitments

Centene and its subsidiaries lease office facilities and various equipment under non-cancelable operating leases which may contain escalation provisions. The rental expense related to these leases is recorded on a straight-line basis over the lease term, including rent holidays. Tenant improvement allowances are recorded as a liability and amortized against rent expense over the term of the lease. Rent expense was $22,734, $21,393 and $20,211 for the years ended December 31, 2011, 2010 and 2009, respectively. Annual non-cancelable minimum lease payments over the next five years and thereafter are as follows:

2012	$ 21,187
2013	17,858
2014	15,449
2015	12,884
2016	11,620
Thereafter	17,004
	$ 96,002

18. Contingencies

The IRS performed an examination of the Company's 2006 and 2007 tax returns and initially denied a tax benefit related to the abandonment of the FirstGuard stock in 2007. In 2011, the Company agreed to a settlement for the open tax years of 2006 and 2007. The settlement did not have a material impact on the consolidated financial statements.

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

19. Earnings Per Share

The following table sets forth the calculation of basic and diluted net earnings per share for the years ended December 31:

	2011	2010	2009
Earnings (loss) attributable to Centene Corporation common shareholders:			
Earnings from continuing operations, net of tax	$ 111,218	$ 90,947	$ 86,093
Discontinued operations, net of tax	—	3,889	(2,422)
Net earnings	$ 111,218	$ 94,836	$ 83,671
Shares used in computing per share amounts:			
Weighted average number of common shares outstanding	50,198,954	48,754,947	43,034,791
Common stock equivalents (as determined by applying the treasury stock method)	2,275,284	1,692,941	1,281,676
Weighted average number of common shares and potential dilutive common shares outstanding	52,474,238	50,447,888	44,316,467
Net earnings (loss) per share attributable to Centene Corporation:			
Basic:			
Continuing operations	$ 2.22	$ 1.87	$ 2.00
Discontinued operations	—	0.08	(0.06)
Earnings per common share	$ 2.22	$ 1.95	$ 1.94
Diluted:			
Continuing operations	$ 2.12	$ 1.80	$ 1.94
Discontinued operations	—	0.08	(0.05)
Earnings per common share	$ 2.12	$ 1.88	$ 1.89

The calculation of diluted earnings per common share for 2011, 2010 and 2009 excludes the impact of 106,219 shares, 2,010,183 shares and 2,351,679 shares, respectively, related to anti-dilutive stock options, restricted stock and restricted stock units.

20. Segment Information

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

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.

Segment information as of and for the year ended December 31, 2011, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 4,450,336	$ 730,671	$ —	$ 5,181,007
Premium and service revenues from internal customers	65,215	753,596	(818,811)	—
Total premium and service revenues	4,515,551	1,484,267	(818,811)	5,181,007
Earnings from operations	152,995	37,329	—	190,324
Total assets	1,754,108	436,228	—	2,190,336

Segment information as of and for the year ended December 31, 2010, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 3,679,807	$ 604,026	$ —	$ 4,283,833
Premium and service revenues from internal customers	60,676	508,157	(568,833)	—
Total premium and service revenues	3,740,483	1,112,183	(568,833)	4,283,833
Earnings from operations	117,106	39,963	—	157,069
Total assets	1,552,886	390,996	—	1,943,882

Segment information as of and for the year ended December 31, 2009, follows:

	Medicaid Managed Care	Specialty Services	Eliminations	Consolidated Total
Premium and service revenues from external customers	$ 3,398,009	$ 480,274	$ —	$ 3,878,283
Premium and service revenues from internal customers	66,763	569,191	(635,954)	—
Total premium and service revenues	3,464,772	1,049,465	(635,954)	3,878,283
Earnings from operations	99,307	38,828	—	138,135
Total assets	1,330,987	371,377	—	1,702,364

21. Comprehensive Earnings

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

	Year Ended December 31,		
	2011	2010	2009
Net earnings	$ 111,218	$ 94,836	$ 83,671
Other comprehensive earnings, net of tax:			
Change in unrealized gains on investments available for sale securities	(114)	736	3,944
Reclassification adjustment	(549)	(1,660)	252
Unrealized gain on available for sale securities	(663)	(924)	4,196
Other Comprehensive earnings	110,555	93,912	87,867
Less: Comprehensive earnings attributable to the noncontrolling interest	(2,855)	3,435	2,574
Comprehensive earnings attributable to Centene Corporation	$ 113,410	$ 90,477	$ 85,293

22. Quarterly Selected Financial Information

(In thousands, except share data and membership data)
(Unaudited)

	For the Quarter Ended			
	March 31, 2011	June 30, 2011	September 30, 2011	December 31, 2011
Total revenues	$ 1,216,357	$ 1,315,014	$ 1,302,035	$ 1,507,176
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	23,745	28,374	28,987	30,112
Discontinued operations, net of income tax expense	—	—	—	—
Net earnings	$ 23,745	$ 28,374	$ 28,987	$ 30,112
Net earnings per share attributable to Centene Corporation:				
Basic:				
Continued operations	$ 0.48	$ 0.57	$ 0.58	$ 0.60
Discontinued operations	—	—	—	—
Basic earnings per common share	$ 0.48	$ 0.57	$ 0.58	$ 0.60
Diluted:				
Continued operations	$ 0.46	$ 0.54	$ 0.55	$ 0.57
Discontinued operations	—	—	—	—
Diluted earnings per common share	$ 0.46	$ 0.54	$ 0.55	$ 0.57
Health Benefits Ratio	84.9%	84.8%	85.0%	85.9%
General & Administrative Expense Ratio	12.0%	11.2%	11.3%	11.0%
Period end at-risk membership	1,542,500	1,580,500	1,615,700	1,816,000

	For the Quarter Ended			
	March 31, 2010	June 30, 2010	September 30, 2010	December 31, 2010
Total revenues	$ 1,068,721	$ 1,076,772	$ 1,121,861	$ 1,180,969
Amounts attributable to Centene Corporation common shareholders:				
Earnings from continuing operations, net of income tax expense	20,082	22,999	22,402	25,464
Discontinued operations, net of income tax expense (benefit)	3,920	(226)	260	(65)
Net earnings	$ 24,002	$ 22,773	$ 22,662	$ 25,399
Net earnings per share attributable to Centene Corporation:				
Basic:				
Continued operations	$ 0.43	$ 0.46	$ 0.46	$ 0.52
Discontinued operations	0.08	—	—	—
Basic earnings per common share	$ 0.51	$ 0.46	$ 0.46	$ 0.52
Diluted:				
Continued operations	$ 0.41	$ 0.45	$ 0.44	$ 0.50
Discontinued operations	0.08	—	—	—
Diluted earnings per common share	$ 0.49	$ 0.45	$ 0.44	$ 0.50
Health Benefits Ratio	85.7%	85.4%	85.9%	85.0%
General & Administrative Expense Ratio	11.7%	11.1%	10.6%	11.3%
Period end at-risk membership	1,471,300	1,534,600	1,473,800	1,533,500

The Health Benefits Ratios and General and Administrative Expense Ratios shown above reflect the reclassification of certain medical costs and general and administrative expenses as discussed in Note 3, *Reclassifications*.

23. Condensed Financial Information of Registrant

Centene Corporation (Parent Company Only)
Condensed Balance Sheets
(In thousands, except share data)

	December 31,	
	2011	2010
ASSETS		
Current assets:		
Cash and cash equivalents	$ 28,527	$ 9,380
Short-term investments, at fair value (amortized cost $0 and $560, respectively)	—	568
Other current assets	36,354	102,754
Total current assets	64,881	112,702
Long-term investments, at fair value (amortized cost $4,164 and 10,848, respectively)	4,164	11,109
Investment in subsidiaries	1,105,491	898,601
Other long-term assets	32,105	17,134
Total assets	$ 1,206,641	$ 1,039,546
LIABILITIES AND STOCKHOLDERS' EQUITY		
Current liabilities	$ 3,100	$ 6,193
Long-term debt	258,617	235,000
Other long-term liabilities	8,505	1,298
Total liabilities	270,222	242,491
Stockholders' equity:		
Common stock, $.001 par value; authorized 100,000,000 shares; 53,586,726 issued and 50,864,618 outstanding at December 31, 2011, and 52,172,037 issued and 49,616,824 outstanding at December 31, 2010	54	52
Additional paid-in capital	421,981	384,206
Accumulated other comprehensive income:		
Unrealized gain on investments, net of tax	5,761	6,424
Retained earnings	564,961	453,743
Treasury stock, at cost (2,722,108 and 2,555,213 shares, respectively)	(57,123)	(50,486)
Total Centene stockholders' equity	935,634	793,939
Noncontrolling interest	785	3,116
Total stockholders' equity	936,419	797,055
Total liabilities and stockholders' equity	$ 1,206,641	$ 1,039,546

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Operations
(In thousands, except share data)

	Year Ended December 31,		
	2011	**2010**	**2009**
Expenses:			
General and administrative expenses	$ (4,488)	$ (3,502)	$ (2,906)
Other income (expense):			
Investment and other income	(8,790)	(4,700)	6
Interest expense	(15,494)	(14,844)	(15,692)
Loss before income taxes	(28,772)	(23,046)	(18,592)
Income tax benefit	(12,825)	(8,576)	(6,004)
Net earnings (loss) before equity in subsidiaries	(15,947)	(14,470)	(12,588)
Equity in earnings from subsidiaries	127,165	109,306	96,259
Net earnings	$ 111,218	$ 94,836	$ 83,671
Net earnings per share from continuing operations:			
Basic earnings per common share	$ 2.22	$ 1.87	$ 2.00
Diluted earnings per common share	$ 2.12	$ 1.80	$ 1.94
Weighted average number of shares outstanding:			
Basic	50,198,954	48,754,947	43,034,791
Diluted	52,474,238	50,447,888	44,316,467

See notes to condensed financial information of registrant.

Centene Corporation (Parent Company Only)
Condensed Statements of Cash Flows
(In thousands)

	Year Ended December 31,		
	2011	**2010**	**2009**
Cash flows from operating activities:			
Cash provided by operating activities	$ 72,754	$ 23,504	$ 92,711
Cash flows from investing activities:			
Net dividends from and capital contributions to subsidiaries	(50,581)	(17,172)	(67,328)
Purchase of investments	(21,915)	(86,549)	(17,181)
Sales and maturities of investments	11,111	90,121	9,189
Acquisitions, net of cash acquired	(1,773)	(48,656)	(38,563)
Proceeds from asset sales	—	13,420	—
Net cash used in investing activities	(63,158)	(48,836)	(113,883)
Cash flows from financing activities:			
Proceeds from borrowings	419,183	91,000	616,500
Payment of long-term debt and notes payable	(413,644)	(115,000)	(595,500)
Proceeds from exercise of stock options	15,815	3,419	2,365
Common stock offering	—	104,534	—
Common stock repurchases	(7,809)	(3,224)	(6,304)
Debt issue costs	(9,242)	—	(368)
Distribution to noncontrolling interest	—	(8,158)	(3,170)
Contributions from noncontrolling interest	813	771	11,219
Purchase of noncontrolling interest	—	(48,257)	—
Excess tax benefits from stock compensation	4,435	963	53
Net cash provided by financing activities	9,551	26,048	24,795
Net increase (decrease) in cash and cash equivalents	19,147	716	3,623
Cash and cash equivalents, beginning of period	9,380	8,664	5,041
Cash and cash equivalents, end of period	$ 28,527	$ 9,380	$ 8,664

See notes to condensed financial information of registrant.

Notes to Condensed Financial Information of Registrant

Note A – Basis of Presentation and Significant Accounting Policies

In Centene Corporation's parent company only financial statements, Centene Corporation's investment in subsidiaries is stated at cost plus equity in undistributed earnings of the subsidiaries. Centene Corporation's share of net income of its unconsolidated subsidiaries is included in income using the equity method of accounting.Centene Corporation has unrestricted subsidiaries that receive monthly management fees from our restricted subsidiaries. The management and service fees received by our unrestricted subsidiaries are associated with all of the functions required to manage the restricted subsidiaries including but not limited to salaries and wages for all personnel, rent, utilities, medical management, provider contracting, compliance, member services, claims processing, information technology, cash management, finance and accounting, and other services. The management fees are based on a percentage of the restricted subsidiaries revenue.

Due to our centralized cash management function, all cash flows generated by our unrestricted subsidiaries, including management fees, are transferred to the parent company, primarily to repay borrowings on the parent company's revolving credit facility. The parent company may also utilize the cash flow to make acquisitions, fund capital contributions to subsidiaries and fund its operations. During the years ended December 31, 2011, 2010, and 2009, cash flows received by the parent from unrestricted subsidiaries was $88.7 million, $38.0 million, and $102.2 million and was included in cash flows from operating activities.

Certain amounts presented in the parent company only financial statements are eliminated in the consolidated financial statements of Centene Corporation.

Centene Corporation's parent company only financial statements should be read in conjunction with Centene Corporation's audited consolidated financial statements and the notes to consolidated financial statements included in this Form 10-K.

Note B – Dividends

During 2011, 2010 and 2009, the Registrant received dividends from its subsidiaries totaling $69.1 million, $67.9 million and $19.1 million, respectively.

Item 9. ***Changes in and Disagreements With Accountants on Accounting and Financial Disclosure***

None.

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

Evaluation of Disclosure 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 of December 31, 2011. The term "disclosure controls and procedures," as defined in Rules 13a-15(e) and 15d-15(e) under the Exchange Act, means controls and other procedures of a company that are designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is recorded, processed, summarized and reported, within the time periods specified in the SEC's rules and forms. Disclosure controls and procedures include, without limitation, controls and procedures designed to ensure that information required to be disclosed by a company in the reports that it files or submits under the Exchange Act is accumulated and communicated to the company's management, including its principal executive and principal financial officers, as appropriate to allow timely decisions regarding required disclosure. Management recognizes that any controls and procedures, no matter how well designed and operated, can provide only reasonable assurance of achieving their objectives and management necessarily applies its judgment in evaluating the cost-benefit relationship of possible controls and procedures. Based on the evaluation of our disclosure controls and procedures as of December 31, 2011, our Chief Executive Officer and Chief Financial Officer concluded that, as of such date, our disclosure controls and procedures were effective at the reasonable assurance level.

Management's Report on Internal Control Over Financial Reporting - Our management is responsible for establishing and maintaining adequate internal control over financial reporting, as such term is defined in Exchange Act Rules 13a-15(f) and 15d-15(f). Under the supervision and with the participation of our management, including our principal executive officer and principal financial officer, we conducted an evaluation of the effectiveness of our internal control over financial reporting based on the framework in *Internal Control – Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission. Based on our evaluation under the framework in *Internal Control - Integrated Framework*, our management concluded that our internal control over financial reporting was effective at the reasonable assurance level as of December 31, 2011. Our management's assessment of the effectiveness of our internal control over financial reporting as of December 31, 2011 has been audited by KPMG LLP, an independent registered public accounting firm, as stated in their report which is included herein.

Changes in Internal Control Over Financial Reporting - No change in our internal control over financial reporting (as defined in Rules 13a-15(f) and 15d-15(f) under the Exchange Act) occurred during the quarter ended December 31, 2011 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Report of Independent Registered Public Accounting Firm

The Board of Directors and Stockholders

Centene Corporation:

We have audited Centene Corporation's internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission (COSO). Centene Corporation's management is responsible for maintaining effective internal control over financial reporting and for its assessment of the effectiveness of internal control over financial reporting, included in the accompanying Management's Report on Internal Control Over Financial Reporting. Our responsibility is to express an opinion on the Company's internal control over financial reporting based on our audit.

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

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

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

In our opinion, Centene Corporation maintained, in all material respects, effective internal control over financial reporting as of December 31, 2011, based on criteria established in *Internal Control - Integrated Framework* issued by the Committee of Sponsoring Organizations of the Treadway Commission.

We also have audited, in accordance with the standards of the Public Company Accounting Oversight Board (United States), the consolidated balance sheets of Centene Corporation and subsidiaries as of December 31, 2011 and 2010, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2011, and our report dated February 20, 2012 expressed an unqualified opinion on those consolidated financial statements.

/s/ KPMG LLP

St. Louis, Missouri
February 20, 2012

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

None.

PART III

Item 10. ***Directors, Executive Officers and Corporate Governance***

(a) Directors of the Registrant

Information concerning our directors will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Proposal One: Election of Directors". This portion of the Proxy Statement is incorporated herein by reference.

(b) Executive Officers of the Registrant

Pursuant to General Instruction G(3) to Form 10-K and Instruction 3 to Item 401(b) of Regulation S-K, information regarding our executive officers is provided in Item 1 of Part I of this Annual Report on Form 10-K under the caption "Executive Officers of the Registrant."

Information concerning our executive officers' compliance with Section 16(a) of the Exchange Act will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Section 16(a) Beneficial Ownership Reporting Compliance." Information concerning our audit committee financial expert and identification of our audit committee will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Board of Directors Standing Committees." Information concerning our code of ethics will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

(c) Corporate Governance

Information concerning certain corporate governance matters will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Corporate Governance and Risk Management." These portions of our Proxy Statement are incorporated herein by reference.

Item 11. ***Executive Compensation***

Information concerning executive compensation will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Information About Executive Compensation." Information concerning Compensation Committee interlocks and insider participation will appear in the Proxy Statement for our 2012 Annual Meeting of Stockholders under "Compensation Committee Interlocks and Insider Participation." These portions of the Proxy Statement are incorporated herein by reference.

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

Information concerning the security ownership of certain beneficial owners and management and our equity compensation plans will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Information About Stock Ownership" and "Equity Compensation Plan Information." These portions of the Proxy Statement are incorporated herein by reference.

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

Information concerning director independence, certain relationships and related transactions will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Corporate Governance and Risk Management" and "Related Party Transactions." These portions of our Proxy Statement are incorporated herein by reference.

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

Information concerning principal accountant fees and services will appear in our Proxy Statement for our 2012 annual meeting of stockholders under "Proposal Two: Ratification of Appointment of Independent Registered Public Accounting Firm." This portion of our Proxy Statement is incorporated herein by reference.

PART IV

Item 15. ***Exhibits and Financial Statement Schedules***

(a) Financial Statements and Schedules

The following documents are filed under Item 8 of this report:

1. Financial Statements:

Report of Independent Registered Public Accounting Firm
Consolidated Balance Sheets as of December 31, 2011 and 2010
Consolidated Statements of Operations for the Years Ended December 31, 2011, 2010 and 2009
Consolidated Statements of Stockholders' Equity for the Years Ended December 31, 2011, 2010 and 2009
Consolidated Statements of Cash Flows for the Years Ended December 31, 2011, 2010 and 2009
Notes to Consolidated Financial Statements

2. Financial Statement Schedules:

None.

3. The exhibits listed in the accompanying Exhibit Index are filed or incorporated by reference as part of this filing.

EXHIBIT INDEX

EXHIBIT NUMBER	DESCRIPTION	FILED WITH THIS FORM 10-K	INCORPORATED BY REFERENCE [1]		
			FORM	FILING DATE WITH SEC	EXHIBIT NUMBER
3.1	Certificate of Incorporation of Centene Corporation		S-1	October 9, 2001	3.2
3.1a	Certificate of Amendment to Certificate of Incorporation of Centene Corporation, dated November 8, 2001		S-1/A	November 13, 2001	3.2a
3.1b	Certificate of Amendment to Certificate of Incorporation of Centene Corporation as filed with the Secretary of State of the State of Delaware		10-Q	July 26, 2004	3.1b
3.2	By-laws of Centene Corporation		S-1	October 9, 2001	3.4
4.1	Rights Agreement between Centene Corporation and Mellon Investor Services LLC, as Rights Agent, dated August 30, 2002		8-K	August 30, 2002	4.1
4.1a	Amendment No. 1 to Rights Agreement by and between Centene Corporation and Mellon Investor Services LLC, as Rights Agent, dated April 23, 2007		8-K	April 26, 2007	4.1
4.2	Indenture, dated May 27, 2011, among the Company and The Bank of New York Mellon Trust Company, N.A., relating to the Company's 5.75% Senior Notes due 2017 (including Form of Global Note as Exhibit A thereto)		8-K	May 27, 2011	4.1
10.1	Contract Between the Georgia Department of Community Health and Peach State Contract for provision of Services to Georgia Healthy Families		8-K	July 22, 2005	10.1
10.1a	Amendment #1 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-Q	October 25, 2005	10.9
10.1b	Amendment #2 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-K	February 23, 2008	10.1b
10.1c	Amendment #3 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-K	February 23, 2009	10.1c
10.1d	Amendment #4 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-K	February 23, 2009	10.1d
10.1e	Amendment #6 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-K	February 22, 2010	10.1e
10.1f	Amendment #7 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-K	February 22, 2011	10.1f
10.1g	Amendment #8 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-K	February 22, 2011	10.1g
10.1h	Amendment #10 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State		10-Q/A	October 28, 2011	10.1
10.1i **	Amendment #11 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State	X			
10.1j **	Amendment #12 to the Contract No. 0653 Between Georgia Department of Community Health and Peach State	X			
10.2	Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-K	February 24, 2006	10.5
10.2a	Amendment T (Version 1.19) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	October 25, 2011	10.1
10.2b **	Amendment U (Version 1.20) to Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.	X			
10.3	Contract between the Texas Health and Human Services Commission and Superior HealthPlan, Inc.		10-Q	October 25, 2011	10.2
10.4	Contract between the Texas Health and Human Services Commission and Bankers Reserve Life Insurance Company of Wisconsin d.b.a. Superior HealthPlan Network.		10-Q	October 25, 2011	10.3
10.5 *	1996 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.9
10.6 *	1998 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File number 333-83190		S-1	October 9, 2001	10.10
10.7 *	1999 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.11
10.8 *	2000 Stock Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-83190		S-1	October 9, 2001	10.12
10.9 *	2002 Employee Stock Purchase Plan of Centene Corporation, shares which are registered on Form S-8 – File Number 333-90976		10-Q	April 29, 2002	10.5

10.9a *	First Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2005	10.9a
10.9b *	Second Amendment to the 2002 Employee Stock Purchase Plan		10-K	February 24, 2006	10.10b
10.10 *	Centene Corporation Amended and Restated 2003 Stock Incentive Plan, shares which are registered on Form S-8 – File Number 333-108467		8-K	April 30, 2010	10.1
10.11 *	Centene Corporation Non-Employee Directors Deferred Stock Compensation Plan		10-Q	October 25, 2004	10.1
10.11a *	First Amendment to the Non-Employee Directors Deferred Stock Compensation Plan		10-K	February 24, 2006	10.12a
10.12 *	Centene Corporation Employee Deferred Compensation Plan		10-K	February 22, 1010	10.10
10.13 *	Centene Corporation 2007 Long-Term Incentive Plan		8-K	April 26, 2007	10.2
10.14 *	Centene Corporation Short-Term Executive Compensation Plan		10-K	February 22, 2011	10.12
10.15 *	Executive Employment Agreement between Centene Corporation and Michael F. Neidorff, dated November 8, 2004		8-K	November 9, 2004	10.1
10.15a *	Amendment No. 1 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	October 28, 2008	10.2
10.15b *	Amendment No. 2 to Executive Employment Agreement between Centene Corporation and Michael F. Neidorff		10-Q	April 28, 2009	10.2
10.16 *	Form of Executive Severance and Change in Control Agreement		10-Q	October 28, 2008	10.3
10.17 *	Form of Restricted Stock Unit Agreement		10-Q	October 28, 2008	10.4
10.18 *	Form of Non-statutory Stock Option Agreement (Non-Employees)		8-K	July 28, 2005	10.3
10.19 *	Form of Non-statutory Stock Option Agreement (Employees)		10-Q	October 28, 2008	10.5
10.20 *	Form of Non-statutory Stock Option Agreement (Directors)		10-K	February 23, 2009	10.18
10.21 *	Form of Incentive Stock Option Agreement		10-Q	October 28, 2008	10.6
10.22 *	Form of Stock Appreciation Right Agreement		8-K	July 28, 2005	10.6
10.23 *	Form of Restricted Stock Agreement		10-Q	October 25, 2005	10.8
10.24 *	Form of Performance Based Restricted Stock Unit Agreement #1		10-Q	October 28, 2008	10.7
10.25 *	Form of Performance Based Restricted Stock Unit Agreement #2		10-K	February 23, 2009	10.23
10.26 *	Form of Long Term Incentive Plan Agreement		8-K	February 7, 2008	10.1
10.27	Credit Agreement dated as of January 31, 2011 among Centene Corporation, the various financial institutions party hereto and Barclays Bank PLC		10-K	February 22, 2011	10.26
12.1	Computation of ratio of earnings to fixed charges	X			
21	List of subsidiaries	X			
23	Consent of Independent Registered Public Accounting Firm incorporated by reference in each prospectus constituting part of the Registration Statements on Form S-3 (File Numbers 333-164390 and 333-174164) and on Form S-8 (File Numbers 333-108467, 333-90976 and 333-83190)	X			
31.1	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Executive Officer)	X			
31.2	Certification Pursuant to Rule 13a-14(a) and 15d-14(a) of the Exchange Act, as Adopted Pursuant to Section 302 of the Sarbanes-Oxley Act of 2002 (Chief Financial Officer)	X			
32.1	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Executive Officer)	X			
32.2	Certification Pursuant to 18 U.S.C. Section 1350 (Chief Financial Officer)	X			
101.1[2]	XBRL Taxonomy Instance Document.	X			
101.2[2]	XBRL Taxonomy Extension Schema Document.	X			
101.3[2]	XBRL Taxonomy Extension Calculation Linkbase Document.	X			
101.4[2]	XBRL Taxonomy Extension Definition Linkbase Document.	X			
101.5[2]	XBRL Taxonomy Extension Label Linkbase Document.	X			
101.6[2]	XBRL Taxonomy Extension Presentation Linkbase Document.	X			

[1] SEC File No. 001-31826 (for filings prior to October 14, 2003, the Registrant's SEC File No. was 000-33395).

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

* Indicates a management contract or compensatory plan or arrangement.

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

SIGNATURES

Pursuant to the requirements of Section 13 or 15(d) 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 February 21, 2012.

CENTENE CORPORATION

By: /s/ MICHAEL F. NEIDORFF
Michael F. Neidorff
Chairman and Chief Executive Officer

Pursuant to the requirements of the Securities Exchange Act of 1934, this report has been signed below by the following persons on behalf of the registrant and in the capacities as indicated, as of February 21, 2012.

Signature	Title
/s/ MICHAEL F. NEIDORFF **Michael F. Neidorff**	Chairman and Chief Executive Officer (principal executive officer)
/s/ WILLIAM N. SCHEFFEL **William N. Scheffel**	Executive Vice President and Chief Financial Officer (principal financial officer)
/s/ JEFFREY A. SCHWANEKE **Jeffrey A. Schwaneke**	Senior Vice President, Corporate Controller and Chief Accounting Officer (principal accounting officer)
/s/ ORLANDO AYALA **Orlando Ayala**	Director
/s/ ROBERT K. DITMORE **Robert K. Ditmore**	Director
/s/ FRED H. EPPINGER **Fred H. Eppinger**	Director
/s/ RICHARD A. GEPHARDT **Richard A. Gephardt**	Director
/s/ PAMELA A. JOSEPH **Pamela A. Joseph**	Director
/s/ JOHN R. ROBERTS **John R. Roberts**	Director
/s/ DAVID L. STEWARD **David L. Steward**	Director
/s/ TOMMY G. THOMPSON **Tommy G. Thompson**	Director

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

AMENDED AND RESTATED

CONTRACT BETWEEN

THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH

AND

PEACH STATE HEALTH PLAN

FOR

PROVISION OF SERVICES TO GEORGIA FAMILIES

CONTRACT NO. 0653

AMENDMENT #11

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THIS AMENDED AND RESTATED CONTRACT is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as "DCH" or the "Department") and Peach State Health Plan, (hereinafter referred to as the "Contractor") and is made effective on the date signed by the DCH Commissioner (hereinafter referred to as the "Effective Date").

WHEREAS, DCH is responsible for health care policy, purchasing, planning and regulation pursuant to the Official Code of Georgia Annotated (O.C.G.A.) § 31-2-1 *et seq.*;

WHEREAS, DCH is the single State agency designated to administer medical assistance in Georgia under Title XIX of the Social Security Act of 1935, as amended, and O.C.G.A. §§ 49-4-140 *et seq*. (the "Medicaid Program"), and is charged with ensuring the appropriate delivery of health care services to Medicaid recipients and PeachCare for Kids® Members;

WHEREAS, DCH caused Request for Proposals Number 41900-001-0000000027 (hereinafter the "RFP") to be issued through the Department of Administrative Services (DOAS), and it is expressly incorporated as if completely restated herein;

WHEREAS, DCH received from Contractor a proposal in response to RFP Number 41900-001-0000000027 on or about April 4, 2005 (hereinafter "Contractor's Proposal") which is expressly incorporated as if completely restated herein;

WHEREAS, DCH accepted Contractor's Proposal and entered into a contract with Contractor on July 18, 2005, for the provision of various services for the Department;

WHEREAS, DCH and Contractor now wish to amend and restate the Contract in its entirety; and

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

NOW, THEREFORE, **FOR AND IN CONSIDERATION** of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, the Department and the Contractor (each individually a "Party" and collectively the "Parties") hereby agree as follows:

1.0 SCOPE OF SERVICE

1.0.1 The State of Georgia is implementing reforms to the Medicaid and PeachCare for Kids® programs. These reforms will focus on system-wide improvements in performance and quality, will consolidate fragmented systems of care, and will prevent unsustainable trend rates in Medicaid and PeachCare for Kids® expenditures. The reforms will be implemented through a management of care approach to achieve the greatest value for the most efficient use of resources.

1.0.2 The Contractor shall assist the State of Georgia in this endeavor through the following tasks, obligations, and responsibilities.

1.1 BACKGROUND

1.1.1 In 2003, the Georgia Department of Community Health (DCH) identified unsustainable Medicaid growth and projected that without a change to the system, Medicaid would require 50 percent of all new State revenue by 2008. In addition, Medicaid utilization was driving more than 35 percent of total growth each year. For that reason, DCH decided to employ a management of care approach to organize its fragmented system of care, enhance access, achieve budget predictability, explore possible cost containment opportunities and focus on system-wide performance improvements. Furthermore, DCH believed that managed care could continuously and incrementally improve the quality of healthcare and services provided to patients and improve efficiency by utilizing both human and material resources more effectively and more efficiently. The DCH Division of Managed Care and Quality submitted a State Plan Amendment in 2004 to implement a full-risk mandatory Medicaid Managed Care program called Georgia Families.

1.1.2 Effective June 1, 2006 the state of Georgia implemented Georgia Families (GF), a managed care program through which health care services are delivered to members of Medicaid and PeachCare for Kids®. The intent of this program is to:

- Offer care coordination to members
- Enhance access to health care services
- Achieve budget predictability as well as cost containment
- Create system-wide performance improvements
- Continually and incrementally improve the quality of health care and services provided to members
- Improve efficiency at all levels

1.1.3 The GF program is designed to:

- Improve the Health Care status of the Member and Planning for Healthy Babies (P4HB) 1115 Demonstration Participant population;
- Establish a Provider Home for the Member and P4HB Interpregnancy Care Participant through its use of assigned Primary Care Providers (PCPs);
- Establish a climate of contractual accountability among the state, the care management organizations and the health care Providers;
- Slow the rate of expenditure growth in the Medicaid program; and
- Expand and strengthen a sense of the Member's and P4HB Participant's responsibility that leads to more appropriate utilization of health care services

1.2 ELIGIBILITY FOR GEORGIA FAMILIES

1.2.1 Medicaid

1.2.1.1 The following Medicaid eligibility categories are required to enroll in GF:

- Low Income Families – Adults and children who meet the standards of the old AFDC (Aid to Families with Dependent Children) program.
- Transitional Medicaid – Former Low-Income Medicaid (LIM) families who are no longer eligible for LIM because their earned income exceeds the income limit.
- Pregnant Women (Right from the Start Medicaid - RSM) – Pregnant women with family income at or below two hundred percent (200%) of the federal poverty level who receive Medicaid through the RSM program.
- Children (Right from the Start Medicaid - RSM) – Children less than nineteen (19) years of age whose family income is at or below the appropriate percentage of the federal poverty level for their age and family.
- Children (newborn) – A child born to a woman who is eligible for Medicaid on the day the child is born.
- Women Eligible Due to Breast and Cervical Cancer Women less than sixty-five (65) years of age who have been screened through Title XV Center for Disease Control (CDC) screening and have been diagnosed with breast or cervical cancer.
- Refugees – Those individuals who have the required INS documentation showing they meet a status in one of these groups: refugees, asylees, Cuban parolees/Haitian entrants, Amerasians or human trafficking victims.
- Planning for Healthy Babies 1115 Demonstration Waiver Participants (otherwise known as P4HB Participants) – Women ages 18 through 44 who are otherwise uninsured with family income at or below two hundred percent (200%) of the Federal poverty level. This Demonstration includes two distinct groups: women eligible for Family Planning Services only and women eligible for Interpregnancy Care and Family Planning Services.

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

- Women ages 18 through 44 who qualify under the Low Income Medicaid Class of Assistance under the Georgia Medicaid State Plan who are already enrolled in GF and who deliver a Very Low Birth Weight (VLBW) baby on or after January 1, 2011.
- Women ages 18 through 44 who qualify under the Aged Blind and Disabled Classes of Assistance under the Georgia Medicaid State Plan and who deliver a VLBW baby on or after January 1, 2011.

1.2.2 PeachCare for Kids®

1.2.2.1 PeachCare for Kids® – The State Children's Health Insurance Program (SCHIP) in Georgia. Children less than nineteen (19) years of age who have family income that is less than two hundred thirty-five percent (235%) of the federal poverty level, who are not eligible for Medicaid, or any other health insurance program are eligible for services under PeachCare for Kids®. Effective January 1, 2012, employees of the State of Georgia may enroll their children in PeachCare for Kids® if the employee meets income and other eligibility requirements of the program.

1.2.3 Exclusions

1.2.3.1 The following recipients are excluded from Enrollment in GF, even if the recipient is otherwise eligible for GF per section 1.2.1 and section 1.2.2.

- Recipients eligible for Medicare;
- Recipients that are Members of a Federally Recognized Indian Tribe;
- Recipients that are enrolled in fee-for-service Medicaid through Supplemental Security Income prior to enrollment in GF. Members that are already enrolled in a CMO through GF will remain in that CMO until the disenrollment is completed through the normal monthly process.
- Children less than twenty-one (21) years of age who are in foster care or other out-of-home placement;
- Children less than twenty-one (21) years of age who are receiving foster care or other adoption assistance under Title IV-E of the Social Security Act.
- Medicaid children enrolled in the Children's Medical Services program administered by the Georgia Department of Public Health;
- Children less than twenty-one (21) years of age who are receiving foster care or other adoption assistance under Title IV-E of the Social Security Act (NOTE: Foster Children in "Relative" placement remain within the Georgia Families program);
- Children enrolled in the Georgia Pediatric Program (GAPP);
- Recipients enrolled under group health plans for which DCH provides payment for premiums, deductibles, coinsurance and other cost sharing, pursuant to Section 1906 of the Social Security Act.
- Individuals enrolled in a Hospice category of aid.
- Individuals enrolled in a Nursing Home category of aid.
- Individuals enrolled in a Community Based Alternative for Youths (CBAY)

1.2.3.2 The following recipients are excluded from the P4HB Demonstration (hereinafter referred to as "the Demonstration"):

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

1.3 SERVICE REGIONS

1.3.1 For the purposes of coordination and planning, DCH has divided the State, by county, into six (6) Service Regions. See Attachment J for a listing of the counties in each Service Region.

1.3.2 Members and P4HB Participants will choose or will be assigned to a Care Management Organization (CMO) plan that is operating in the Service Region in which they reside.

1.3.3 Contractor has the option of operating in all six (6) Service Regions within the State. Should Contractor choose this option, Contractor shall seek DCH approval pursuant to Section 1.3.4. Once approval is obtained, Contractor shall provide health care services in no less than all six (6) Service Regions and must meet all requirements set forth in the Contract, including, but not limited to, the following Sections: 4.8.5.2, 4.8.7.1, 4.8.8.1, 4.8.9.1, 4.8.13, 4.8.14, 4.8.17.1, 4.11.1.2, 4.11.1.3, 4.15.2.1, and 26.1.

1.3.4 Before DCH will approve the Contractor's expansion into all six (6) Service Regions, the Contractor must demonstrate its ability to comply with all Contract requirements in these Service Regions by submitting the following to DCH no later than 5:00 pm EST on December 5, 2011: (a) an affidavit that the Contractor has met all applicable Contract requirements in these Service Regions; and (b) geographic access reports and supporting documentation regarding network access. If the Department approves the Contractor's request, the effective date of the Service Region expansion will be January 1, 2012.

1.3.5 DCH reserves the right to require that the Contractor's expansion in a particular Service Region reach all areas of the Service Region in question.

1.4 DEFINITIONS

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

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

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

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

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

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

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

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

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

Agent: An entity that contracts with the State of Georgia to perform administrative functions, including but not limited to: fiscal agent activities; outreach, eligibility, and Enrollment activities; Systems and technical support; etc.

Appeal: A request for review of an action, as "action" is defined in 42 C.F.R. §438.400.

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

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

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

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

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

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

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

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

Business Days: Monday through Friday from 9 A.M. to 5 P.M., excluding State holidays.

Calendar Days: All seven days of the week.

Capitation: A Contractual agreement through which a Contractor agrees to provide specified Health Care services to Members and P4HB Participants for a fixed amount per month. Payments are contingent upon the availability of appropriated funds.

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

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

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

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

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

Case Management: Any intensive intervention undertaken with the purpose of helping Members and P4HB IPC Participants receive appropriate care. In the case of a P4HB IPC Participant, case management follows the delivery of a Very Low Birth Weight infant where that P4HB Participant has any disease(s) or condition(s) which may have contributed to the Very Low Birth Weight birth. Case Management is distinguished from utilization management in that it is voluntary and it is distinguished from disease management by its intensity and focus on any disease(s) or conditions the Member and P4HB IPC Participant has.

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

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

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

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

Claim: A bill for services, a line item of services, or all services for one recipient within a bill.

Claims Administrator: The entity engaged by DCH to provide Administrative Service(s) to the CMO Plans in connection with processing and adjudicating risk-based payment, and recording health benefit encounter Claims for Members and P4HB Participants.

Claim Adjustment: A claim that has been incorrectly paid, incorrectly submitted or, as the result of an updated payment policy, the payment amount can be changed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Demonstration: The 1115 Demonstration waiver program in Georgia supported by CMS that expands the delivery of family planning services to uninsured women, ages 18 through 44, who have family income at or below 200 percent of the Federal poverty level (FPL) and who are not otherwise eligible for Medicaid or the Children's Health Insurance Program (CHIP). Also referred to as the Family Planning Waiver or the P4HB Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Enrollee: See Member.

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

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

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

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

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

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

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

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

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

Family Planning Waiver: See Demonstration.

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

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

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

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

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

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

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

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

Grievance System: The overall system that address the manner in which the CMO handles Grievances at the Contractor level.

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

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

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

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

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

Health Insurance Portability and Accountability Act (HIPAA): A federal law that includes requirements to protect the privacy of individually identified health information in any format, including written or printed, oral and electronic, to protect the security of individually identified health information in electronic format, to prescribe methods and formats for exchange of electronic medical information, and to uniformly identify providers. When referenced in this Contract it includes all related rules, regulations and procedures.

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

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

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

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

Immediately: Within twenty-four (24) hours.

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

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

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

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

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

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

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

Insolvent: Unable to meet or discharge financial liabilities.

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

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

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

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

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

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

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

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

Material Subcontractor: A Subcontractor, excluding Providers, receiving Subcontractor payments from the Contractor in amounts equal to or greater than $10 million annually during the state fiscal year.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Non-Emergency Transportation (NET): A ride, or reimbursement for a ride, provided so that a Member or P4HB Participant with no other transportation resources can receive services from a medical provider. NET does not include transportation provided on an emergency basis, such as trips to the emergency room in life threatening situations.

Non-Institutional Claims: Claims submitted by a medical Provider other than a hospital, nursing facility, or intermediate care facility/mentally retarded (ICF/MR).

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

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

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

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

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

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

Patient Protection and Affordable Care Act (PPACA): The Patient Protection and Affordable Care Act is a federal statute, signed into law on March 23, 2010. The law includes numerous health-related provisions that will take effect over a four year period, including expanding Medicaid eligibility, subsidizing insurance premiums, establishing health insurance exchanges and support of medical research.

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

P4HB Provider: See Demonstration Provider.

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

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

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

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

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

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

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

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

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

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

Potential Enrollee: See Potential Member.

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

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

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

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

Pregnancy Rate: The number of pregnancies occurring to females in a specified age group per 1,000 females in the specified age group. The rate is calculated by using the following formula: Pregnancy rate = [Number of pregnancies in age group / Female population in age group] * 1000. Rates that use Census Population Estimates in the denominator are unable to be calculated when the selected population is unknown.

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

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

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

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

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

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

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

Provider: Any person (including physicians or other Health Care Professionals), partnership, professional association, corporation, facility, hospital, or institution certified, licensed, or registered by the State of Georgia to provide Health Care Services that has contracted with a Care Management Organization to provide health care services to Members and P4HB Participants.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Resource Mother: A paraprofessional that provides a broad range of services to P4HB IPC Participants and their families.

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

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

Rural Health Clinic (RHC): A clinic certified to receive special Medicare and Medicaid reimbursement. The purpose of the RHC program is improving access to primary care in underserved rural areas. RHCs are required to use a team approach of physicians and midlevel practitioners (nurse practitioners, physician assistants, and certified nurse midwives) to provide services. The clinic must be staffed at least 50% of the time with a midlevel practitioner. RHCs may also provide other health care services, such as mental health or vision services, but reimbursement for those services may not be based on their allowable costs.

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

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

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

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

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

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

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

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

State: The State of Georgia.

State Fair Hearing: See Administrative Law Hearing

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

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

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

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

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

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

Systems: See Information Systems.

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

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

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

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

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

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

Utilization Review (UR): Evaluation of the clinical necessity, appropriateness, efficacy, or efficiency of Health Care services, procedures or settings, and ambulatory review, prospective review, concurrent review, second opinions, care management, discharge planning, or retrospective review.

Validation: The review of information, data, and procedures to determine the extent to which they are accurate, reliable, free from bias and in accord with standards for data collection and analysis.

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

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

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

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

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

1.5 ACRONYMS

AFDC – Aid to Families with Dependent Children

AICPA – American Institute of Certified Public Accountants

CAH – Critical Access Hospital

CAPA – Corrective Action Preventive Action

CAPA/PC – Corrective Action Preventive Action/Performance Concern

CDC – Centers for Disease Control

CFR – Code of Federal Regulations

CHIP – Children's Health Insurance Program – formerly known as the State Children's Health Insurance Program (SCHIP)

CMO – Care Management Organization

CMS – Centers for Medicare & Medicaid Services

CNM – Certified Nurse Midwives

CSB – Community Service Boards

DCH – Department of Community Health

DME – Durable Medical Equipment

DOI – Department of Insurance

EB – Enrollment Broker

EPSDT – Early and Periodic Screening, Diagnostic, and Treatment

EQR – External Quality Review

EQRO – External Quality Review Organization

EVS - Eligibility Verification System

FFS – Fee-for-Service

FQHC – Federally Qualified Health Center

GF – Georgia Families

GTA - Georgia Technology Authority

HHS – US Department of Health and Human Services

HIPAA – Health Insurance Portability and Accountability Act

HMO – Health Management Organization

IBNR – Incurred-But-Not-Reported

INS – U.S. Immigration and Naturalization Services

IPC – Interpregnancy Care component of the 1115 Demonstration Waiver

LIM – Low-Income Medicaid

MMIS – Medicaid Management Information System

NAIC – National Association of Insurance Commissioners

NCQA – National Committee for Quality Assurance

NET – Non-Emergency Transportation

NP-C – Certified Nurse Practitioners

NPI – National Provider Identifier

P4HB – Planning for Healthy Babies 1115 Demonstration Waiver

PA – Physician Assistant

PBM – Pharmacy Benefit Manager

PC - Performance Concern

PCP – Primary Care Provider

PPS – Prospective Payment System

QAPI – Quality Assessment Performance Improvement

RHC – Rural Health Clinic

RSM – Right from the Start Medicaid

SCHIP – State Children's Health Insurance Program

SSA – Social Security Act

TANF – Temporary Assistance for Needy Families

TDD – Telecommunication Device for the Deaf

UM – Utilization Management

UPIN – Unique Physician Identifier Number

UR – Utilization Review

2.0 DCH RESPONSIBILITIES

2.1 GENERAL PROVISIONS

2.1.1 DCH is responsible for administering the GF program. The agency will administer Contracts, monitor Contractor performance, and provide oversight in all aspects of the Contractor operations.

2.1.2 DCH is responsible for providing training materials regarding the P4HB Demonstration including specific materials regarding the Resource Mothers Outreach component of the Demonstration.

2.2 LEGAL COMPLIANCE

DCH will comply with, and will monitor the Contractor's compliance with, all applicable State and federal laws and regulations. Notwithstanding the foregoing, the CMO remains responsible for compliance with all applicable State and federal laws and regulations.

2.3 ELIGIBILITY AND ENROLLMENT

2.3.1 The State of Georgia has the sole authority for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for Enrollment in GF. DCH or its Agent will determine eligibility for PeachCare for Kids® and will collect applicable premiums. DCH or its agent will continue responsibility for the electronic eligibility verification system (EVS).

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

2.3.2 DCH or its Agent will review the Medicaid Management Information System (MMIS) file daily and send written notification and information within two (2) Business Days to all Members who are determined eligible for GF. A Member shall have thirty (30) Calendar Days to select a CMO plan and a PCP. Each Family Head of Household shall have thirty (30) Calendar Days to select one (1) CMO plan for the entire Family and PCP for each member. DCH or its Agent will issue a monthly notice of all Enrollments to the CMO plan.

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

2.3.3 If the Member does not choose a CMO plan within thirty (30) Calendar Days of being deemed eligible for GF, DCH or its Agent will Auto-Assign the individual to a CMO plan using the following algorithm:

- If an immediate family member(s) of the Member is already enrolled in one CMO plan, the Member will be Auto-Assigned to that plan;
- If there are no immediate family members already enrolled and the Member has a Historical Provider Relationship with a Provider, the Member will be Auto-Assigned to the CMO plan where the Provider is contracted;
- If the Member does not have a Historical Provider Relationship with a Provider in any CMO plan, or the Provider contracts with all plans, the Member will be Auto-Assigned based on an algorithm determined by

DCH that may include quality, cost, or other measures.

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

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

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

2.3.4 Enrollment, whether chosen or Auto-Assigned, will be effective at 12:01 a.m. on the first (1st) Calendar Day of the month following the Member or P4HB Participant's selection or Auto-Assignment, for those Members or P4HB Participants assigned on or between the first (1st) and twenty-fourth (24th) Calendar Day of the month. For those Members or P4HB Participants assigned on or between the twenty-fifth (25th) and thirty-first (31st) Calendar Day of the month, Enrollment will be effective at 12:01 a.m. on the first (1st) Calendar Day of the second (2nd) month after assignment.

2.3.5 DCH or its Agent may include quality measures in the Auto-Assignment algorithm. Members or P4HB Participants will be Auto-Assigned to those plans that have higher scores based on quality, cost, or other measures to be defined by DCH. This factor will be applied after determining that there are no Historical Provider Relationships.

2.3.6 In any Service Region, DCH may, at its discretion, set a threshold percentage for the enrollment of members or P4HB Participants in a single plan and change this threshold percentage at its discretion. Members or P4HB Participants will not be Auto-Assigned to a CMO plan that exceeds this threshold unless a family member or P4HB Participant is enrolled in the CMO plan or a Historical Provider Relationship exists with a Provider that does not participate in any other CMO plan in the Service Region. When DCH changes the threshold percentage in any Service Region, DCH will provide the CMOs in the Service Region with a minimum of fourteen (14) days advance notice in writing.

2.3.7 DCH or its Agent will have five (5) Business Days to notify Members or P4HB Participants and the CMO plan of the Auto-Assignment. Notice to the Member or P4HB Participant will be made in writing and sent via surface mail. Notice to the CMO plan will be made via file transfer.

2.3.8 DCH or its Agent will be responsible for the consecutive Enrollment period and re-Enrollment functions.

2.3.9 Conditioned on continued eligibility, all Members or P4HB Participants will be enrolled in a CMO plan for a period of twelve (12) consecutive months. This consecutive Enrollment period will commence on the first (1st) day of Enrollment or upon the date the notice is sent, whichever is later. If a Member or P4HB Participant disenrolls from one CMO plan and enrolls in a different CMO plan, consecutive Enrollment period will begin on the effective date of Enrollment in the second (2nd) CMO plan.

2.3.10 DCH or its Agent will automatically enroll a Member or P4HB Participant into the CMO plan in which he or she was most recently enrolled if the Member or P4HB Participant has a temporary loss of eligibility, defined as less than sixty (60) Calendar Days. In this circumstance, the consecutive Enrollment period will continue as though there has been no break in eligibility, keeping the original twelve (12) month period.

2.3.11 DCH or its Agent will notify Members or P4HB Participants at least once every twelve (12) months, and at least sixty (60) Calendar Days prior to the date upon which the consecutive Enrollment period ends (the annual Enrollment opportunity), that they have the opportunity to switch CMO plans. Members or P4HB Participants who do not make a choice will be deemed to have chosen to remain with their current CMO plan.

2.3.12 In the event a temporary loss of eligibility has caused the Member or P4HB Participant to miss the annual Enrollment opportunity, DCH or its Agent will enroll the Member or P4HB Participant in the CMO plan in which he or she was enrolled prior to the loss of eligibility. The Member or P4HB Participant will receive a new 60-calendar day notification period beginning the first day of the next month.

2.3.13 In accordance with current operations, the State will issue a Medicaid number to a newborn upon notification from the hospital, or other authorized Medicaid Provider.

2.3.14 Upon notification from a CMO plan that a Member is an expectant mother, DCH or its Agent shall mail a newborn enrollment packet to the expectant mother. This packet shall include information that the newborn will be Auto-Assigned to the mother's CMO plan and that she may, if she wants, select a PCP for her newborn prior to the birth by contacting her CMO plan. The mother shall have ninety (90) Calendar Days from the day a Medicaid number was assigned to her newborn to choose a different CMO plan.

2.3.15 DCH may, at its sole discretion, elect to modify this threshold and/or use quality based auto-assignments for reasons it deems necessary and proper.

2.4 DISENROLLMENT

2.4.1 DCH or its Agent will process all CMO plan Disenrollments. This includes Disenrollments due to non-payment of the PeachCare for Kids® premiums, loss of eligibility for GF due to other reasons, and all Disenrollment requests Members or P4HB Participants or CMO plans submit via telephone, surface mail, internet, facsimile, and in person.

2.4.2 DCH or its Agent will make final determinations about granting Disenrollment requests and will notify the CMO plan via file transfer and the Member or P4HB Participant via surface mail of any Disenrollment decision within five (5) Calendar Days of making the final determination

Whether requested by the Member or P4HB Participant or the Contractor the following are the Disenrollment timeframes:

- If the Disenrollment request is received by DCH or its agent on or before the managed care monthly process on the twenty-fourth (24th) Calendar Day of the month, the Disenrollment will be effective at midnight the first (1st) day of the month following the month in which the request was filed; and
- If the Disenrollment request is received by DCH or its agent after the managed care monthly process on the twenty-fourth (24th) Calendar Day of the month, the Disenrollment will be effective at midnight the first (1st) day of the second (2nd) month following the month in which the request was filed.

2.4.3 If a Member is hospitalized in an acute inpatient facility on the first day of the month their Disenrollment is to be effective, the Member will remain enrolled until the month following their discharge from the inpatient facility. When Disenrollment is necessary due to a change in eligibility category, or eligibility for GF, the Member will be disenrolled according to the timeframes identified in Section 2.4.2.

2.4.4 When disenrollment is necessary because a Member loses Medicaid or PeachCare for Kids® eligibility (for example, he or she has died, been incarcerated, or moved out-of-state) disenrollment shall be immediate.

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

2.5 MEMBER AND P4HB PARTICIPANT SERVICES AND MARKETING

2.5.1 DCH will provide to the Contractor its methodology for identifying the prevalent non-English languages spoken. For the purposes of this Section, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State.

2.5.2 DCH will review and prior approve all marketing materials.

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

2.6 COVERED SERVICES & SPECIAL COVERAGE PROVISIONS

DCH will use submitted Encounter Data, and other data sources, to determine Contractor compliance with federal requirements that eligible Members under the age of twenty-one (21) receive periodic screens and preventive/well child visits in accordance with the specified periodicity schedule. DCH will use the participant ratio as calculated using the CMS 416 methodology for measuring the Contractor's performance.

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

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

2.7 NETWORK

2.7.1 DCH will provide to the Contractor up-to-date changes to the State's list of excluded Providers, as well as any additional information that will affect the Contractor's Provider network.

2.7.2 DCH will consider all Contractors' requests to waive network geographic access requirements in rural areas. All such requests shall be submitted in writing.

2.7.3 DCH will provide the State's Provider Credentialing policies to the Contractor upon execution of this Contract.

2.8 QUALITY MONITORING

2.8.1 DCH will have a written strategy for assessing and improving the quality of services provided by the Contractor. In accordance with 42 CFR 438.204, this strategy will, at a minimum, monitor:

- The availability of services;
- The adequacy of the Contractor's capacity and services;
- The Contractor's coordination and continuity of care for Members;

- The coverage and authorization of services;
- The Contractor's policies and procedures for selection and retention of Providers;
- The Contractor's compliance with Member information requirements in accordance with 42 CFR §438.10;
- The Contractor's compliance with State and federal privacy laws and regulations relative to Member's confidentiality;
- The Contractor's compliance with Member Enrollment and Disenrollment requirements and limitations;
- The Contractor's Grievance System;
- The Contractor's oversight of all Subcontractor relationships and delegations;
- The Contractor's adoption of practice guidelines, including the dissemination of the guidelines to Providers and Providers' application of them;
- The Contractor's quality assessment and performance improvement program; and
- The Contractor's health information systems.
- The Contractor shall respond to requests for information within the stipulated time frame.

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

2.9 COORDINATION WITH CONTRACTOR'S KEY STAFF

2.9.1 DCH will make diligent good faith efforts to facilitate effective and continuous communication and coordination with the Contractor in all areas of GF operations.

2.9.2 Specifically, DCH will designate individuals within the department who will serve as a liaison to the corresponding individual on the Contractor's staff, including:

- A program integrity staff Member;
- A quality oversight staff Member;
- A Grievance System staff Member who will also ensure that the State Administrative Law Hearing process is consistent with the Rules of the Office of the State Administrative Hearings Chapter 616-1-2 and with any other applicable rule, regulation, or procedure whether State or federal;
- An information systems coordinator; and
- A vendor management staff Member.

2.10 FORMAT STANDARDS

DCH will provide to the Contractor its standards for formatting all Reports requested of the Contractor. DCH will require that all Reports be submitted electronically.

DCH and Contractor agree that any change (new or revised standards) to Contractor's Reports which is set forth in Amendment 11 to the Contract (new or revised standards) shall not become effective until January 1, 2012.

2.11 FINANCIAL MANAGEMENT

2.11.1 In order to facilitate the Contractor's efforts in using Cost Avoidance processes to ensure that primary payments from the liable third party are identified and collected to offset medical expenses; DCH will include information about known Third Party Resources on the electronic Enrollment data given to the Contractor.

2.11.2 DCH will monitor Contractor compliance with federal and State physician incentive plan rules and regulations.

2.12 INFORMATION SYSTEMS

2.12.1 DCH will supply the following information to the Contractor:

- Application and database design and development requirements (standards) that is specific to the State of Georgia.
- Networking and data communications requirements (standards) that are specific to the State of Georgia.
- Specific information for integrity controls and audit trail requirements.
- State web portal (Georgia.gov) integration standards and design guidelines.
- Specifications for data files to be transmitted by the Contractor to DCH and/or its agents.
- Specifications for point-to-point, uni-directional or bi-directional interfaces between Contractor and DCH systems.

2.13 READINESS OR ANNUAL REVIEW

2.13.1 DCH will conduct a readiness review of each new CMO at least 30 days prior to Enrollment of Medicaid and/or PeachCare for Kids® recipients in the CMO plan and an annual review of each existing CMO plan. The readiness and financial review will include, at a minimum, one (1) or more as determined by DCH on-site review. DCH will conduct the reviews to provide assurances that the Contractor is able and prepared to perform all administrative functions and is providing for high quality of services to Members.

2.13.2 Specifically, DCH's review will document the status of the Contractor with respect to meeting program standards set forth in this Contract, as well as any goals established by the Contractor. A multidisciplinary team appointed by DCH will conduct the readiness and annual review. The scope of the reviews will include, but not be limited to, review and/or verification of:

- Network Provider composition and access;
- Staff;
- Marketing materials;
- Content of Provider agreements;
- EPSDT plan;
- Member services capability;
- Comprehensiveness of quality and Utilization Management strategies;
- Policies and procedures for the Grievance System and Complaint System;
- Financial solvency;
- Contractor litigation history, current litigation, audits and other government investigations both in Georgia and in other states; and
- Information systems' Claims payment system performance and interfacing capabilities.

The readiness review may assess the Contractor's ability to meet any requirements set forth in this Contract and the documents referenced herein.

Members may not be enrolled in a CMO plan until DCH has determined that the Contractor is capable of meeting these standards. A Contractor's failure to pass the readiness review 30 days prior to the beginning of service delivery may result in immediate Contract termination. Contractor's failure to pass the annual review may result in corrective action and pending contract termination.

DCH will provide the Contractor with a summary of the findings as well as areas requiring remedial action.

3.0 GENERAL CONTRACTOR RESPONSIBILITIES

The Contractor shall immediately notify DCH of any of the following:

- Change in business address, telephone number, facsimile number, and e-mail address;
- Change in corporate status or nature;
- Change in business location;
- Change in solvency;
- Change in corporate officers, executive employees, or corporate structure;
- Change in ownership, including but not limited to the new owner's legal name, business address, telephone number, facsimile number, and e-mail address;
- Change in incorporation status; or
- Change in federal employee identification number or federal tax identification number.
- Change in CMO litigation history, current litigation, audits and other government investigations both in Georgia and in other states.

3.1 The Contractor shall not make any changes to any of the requirements herein, without explicit written approval from Commissioner of DCH, or his or her designee.

4.0 SPECIFIC CONTRACTOR RESPONSIBILITIES

The Contractor shall complete the following actions, tasks, obligations, and responsibilities:

4.1 ENROLLMENT

4.1.1 Enrollment Procedures

4.1.1.1 DCH or its Agent is responsible for Enrollment, including auto-assignment of a CMO plan; Disenrollment; education; and outreach activities. The Contractor shall coordinate with DCH and its Agent as necessary for all Enrollment and Disenrollment functions.

4.1.1.2 DCH or its Agent will make every effort to ensure that recipients ineligible for Enrollment in GF are not enrolled in GF. However, to ensure that such recipients are not enrolled in GF, the Contractor shall assist DCH or its Agent in the identification of recipients that are ineligible for Enrollment in GF, as discussed in Section 1.2.3, should such recipients inadvertently become enrolled in GF.

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

4.1.1.3 The Contractor shall assist DCH or its Agent in the identification of recipients that become ineligible for Medicaid (for example, those who have died, been incarcerated, or moved out-of-state).

4.1.1.4 The Contractor shall accept all individuals for enrollment without restrictions. The Contractor shall not discriminate against individuals on the basis of religion, gender, race, color, or national origin, and will not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color, or national origin or on the basis of health, health status, pre-existing Condition, or need for Health Care services.

4.1.2 Selection of a Primary Care Provider (PCP)

4.1.2.1 At the time of plan selection, Members, with counseling and assistance from DCH or its Agent, will choose an In-Network PCP. If a Member fails to select a PCP, or if the Member has been Auto-Assigned to the CMO plan, the Contractor shall Auto-Assign Members to a PCP based on the following algorithm:

- Assignment shall be made to a Provider with whom, based on FFS Claims history, the Member has a Historical Provider Relationship, provided that the geographic access requirements in 4.8.13 are met;
- If there is no Historical Provider Relationship the Member shall be Auto-Assigned to a Provider who is the assigned PCP for an immediate family member enrolled in the CMO plan, if the Provider is an appropriate Provider based on the age and gender of the Member;
- If other immediate family members do not have an assigned PCP, Auto-Assignment shall be made to a Provider with whom a family member has a Historical Provider Relationship; if the Provider is an appropriate Provider based on the age and gender of the Member;
- If there is no Member or immediate family member historical usage Members shall be Auto-Assigned to a PCP, using an algorithm developed by the Contractor, based on the age and sex of the Member, and geographic proximity.

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

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

4.1.2.2 PCP assignment shall be effective immediately. The Contractor shall notify the Member via surface mail of their Auto-Assigned PCP within ten (10) Calendar Days of Auto-Assignment.

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

4.1.2.3 The Contractor shall submit its PCP Auto-Assignment Policies and Procedures to DCH for review and approval as updated.

4.1.3 Newborn Enrollment

4.1.3.1 All newborns shall be Auto-Assigned by DCH or its Agent to the mother's CMO plan.

4.1.3.2 The Contractor shall be responsible for notifying DCH or its Agent of any Members who are expectant mothers at least sixty (60) Calendar Days prior to the expected date of delivery. The Contractor shall be responsible for notifying DCH or its Agent of newborns born to enrolled members that do not appear on a monthly roster within 60 days after birth.

4.1.3.3 The Contractor shall provide assistance to any expectant mother who contacts them wishing to make a PCP selection for her newborn and record that selection.

4.1.3.4 Within twenty-four (24) hours of the birth, the Contractor shall ensure the submission of a newborn notification form to DCH or its agent. If the mother has made a PCP selection, this information shall be included in the newborn notification form. If the mother has not made a PCP selection, the Contractor shall Auto-Assign the newborn to a PCP within thirty (30) days of the birth. Auto-Assignment shall be made using the algorithm described in Section 4.1.2.1. Notice of the PCP Auto-Assignment shall be mailed to the mother within twenty-four (24) hours.

4.1.4 Reporting Requirements

4.1.4.1 The Contractor shall submit to DCH monthly Member Data Conflict Report (formerly Member Information Reports) as described in Section 4.18.3.7.

4.1.4.2 The Contractor shall submit to DCH monthly Eligibility and Enrollment Reconciliation Reports as described in Section 4.18.3.2.

4.2 DISENROLLMENT

4.2.1 Disenrollment Initiated by the Member or P4HB Participant

4.2.1.1 A Member or P4HB Participant may request Disenrollment from a CMO plan without cause during the ninety (90) Calendar Days following the date of the Member's or P4HB Participants initial Enrollment with the CMO plan or the date DCH or its Agent sends the Member or P4HB Participant notice of the Enrollment, whichever is later. A Member or P4HB Participant may request Disenrollment without cause every twelve (12) months thereafter.

4.2.1.2 A Member or P4HB Participant may request Disenrollment from a CMO plan for cause at any time. The following constitutes cause for Disenrollment by the Member or P4HB Participant:

- The Member or P4HB Participant moves out of the CMO plan's Service Region;
- The CMO plan does not, because of moral or religious objections, provide the Covered Service the Member or P4HB Participant seeks;
- The Member or P4HB Participant needs related services to be performed at the same time and not all related services are available within the network. The Member's or P4HB Participants Provider or another Provider have determined that receiving service separately would subject the Member or P4HB Participant to unnecessary risk;
- The Member or P4HB Participant requests to be assigned to the same CMO plan as family members or P4HB Participants; and
- The Member's or P4HB Participants Medicaid eligibility category changes to a category ineligible for GF, and/or the Member or P4HB Participant otherwise becomes ineligible to participate in GF.
- Other reasons, per 42 CFR 438.56(d)(2), include, but are not limited to, poor quality of care, lack of access to services covered under the Contract, or lack of Providers experienced in dealing with the Member's or P4HB Participants Health Care needs. (DCH or its Agent shall make determination of these reasons.)

4.2.1.3 The Contractor shall provide assistance to Members or P4HB Participants seeking to disenroll. This assistance shall consist of providing the forms to the Member or P4HB Participant and referring the Member or P4HB Participant to DCH or its Agent who will make Disenrollment determinations.

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

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

4.2.2 Disenrollment Initiated by the Contractor

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

4.2.2.1.1 The Contractor shall complete all Disenrollment paperwork for any P4HB Participants it seeks to disenroll.

4.2.2.2 The Contractor shall notify DCH or its Agent upon identification of a Member or P4HB Participant who it knows or believes meets the criteria for Disenrollment, as defined in Section 4.2.3.

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

- The P4HB Participant no longer meets the eligibility criteria for the Demonstration.
- The IPC P4HB Participant has reached the end of the twenty-four (24) months of eligibility for the IPC component of the Demonstration.
- The P4HB Participant becomes pregnant while enrolled in the Demonstration;
- The P4HB Participant becomes infertile through a sterilization procedure;
- The P4HB Participant moves out of the CMO plan's Service Region;
- The P4HB Participant's utilization of services is fraudulent or abusive;
- The Participant's eligibility category changes to a category ineligible for participation in the P4HB program;
- The P4HB Participant has died, been incarcerated, or moved out of State, thereby making her ineligible for Medicaid.

4.2.2.3 Prior to requesting Disenrollment of a Member or P4HB Participant for reasons described in Sections 4.2.3, the Contractor shall document at least three (3) interventions over a period of ninety (90) Calendar Days that occurred through treatment, case management, and Care Coordination to resolve any difficulty leading to the request. The Contractor shall provide at least one (1) written warning to the Member or P4HB Participant, certified return receipt requested, regarding implications of his or her actions. DCH recommends that this notice be delivered within ten (10) Business Days of the Member's or P4HB Participants action.

4.2.2.4 The Contractor shall cite to DCH or its Agent at least one (1) acceptable reason for Disenrollment outlined in Section 4.2.3 before requesting Disenrollment of the Member or P4HB Participant.

4.2.2.5 The Contractor shall submit Disenrollment requests to DCH or its Agent and the Contractor shall honor all Disenrollment determinations made by DCH or its Agent. DCH's decision on the matter shall be final, conclusive and not subject to appeal.

4.2.3 Acceptable Reasons for Disenrollment Requested by Contractor

The Contractor may request Disenrollment if:

- The Member's Utilization of services is Fraudulent or abusive;
- The Member has moved out of the Service Region;
- The Member is placed in a long-term care nursing facility, State institution, or intermediate care facility for the mentally retarded;
- The Member's Medicaid eligibility category changes to a category ineligible for GF, and/or the Member otherwise becomes ineligible to participate in GF. Disenrollments due to Member eligibility will follow the normal monthly process as described in Section 2.4.3. Disenrollments will be processed as of the date that the member eligibility category actually changes and will not be made retroactive, regardless of the effective date of the new eligibility category. Note exception when SSI members are hospitalized.
- The Member has any other condition as so defined by DCH; or
- The Member has died, been incarcerated, or moved out of State, thereby making them ineligible for Medicaid.

4.2.4 Unacceptable Reasons for Disenrollment Requests by Contractor

4.2.4.1 The Contractor shall not request Disenrollment of a Member or P4HB Participant for discriminating reasons, including:

- Adverse changes in a Member's or P4HB Participants health status;
- Missed appointments;
- Utilization of medical services;
- Diminished mental capacity;
- Pre-existing medical condition;
- Uncooperative or disruptive behavior resulting from his or her special needs; or
- Lack of compliance with the treating physician's plan of care.

4.2.4.2 The Contractor shall not request Disenrollment because of the Member's or P4HB Participants attempt to exercise his or her rights under the Grievance System.

4.2.4.3 The request of one PCP to have a Member or P4HB IPC Participant assigned to a different Provider shall not be sufficient cause for the Contractor to request that the Member or P4HB IPC Participant be disenrolled from the plan. Rather, the Contractor shall utilize its PCP assignment process to assign the Member or P4HB IPC Participant to a different and available PCP.

4.3 MEMBER AND P4HB PARTICIPANT SERVICES

4.3.1 General Provisions

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

4.3.2 Requirements for Written Materials

4.3.2.1 The Contractor shall make all written materials available in alternative formats and in a manner that takes into consideration the Member's or P4HB Participants special needs, including those who are visually impaired or have limited reading proficiency. The Contractor shall notify all Members or P4HB Participants and Potential Members that information is available in alternative formats and how to access those formats.

4.3.2.2 The Contractor shall make all written information available in English, Spanish and all other prevalent non-English languages, as defined by DCH. For the purposes of this Contract, prevalent means a non-English language spoken by a significant number or percentage of Medicaid and PeachCare for Kids® eligible individuals in the State.

4.3.2.3 All written materials distributed to Members or P4HB Participants shall include a language block, printed in Spanish and all other prevalent non-English languages, that informs the Member or P4HB Participant that the document contains important information and directs the Member to call the Contractor to request the document in an alternative language or to have it orally translated.

4.3.2.4 All written materials shall be worded such that they are understandable to a person who reads at the fifth (5^{th}) grade level. Suggested reference materials to determine whether this requirement is being met are:

- Fry Readability Index;
- PROSE The Readability Analyst (software developed by Education Activities, Inc.);
- Gunning FOG Index;
- McLaughlin SMOG Index;
- The Flesch-Kincaid Index; or
- Other word processing software approved by DCH.

4.3.2.5 The Contractor shall provide written notice to DCH of any changes to any written materials provided to the Members or P4HB Participant. Written notice shall be provided at least thirty (30) Calendar Days before the effective date of the change.

4.3.2.6 The Contractor must submit all written materials, including information for the Web site, to DCH for approval prior to use or mailing. DCH will approve or identify any required changes to the member or P4HB Participant materials within 30 days of submission. DCH reserves the right to require the discontinuation of any member materials that violate the terms of this contract.

4.3.3 Member Handbook and P4HB Participants Information Requirements

4.3.3.1 The Contractor shall mail to all newly enrolled Members a Member Handbook within ten (10) Calendar Days of receiving the notice of enrollment from DCH or its Agent. The Contractor shall mail to all enrolled Member households a Member Handbook every other year thereafter unless requested sooner by the member.

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

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

4.3.3.2 Pursuant to the requirements set forth in 42 CFR 438.10, the Member Handbook shall include, but not be limited to:

- A table of contents;
- Information about the roles and responsibilities of the Member (this information to be supplied by DCH);
- Information about the role of the PCP;
- Information about choosing a PCP;
- Information about what to do when family size changes;
- Appointment procedures;
- Information on Benefits and services, including a description of all available GF Benefits and services;
- Information on how to access services, including Health Check services, non-emergency transportation (NET) services, and maternity and family planning services;
- An explanation of any service limitations or exclusions from coverage;
- A notice stating that the Contractor shall be liable only for those services authorized by the Contractor;
- Information on where and how Members may access Benefits not available from or not covered by the Contractor;
- The Medical Necessity definition used in determining whether services will be covered;
- A description of all pre-certification, prior authorization or other requirements for treatments and services;
- The policy on Referrals for specialty care and for other Covered Services not furnished by the Member's PCP;
- Information on how to obtain services when the Member is out of the Service Region and for after-hours coverage;
- Cost-sharing;

- The geographic boundaries of the Service Regions;
- Notice of all appropriate mailing addresses and telephone numbers to be utilized by Members seeking information or authorization, including an inclusion of the Contractor's toll-free telephone line and Web site;
- A description of Utilization Review policies and procedures used by the Contractor;
- A description of Member rights and responsibilities as described in Section 4.3.4;
- The policies and procedures for Disenrollment;
- Information on Advance Directives;
- A statement that additional information, including information on the structure and operation of the CMO plan and physician incentive plans, shall be made available upon request;

4.3.3.3 Information on the extent to which, and how, after-hours and emergency coverage are provided, including the following:

i. What constitutes an Urgent and Emergency Medical Condition, Emergency Services, and Post-Stabilization Services;

ii. The fact that Prior Authorization is not required for Emergency Services;

iii. The process and procedures for obtaining Emergency Services, including the use of the 911 telephone systems or its local equivalent;

iv. The locations of any emergency settings and other locations at which Providers and hospitals furnish Emergency Services and Post-Stabilization Services covered herein; and

v. The fact that a Member has a right to use any hospital or other setting for Emergency Services;

4.3.3.4 Information on the Grievance Systems policies and procedures, as described in Section 4.14 of this Contract. This description must include the following:

i. The right to file a Grievance and Appeal with the Contractor;

ii. The requirements and timeframes for filing a Grievance or Appeal with the Contractor;

iii. The availability of assistance in filing a Grievance or Appeal with the Contractor;

iv. The toll-free numbers that the Member can use to file a Grievance or an Appeal with the Contractor by phone;

v. The right to a State Administrative Law Hearing, the method for obtaining a hearing, and the rules that govern representation at the hearing;

vi. Notice that if the Member files an Appeal or a request for a State Administrative Law Hearing within the timeframes specified for filing, the Member may be required to pay the cost of services furnished while the Appeal is pending, if the final decision is adverse to the Member; and

vii. Any Appeal rights that the State chooses to make available to Providers to challenge the failure of the Contractor to cover a service.

4.3.3.5 The Contractor shall submit to DCH for review and approval any changes and edits to the Member Handbook at least thirty (30) Calendar Days before the effective date of change.

4.3.4 Member and P4HB Participant Rights

4.3.4.1 The Contractor shall have written policies and procedures regarding the rights of Members and shall comply with any applicable federal and State laws and regulations that pertain to Member rights. These rights shall be included in the Member Handbook. At a minimum, said policies and procedures shall specify the Member's right to:

- Receive information pursuant to 42 CFR 438.10;
- Be treated with respect and with due consideration for the Member's dignity and privacy;
- Have all records and medical and personal information remain confidential;
- Receive information on available treatment options and alternatives, presented in a manner appropriate to the Member's Condition and ability to understand;
- Participate in decisions regarding his or her Health Care, including the right to refuse treatment;
- Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience or retaliation, as specified in other federal regulations on the use of restraints and seclusion;
- Request and receive a copy of his or her Medical Records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;
- Be furnished Health Care services in accordance with 42 CFR 438.206 through 438.210;
- Freely exercise his or her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the Member is treated;
- Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the Covered Services provided to the Member for which DCH does not pay the Contractor; not be held liable for Covered Services provided to the Member for which DCH or the CMO plan does not pay the Health Care Provider that furnishes the services; and not be held liable for payments of Covered Services furnished under a contract, Referral, or other arrangement to the extent that those payments are in excess of amount the Member would owe if the Contractor provided the services directly; and
- Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60 and Attachment K of this Contract.

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

- Receive information pursuant to 42CFR 438.10;
- Be treated with respect and with due consideration for the P4HB Participant's dignity and privacy;
- Have all records and medical and personal information remain confidential;
- Receive information on available Demonstration related treatment options and alternatives, presented in a manner appropriate to the P4HB Participant's condition and ability to understand;
- Participate in decisions regarding her Demonstration services;
- Request and receive a copy of her Medical Records pursuant to 45 CFR 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR 164.524 and 164.526;
- Be furnished Demonstration related Services in accordance with 42 CFR 438.206 through 438.210 as appropriate;
- Freely exercise her rights, including those related to filing a Grievance or Appeal, and that the exercise of these rights will not adversely affect the way the P4HB Participant is treated;
- Not be held liable for the Contractor's debts in the event of insolvency; not be held liable for the Demonstration related Services provided to the P4HB Participant for which DCH does not pay the Contractor; not be held liable for Demonstration related Services provided to the P4HB Participant for which neither DCH nor the CMO pays the Demonstration Provider that furnishes the Demonstration related Services; and not be held liable for payments of Demonstration related Services furnished under a contract, Referral, or other arrangement to the extent that those payments are in excess of the amount the P4HB Participant would owe if the Contractor provided the services directly; and
- Only be responsible for cost sharing in accordance with 42 CFR 447.50 through 42 CFR 447.60 and Attachment K of this Contract.

4.3.5 Provider Directory

4.3.5.1 The Contractor shall mail via surface mail a Provider Directory to all new Members or P4HB Participants within ten (10) Calendar Days of receiving the notice of Enrollment from DCH or the State's Agent.

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

4.3.5.3 The Contractor shall submit the Provider Directory to DCH for review and prior approval as updated.

4.3.5.4 The Contractor shall up-date and amend the Provider Directory on its Web site within five (5) Business Days of any changes, produces and distributes quarterly up-dates to all Members or P4HB Participants, and re-print the Provider Directory and distribute to all Members at least once per year.

4.3.5.5 The Contractor shall post on its website a searchable list of all providers with which the care management organization has contracted. At a minimum, this list shall be searchable by provider name, specialty, and location.

4.3.6 Member and P4HB Participant Identification (ID) Card

4.3.6.1 The Contractor shall mail via surface mail a Member ID Card to all new Members according to the following timeframes:

- Within ten (10) Calendar Days of receiving the notice of Enrollment from DCH or the Agent for Members who have selected a CMO plan and a PCP;
- Within ten (10) Calendar Days of PCP assignment or selection for Members that are Auto-Assigned to the CMO plan.

4.3.6.2 The Member ID Card must, at a minimum, include the following information:

- The Member's name;
- The Member's Medicaid or PeachCare for Kids® identification number;
- The PCP's name, address, and telephone numbers (including after-hours number if different from business hours number);
- The name and telephone number(s) of the Contractor;
- The Contractor's twenty-four (24) hour, seven (7) day a week toll-free Member services telephone number;
- Instructions for emergencies; and
- Includes minimum or instructions to facilitate the submission of a claim by a Provider.

4.3.6.3 The Contractor shall reissue the Member ID Card within ten (10) Calendar Days of notice if a Member reports a lost card, there is a Member name change, the PCP changes, or for any other reason that results in a change to the information disclosed on the Member ID Card.

4.3.6.4 The Contractor shall submit a front and back sample Member ID Card to DCH for review and approval as updated.

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

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

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

4.3.7 Toll-free Member and P4HB Participant Services Line

4.3.7.1 The Contractor shall operate a toll-free telephone line to respond to Member and P4HB Participant questions, comments and inquiries.

4.3.7.2 The Contractor shall develop Telephone Line Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

4.3.7.3 The Contractor shall submit these Telephone Line Policies and Procedures, including performance standards pursuant to Section 4.3.7.7, to DCH for review and approval as updated.

4.3.7.4 The telephone line shall handle calls from non-English speaking callers, as well as calls from Members and P4HB Participants who are hearing impaired.

4.3.7.5 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment L.

4.3.7.6 The telephone line shall be fully staffed between the hours of 7:00 a.m. and 7:00 p.m. EST, Monday through Friday, excluding State holidays. The telephone line staff shall be trained to accurately respond to Member and P4HB Participant questions in all areas, including, but not limited to, Covered Services, the provider network, and non-emergency transportation (NET).

4.3.7.7 The Contractor shall develop performance standards and monitor Telephone Line performance by recording calls and employing other monitoring activities. At a minimum, the standards shall require that, on a monthly basis, eighty percent (80%) of calls are answered by a person within thirty (30) seconds, the Blocked Call rate does not exceed one percent (1%), and the rate of Abandoned Calls does not exceed five percent (5%).

4.3.7.8 The Contractor shall have an automated system available between the hours of 7:00 p.m. and 7:00 a.m. EST Monday through Friday and at all hours on weekends and holidays. This automated system must provide callers with operating instructions on what to do in case of an emergency and shall include, at a minimum, a voice mailbox for callers to leave messages. The Contractor shall ensure that the voice mailbox has adequate capacity to receive all messages. A Contractor's Representative shall return messages on the next Business Day.

4.3.7.9 The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Telephone Line. The Contractor shall submit the Call Center Quality Criteria and Protocols to DCH for review and approval annually.

4.3.8 Internet Presence/Web Site

4.3.8.1 The Contractor shall provide general and up-to-date information about the CMO plan's program, its Provider network, its customer services, and its Grievance and Appeals Systems on its Web site.

4.3.8.2 The Contractor shall maintain a Member and P4HB Participant portal that allows Members to access a searchable Provider Directory that shall be updated within five (5) Business Days upon changes to the Provider network.

4.3.8.3 The Web site must have the capability for Members and P4HB Participants to submit questions and comments to the Contractor and for members to receive responses.

4.3.8.4 The Web site must comply with the marketing policies and procedures and with requirements for written materials described in this Contract and must be consistent with applicable State and federal laws.

4.3.8.5 In addition to the specific requirements above, the Contractor's Web site shall be functionally equivalent, with respect to functions described in this Contract, to the Web site maintained by the State's Medicaid fiscal agent. www.ghp.georgia.gov/wps/portal

4.3.8.6 The Contractor shall submit Web site screenshots to DCH for review and approval as updated.

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

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

4.3.9 Cultural Competency

4.3.9.1 In accordance with 42 CFR 438.206, the Contractor shall have a comprehensive written Cultural Competency Plan describing how the Contractor will ensure that services are provided in a culturally competent manner to all Members and P4HB Participants, including those with limited English proficiency. The Cultural Competency Plan must describe how the Providers, individuals and systems within the CMO plan will effectively provide services to people of all cultures, races, ethnic backgrounds and religions in a manner that recognizes values, affirms and respects the worth of the individual Members and P4HB Participants and protects and preserves the dignity of each.

4.3.9.2 The Contractor shall submit the Cultural Competency Plan to DCH for review and approval as updated.

4.3.9.3 The Contractor may distribute a summary of the Cultural Competency Plan to the In-Network Providers if the summary includes information on how the Provider may access the full Cultural Competency Plan on the Web site. This summary shall also detail how the Provider can request a hard copy from the CMO at no charge to the Provider.

4.3.10 Translation Services

4.3.10.1 The Contractor is required to provide oral translation services of information to any Member or P4HB Participant who speaks any non-English language regardless of whether a Member or P4HB Participant speaks a language that meets the threshold of a Prevalent Non-English Language. The Contractor is required to notify its Members or P4HB Participants of the availability of oral interpretation services and to inform them of how to access oral interpretation services. There shall be no charge to the Member or P4HB Participant for translation services.

4.3.11 Reporting Requirements

4.3.11.1 The Contractor shall submit monthly Telephone and Internet Activity Reports to DCH as described in Section 4.18.3.1

4.3 MARKETING

4.4.1 Prohibited Activities

4.4.1.1 The Contractor is prohibited from engaging in the following activities:

- Directly or indirectly engaging in door-to-door, telephone, or other Cold-Call Marketing activities to Potential Members or P4HB Participants;
- Offering any favors, inducements or gifts, promotions, and/or other insurance products that are designed to induce Enrollment in the Contractor's plan, and that are not health related and/or worth more than $10.00 cash;
- Distributing information plans and materials that contain statements that DCH determines are inaccurate, false, or misleading. Statements considered false or misleading include, but are not limited to, any assertion or statement (whether written or oral) that the recipient must enroll in the Contractor's plan in order to obtain Benefits or in order to not lose Benefits or that the Contractor's plan is endorsed by the federal or State government, or similar entity; and
- Distributing information or materials that, according to DCH, mislead or falsely describe the Contractor's Provider network, the participation or availability of network Providers, the qualifications and skills of network Providers (including their bilingual skills); or the hours and location of network services.

4.4.2 Allowable Activities

4.4.2.1 The Contractor shall be permitted to perform the following marketing activities:

- Distribute general information through mass media (i.e. newspapers, magazines and other periodicals, radio, television, the Internet, public transportation advertising, and other media outlets);
- Make telephone calls, mailings and home visits only to Members currently enrolled in the Contractor's plan, for the sole purpose of educating them about services offered by or available through the Contractor;
- Distribute brochures and display posters at Provider offices and clinics that inform patients that the clinic or Provider is part of the CMO plan's Provider network, provided that all CMO plans in which the Provider participates have an equal opportunity to be represented; and
- Attend activities that benefit the entire community such as health fairs or other health education and promotion activities.

4.4.2.2 If the Contractor performs an allowable activity, the Contractor shall conduct these activities in the entire Service Region as defined by this Contract.

4.4.2.3 All materials shall comply with the information requirements in 42 CFR 438.10 and detailed in Section 4.3.2 of this Contract.

4.4.3 State Approval of Materials

The Contractor shall submit a detailed description of its Marketing Plan and copies of all Marketing Materials (written and oral) it or its Subcontractors plan to distribute to DCH for review and approval as updated.

4.4.3.1 This requirement includes, but is not limited to posters, brochures, Web sites, and any materials that contain statements regarding the benefit package and Provider network-related materials. Neither the Contractor nor its Subcontractors shall distribute any marketing materials without prior, written approval from DCH.

4.4.3.2 The Contractor shall submit any changes to previously approved marketing materials and receive approval from DCH of the changes before distribution.

4.4.4 Provider Marketing Materials

The Contractor shall collect from its Providers any Marketing Materials they intend to distribute and submit these to DCH for review and approval prior to distribution.

4.5 COVERED BENEFITS AND SERVICES

4.5.1 Included Services

4.5.1.1 The Contractor shall at a minimum provide Medically Necessary services and Benefits pursuant to the Georgia State Medicaid Plan, and the Georgia Medicaid Policies and Procedures Manuals. Such Medically Necessary services shall be furnished in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under Fee-for-Service Medicaid. The Contractor may not arbitrarily deny or reduce the amount, duration or scope of a required service solely because of the diagnosis, type of illness or Condition.

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

4.5.2 Individuals with Disabilities Education Act (IDEA) Services

4.5.2.1 For Members up to and including age two (2), the Contractor shall be responsible for Medically Necessary IDEA Part C services provided pursuant to an Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP).

4.5.2.2 For Members age 3-21, the Contractor shall not be responsible for Medically Necessary IDEA Part B services provided pursuant to an IEP or IFSP. Such services shall remain in FFS Medicaid.

4.5.2.2.1 The Contractor shall be responsible for all other Medically Necessary covered services.

4.5.3 Enhanced Services

4.5.3.1 In addition to the Covered Services provided above, the Contractor shall do the following:

- Place strong emphasis on programs to enhance the general health and well-being of Members;
- Make health promotion materials available to Members;
- Participate in community-sponsored health fairs; and
- Provide education to Members, families and other Health Care Providers about early intervention and management strategies for various illnesses.

4.5.3.2 The Contractor shall not charge a Member for participating in health education services that are defined as either enhanced or Covered Services.

4.5.4 Medical Necessity

4.5.4.1 Based upon generally accepted medical practices in light of Conditions at the time of treatment, Medically Necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating Provider and the omission of which could adversely affect the eligible Member's medical Condition;
- Compatible with the standards of acceptable medical practice in the community;
- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms;
- Not provided solely for the convenience of the Member or the convenience of the Health Care Provider or hospital; and
- Not primarily custodial care unless custodial care is a covered service or benefit under the Members evidence of coverage.

4.5.4.2 There must be no other effective and more conservative or substantially less costly treatment, service and setting available.

4.5.4.3 For children under 21, the Contractor is required to provide medically necessary services to correct or ameliorate physical and behavioral health disorders, a defect, or a condition identified in an EPSDT (Health Check) screening, regardless whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905 (a) of the Social Security Act. See Diagnostic and Treatment, Section 4.7.5.2.

4.5.5 Experimental, Investigational or Cosmetic Procedures, Drugs, Services, or Devices

4.5.5.1 Pursuant to the Georgia State Medicaid Plan and the Georgia Medicaid Policies and Procedures Manuals, in no instance shall the Contractor cover experimental, investigational or cosmetic procedures, drugs, services or devices or those not recognized by the Federal Drug Administration, the United States Public Health Service, Medicaid and/or the Department's contracted peer review organization as universally accepted treatment.

4.5.6 Moral or Religious Objections

4.5.6.1 The Contractor is required to provide and reimburse for all Covered Services. If, during the course of the Contract period, pursuant to 42 CFR 438.102, the Contractor elects not to provide, reimburse for, or

provide coverage of a counseling or Referral service because of an objection on moral or religious grounds, the Contractor shall notify:

- DCH within one hundred and twenty (120) Calendar Days prior to adopting the policy with respect to any service;
- Members within ninety (90) Calendar Days after adopting the policy with respect to any service; and
- Members and Potential Members before and during Enrollment.

4.5.6.2. The Contractor acknowledges that such objection will be grounds for recalculation of rates paid to the Contractor.

4.6 SPECIAL COVERAGE PROVISIONS

4.6.1 Emergency Services

4.6.1.1 Emergency Services shall be available twenty-four (24) hours a day, seven (7) Days a week to treat an Emergency Medical Condition.

4.6.1.2 An Emergency Medical Condition shall not be defined or limited based on a list of diagnoses or symptoms. An Emergency Medical Condition is a medical or mental health Condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman having contractions: (i) That there is inadequate time to affect a safe transfer to another hospital before delivery, or (ii) That transfer may pose a threat to the health or safety of the woman or the unborn child.

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

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

4.6.1.4 The Contractor shall base coverage decisions for Emergency Services on the severity of the symptoms at the time of presentation and shall cover Emergency Services when the presenting symptoms are of sufficient severity to constitute an Emergency Medical Condition in the judgment of a prudent layperson.

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

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

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

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

4.6.1.7 The Contractor may establish guidelines and timelines for submittal of notification regarding provision of emergency services, but, the Contractor shall not refuse to cover an Emergency Service based on the emergency room Provider, hospital, or fiscal agent's failure to notify the Member's PCP, CMO plan representative, or DCH of the Member's screening and treatment within said timeframes.

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

4.6.1.8 When a representative of the Contractor instructs the Member to seek Emergency Services the Contractor shall be responsible for payment for the Medical Screening examination and for other Medically Necessary Emergency Services, without regard to whether the Condition meets the prudent layperson standard.

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

4.6.1.9 The Member who has an Emergency Medical Condition shall not be held liable for payment of subsequent screening and treatment needed to diagnose the specific Condition or stabilize the patient.

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

4.6.1.10 Once the Member's Condition is stabilized, the Contractor may require Pre-Certification for hospital admission or Prior Authorization for follow-up care.

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

4.6.2 Post-Stabilization Services

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

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

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

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

- The Contractor does not respond to the Provider's request for pre-certification or prior authorization within one (1) hour;
- The Contractor cannot be contacted; or
- The Contractor's Representative and the attending physician cannot reach an agreement concerning the Member's care and a CMO plan physician is not available for consultation. In this situation the Contractor shall give the treating physician the opportunity to consult with an In-Network physician and the treating physician may continue with care of the Member until a CMO plan physician is reached or one of the criteria in Section 4.6.2.5 are met.

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

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

4.6.2.6 In the event the Member receives Post-Stabilization Services from a Provider outside the Contractor's network, the Contractor is prohibited from charging the Member more than he or she would be charged if he or she had obtained the services through an In-Network Provider.

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

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

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

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

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

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

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

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

4.6.3 Urgent Care Services

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

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

4.6.4 Family Planning Services

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

4.6.4.2 The Contractor shall inform Members and P4HB Participants of the availability of family planning services and must provide services to Members and P4HB Participants wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy.

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

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

4.6.4.4 The Contractor shall furnish all services on a voluntary and confidential basis, even if the Member is less than eighteen (18) years of age.

4.6.5 Sterilizations, Hysterectomies and Abortions

4.6.5.1 In compliance with federal regulations, the Contractor shall cover sterilizations and hysterectomies, only if all of the following requirements are met:

- The Member is at least twenty-one (21) years of age at the time consent is obtained;
- The Member is mentally competent;
- The Member voluntarily gives informed consent in accordance with the State Policies and Procedures for Family Planning Clinic Services. This includes the completion of all applicable documentation;
- At least thirty (30) Calendar Days, but not more than one hundred and eighty (180) Calendar Days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery. A Member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery, if at least seventy-two (72) hours have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty (30) Calendar Days before the expected date of delivery (the expected date of delivery must be provided on the consent form);
- An interpreter is provided when language barriers exist. Arrangements are to be made to effectively communicate the required information to a Member who is visually impaired, hearing impaired or otherwise disabled; and
- The Member is not institutionalized in a correctional facility, mental hospital or other rehabilitative facility.

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

- The P4HB Participant is at least twenty-one (21) years of age at the time consent is obtained;

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

4.6.5.2 A hysterectomy shall be considered a Covered Service only if the following additional requirements are met:

- The Member must be informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and
- The Member must sign and date the Georgia Families Sterilization Request Consent form prior to the Hysterectomy. Informed consent must be obtained regardless of diagnosis or age.

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

4.6.5.3 Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

- If it is performed solely for the purpose of rendering a Member permanently incapable of reproducing;
- If there is more than one (1) purpose for performing the hysterectomy, but the primary purpose was to render the Member permanently incapable of reproducing; or
- If it is performed for the purpose of cancer prophylaxis.

4.6.5.3.1 Abortions or abortion-related services performed for family planning purposes are not Covered Services. Abortions are Covered Services if a Provider certifies that the abortion is medically necessary to save the life of the mother or if pregnancy is the result of rape or incest. The Contractor shall cover treatment of medical complications occurring as a result of an elective abortion and treatments for spontaneous, incomplete, or threatened abortions and for ectopic pregnancies.

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

4.6.5.4 The Contractor shall maintain documentation of all sterilizations, hysterectomies and abortions and provide documentation to DCH upon the request of DCH.

4.6.6 Pharmacy

4.6.6.1 The Contractor shall provide pharmacy services either directly or through a Pharmacy Benefits Manager (PBM). The Contractor or its PBM may establish a drug formulary if the following minimum requirements are met:

- Drugs from each specific therapeutic drug class are included and are sufficient in amount, duration, and scope to meet Members' medical needs;
- The only excluded drug categories are those permitted under section 1927(d) of the Social Security Act;
- A Pharmacy & Therapeutics Committee that advises and/or recommends formulary decisions; and
- Over-the-counter medications specified in the Georgia State Medicaid Plan are included in the formulary.

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

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

4.6.6.2 The Contractor shall provide the formulary to DCH upon the request of DCH.

4.6.6.3 If the Contractor chooses to implement a mail-order pharmacy program, any such program must be accordance with State and federal law.

4.6.7 Immunizations

4.6.7.1 The Contractor shall provide all Members less than twenty-one (21) years of age with all vaccines and immunizations in accordance with the Advisory Committee on Immunization Practices (ACIP) guidelines.

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

4.6.7.2 The Contractor shall ensure that all Providers use vaccines which have been made available, free of cost, under the Vaccine for Children (VFC) program for Medicaid children eighteen (18) years old and younger. Immunizations shall be given in conjunction with Well-Child/Health Check care.

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

4.6.7.3 The Contractor shall ensure that all Providers administer appropriate vaccines to the PeachCare for Kids® children eighteen (18) years old and younger. Immunizations shall be given in conjunction with Well-Child/Health Check care.

4.6.7.4 The Contractor shall provide all adult immunizations specified in the Georgia Medicaid Policies and Procedures Manuals.

4.6.7.5 The Contractor shall report all immunizations to the Georgia Registry of Immunization Transactions and Services (GRITS) in a format to be determined by DCH.

4.6.8 Transportation

4.6.8.1 The Contractor shall provide emergency transportation and shall not retroactively deny a Claim for emergency transportation to an emergency Provider because the Condition, which appeared to be an Emergency Medical Condition under the prudent layperson standard, turned out to be non-emergency in nature.

4.6.8.2 The Contractor is not responsible for providing non-emergency transportation (NET) but the Contractor shall coordinate with the NET vendors for services required by Members. Non-Emergency Transportation is excluded for Peach Care for Kids™ members.

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

4.6.9 Perinatal Services

4.6.9.1 The Contractor shall ensure that appropriate perinatal care is provided to women and newborn Members. The Contractor shall have adequate capacity such that any new Member who is pregnant is able to have an initial visit with her Provider within fourteen (14) Calendar Days of Enrollment. The Contractor shall have in place a system that provides, at a minimum, the following services:

- Pregnancy planning and perinatal health promotion and education for reproductive-age women;
- Perinatal risk assessment of non-pregnant women, pregnant and post-partum women, and newborns and children up to five (5) months of age;
- Childbirth education classes to all pregnant Members and their chosen partner. Through these classes, expectant parents shall be encouraged to prepare themselves physically, emotionally, and intellectually for the childbirth experience. The classes shall be offered at times convenient to the population served, in locations that are accessible, convenient and comfortable. Classes shall be offered in languages spoken by the Members.
- Access to appropriate levels of care based on risk assessment, including emergency care;
- Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
- Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
- Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

4.6.9.2 The Contractor shall provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to

forty-eight (48) hours following an uncomplicated vaginal delivery and ninety-six (96) hours following an uncomplicated Caesarean delivery.

4.6.10 Parenting Education

4.6.10.1 In addition to individual parent education and anticipatory guidance to parents and guardians at preventive pediatric visits and Health Check screens, the Contractor shall offer or arrange for parenting skills education to expectant and new parents, at no cost to the Member.

4.6.10.2 The Contractor agrees to create effective ways to deliver this education, whether through classes, as a component of post-partum home visiting, or other such means. The educational efforts shall include topics such as bathing, feeding (including breast feeding), injury prevention, sleeping, illness, when to call the doctor, when to use the emergency room, etc. The classes shall be offered at times convenient to the population served, and in locations that are accessible, convenient and comfortable. Convenience will be determined by DCH. Classes shall be offered in languages spoken by the Members.

4.6.11 Mental Health and Substance Abuse

4.6.11.1 The Contractor shall have written Mental Health and Substance Abuse Policies and Procedures that explain how they will arrange or provide for covered mental health and substance abuse services. Such policies and procedures shall include Advance Directives. The Contractor shall assure timely delivery of mental health and substance abuse services and coordination with other acute care services.

4.6.11.2 Mental Health and Substance Abuse Policies and Procedures shall be submitted to DCH for approval as updated.

4.6.11.3 The Contractor shall permit Members to self-refer to an In-Network Provider for an initial mental health or substance abuse visit but prior authorization may be required for subsequent visits.

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

4.6.12 Advance Directives

4.6.12.1 In compliance with 42 CFR 438.6 (i) (1)-(2) and 42 CFR 422.128, the Contractor shall maintain written policies and procedures for Advance Directives, including mental health advance directives. Such Advance Directives shall be included in each Member's and P4HB Participants medical record. The Contractor shall provide these policies to all Members and P4HB Participants eighteen (18) years of age and older and shall advise Members and P4HB Participants of:

4.6.12.1.1 Their rights under the law of the State of Georgia, including the right to accept or refuse medical or surgical treatment and the right to formulate Advance Directives; and

4.6.12.1.2 The Contractor's written policies respecting the implementation of those rights, including a statement of any limitation regarding the implementation of Advance Directives as a matter of conscience.

4.6.12.2 The information must include a description of State law and must reflect changes in State laws as soon as possible, but no later than ninety (90) Calendar Days after the effective change.

4.6.12.3 The Contractor's information must inform Members and P4HB Participants that complaints may be filed with the State's Survey and Certification Agency.

4.6.12.4 The Contractor shall educate its staff about its policies and procedures on Advance Directives, situations in which Advance Directives may be of benefit to Members and P4HB Participants, and their responsibility to educate Members and P4HB Participants about this tool and assist them to make use of it.

4.6.12.5 The Contractor shall educate Members and P4HB Participants about their ability to direct their care using this mechanism and shall specifically designate which staff Members and P4HB Participants and/or network Providers are responsible for providing this education.

4.6.13 Foster Care Forensic Exam

4.6.13.1 The Contractor shall provide a forensic examination to a Member that is less than eighteen (18) years of age that is placed outside the home in State custody. Such exam shall be in accordance with State law and regulations.

4.6.14 Laboratory Services

4.6.14.1 The Contractor shall require all network laboratories to automatically report the Glomerular Filtration Rate (GFR) on any serum creatinine tests ordered by In-Network Providers.

4.6.15 Member Cost-Sharing

4.6.15.1 The Contractor shall ensure that Providers collect Member co-payments as specified in Attachment K.

4.7 EARLY AND PERIODIC SCREENING, DIAGNOSTIC AND TREATMENT (EPSDT) PROGRAM: HEALTH CHECK

4.7.1 General Provisions

4.7.1.1 The Contractor shall provide EPSDT services (called Health Check services) to Medicaid children less than twenty-one (21) years of age and PeachCare for Kids® children less than age nineteen (19) years of age (hereafter referred to as Health Check eligible children), in compliance with all requirements found below.

4.7.1.2 The Contractor shall comply with sections 1902(a)(43) and 1905(a)(4)(B) and 1905(r) of the Social Security Act and federal regulations at 42 CFR 441.50 that require EPSDT services to include outreach and informing, screening, tracking, and, diagnostic and treatment services. The Contractor shall comply with all Health Check requirements pursuant to the Georgia Medicaid Policies and Procedures Manuals.

4.7.1.3 The Contractor shall develop an EPSDT Plan that includes written policies and procedures for conducting outreach, informing, tracking, and follow-up to ensure compliance with the Health Check periodicity schedules. The EPSDT Plan shall emphasize outreach and compliance monitoring for children and adolescents (young adults), taking into account the multi-lingual, multi-cultural nature of the GF population, as well as other unique characteristics of this population. The plan shall include procedures for follow-up of missed appointments, including missed Referral appointments for problems identified through Health Check screens and exams. The plan shall also include procedures for referral, tracking and follow up for annual dental examinations and visits. The Contractor shall submit its EPSDT Plan to DCH for review and approval as updated.

4.7.1.4 The contractor shall ensure Providers perform a full EPSDT (Early and Periodic Screening Diagnostic and Treatment) visit according to the periodic schedule approved by DCH. The visit must include a comprehensive history, unclothed physical examination, appropriate immunizations, lead screening and testing per CMS requirements, and health education/anticipatory guidance. All five (5) components must be performed for the visit to be considered an EPSDT visit.

4.7.2 Outreach and Informing

4.7.2.1 The Contractor's Health Check outreach and informing process shall include:

- The importance of preventive care;
- The periodicity schedule and the depth and breadth of services;
- How and where to access services, including necessary transportation and scheduling services; and
- A statement that services are provided without cost.

4.7.2.2 The Contractor shall inform its newly enrolled families with Health Check eligible children about the Health Check program within sixty (60) Calendar Days of Enrollment with the plan. This requirement includes informing pregnant women and new mothers, either before or within seven (7) days after the birth of their children, that Health Check services are available.

4.7.2.3 The Contractor shall provide written notification to its families with Health Check eligible children when appropriate periodic assessments or needed services are due.

4.7.2.4 The Contractor shall provide to each PCP, on a monthly basis, a list of the PCP's Health Check eligible children that appear not to have had an encounter during the initial one hundred and twenty (120) Calendar Days of CMO plan Enrollment, and/or are not in compliance with the Health Check periodicity schedule. The Contractor and/or the PCP shall contact the Members' parents or guardians to schedule an appointment for those screens and services that appear not to be in compliance with the Health Check periodicity schedule. If the PCP has medical record evidence that appropriate screens have occurred for the member, the Contractor must incorporate this information into its tracking system and remove the member from the PCP's list of non compliant Health Check screenings.

4.7.2.5 Informing may be oral (on the telephone, face-to-face, or films/tapes) or written and may be done by Contractor personnel or Health Care Providers. All outreach and informing shall be documented and shall be conducted in non-technical language at or below a fifth (5^{th}) grade reading level. The Contractor shall use accepted methods for informing persons who are blind or deaf, or cannot read or understand the English language, in accordance with Section 4.3.2 of this Contract.

4.7.2.6 The Contractor may provide incentives to Members and/or Providers to encourage compliance with periodicity schedules. Such incentives shall be established in accordance with all applicable State and Federal laws, rules and regulations. Additionally, Member incentives must be of nominal value ($10 or less per item or $50 in the aggregate on an annual basis) and may include gift cards so long as such gift cards are not redeemable for cash or Co-payments.

4.7.2.7 In accordance with 42 CFR 1003.101, the Nominal Value requirement stated herein is not applicable where the incentive is offered to promote the delivery of preventive care services, provided:
1) the delivery of the preventive services is not tied (directly or indirectly) to the provision of other services reimbursed in whole or in part by Medicare or Medicaid;
2) the incentive is not cash or an instrument convertible to cash; and
3) the value of the incentive is not disproportionally large in relationship to the value of the preventive care service (i.e., either the value of the service itself or the future health care costs reasonably expected to be avoided as a result of the preventive care).

4.7.3 Screening

4.7.3.1 The Contractor is responsible for periodic screens in accordance with the State's periodicity schedule. Such screens must include all of the following:

- A comprehensive health and developmental history;
- Developmental assessment, including mental, emotional, and behavioral health development;
- Measurements (including head circumference for infants);
- An assessment of nutritional status;
- A comprehensive unclothed physical exam;
- Immunizations according to the Advisory Committee of Immunization Practices (ACIP);
- Certain laboratory tests (including the federally required blood lead screening);
- Anticipatory guidance and health education;
- Vision screening;
- Tuberculosis and lead risk screening;
- Hearing screening; and
- Dental and oral health assessment.

4.7.3.2 The Contractor shall provide for a blood lead screening test for all Health Check eligible children at twelve (12) and twenty-four (24) months of age. Children between thirty-six (36) months of age and seventy-two (72) months of age should receive a blood lead screening test if there is no record of a previous test.

4.7.3.3 The Contractor shall have a lead case management program for Health Check eligibles and their households when there is a positive blood lead test equal to or greater than ten (10) micrograms per deciliter. The lead case management program shall include education, a written case management plan that includes all necessary referrals, coordination with other specific agencies, environmental lead assessments, and aggressive pursuit of non-compliance with follow-up tests and appointments. The contractor must ensure reporting of all blood lead levels to the Department of Public Health.

4.7.3.4 The Contractor shall have procedures for Referral to and follow up with oral health professionals, including annual dental examinations and services by an oral health professional.

4.7.3.5 The Contractor shall provide inter-periodic screens, which are screens that occur between the complete periodic screens and are Medically Necessary to determine the existence of suspected physical or mental illnesses or Conditions. This includes at a minimum vision and hearing services.

4.7.3.6 The Contractor shall allow Referrals for further diagnostic and/or treatment services to correct or ameliorate defects, and physical and mental illnesses and Conditions discovered by the Health Check screens. The PCP may make such Referrals and follow up pursuant to the PCP's contract with the Contractor, as appropriate.

4.7.3.7 The Contractor shall ensure an initial health and screening visit is performed, as appropriate, for all newly enrolled GF Health Check eligible children within ninety (90) Calendar Days and within twenty-four (24) hours of birth to all newborns. If the member's PCP provides medical record evidence to the Contractor that the initial health and screening visit have already taken place, this evidence will meet this contract requirement. The Contractor should incorporate this evidence for this member in its tracking system.

4.7.3.8 Minimum Contractor compliance with the Health Check screening requirements is an eighty percent (80%) screening rate, using the methodology prescribed by CMS to determine the screening rate. This requirement and screening percentage is related to the CMS-416 Report requirements.

4.7.4 Tracking

4.7.4.1 The Contractor shall establish a tracking system that provides information on compliance with Health Check requirements. This system shall track, at a minimum, the following areas:

- Initial newborn Health Check visit occurring in the hospital;
- Periodic and preventive/well child screens and visits as prescribed by the periodicity schedule;
- Diagnostic and treatment services, including Referrals;
- Immunizations, lead, tuberculosis and dental services; and
- A reminder/notification system.

4.7.4.2 All information generated and maintained in the tracking system shall be consistent with Encounter Data requirements as specified elsewhere herein.

4.7.5 Diagnostic and Treatment Services

4.7.5.1 If a suspected problem is detected by a screening examination as described above, the child shall be evaluated as necessary for further diagnosis. This diagnosis is used to determine treatment needs.

4.7.5.2 Health Check requires coverage for all follow-up diagnostic and treatment services deemed Medically Necessary to ameliorate or correct a problem discovered during a Health Check screen. Such Medically Necessary diagnostic and treatment services must be provided regardless of whether such services are covered by the State Medicaid Plan, as long as they are Medicaid-Covered Services as defined in Title XIX of the Social Security Act. The Contractor shall provide Medically Necessary, Medicaid-covered diagnostic and treatment services.

4.7.6 Reporting Requirements

4.7.6.1 The Contractor shall submit all required Health Check Reports.

4.8 PROVIDER NETWORK AND ACCESS

4.8.1 General Provisions

4.8.1.1 The Contractor is solely responsible for providing a network of physicians, pharmacies, hospitals, and other health care Providers through whom it provides the items and services included in Covered Services.

4.8.1.2 The Contractor shall ensure that its network of Providers is adequate to assure access to all Covered Services, and that all Providers are appropriately credentialed, maintain current licenses, and have appropriate locations to provide the Covered Services.

4.8.1.3 The Contractor shall notify DCH sixty (60) days in advance when a decision is made to close network enrollment for new provider contracts and also notify DCH when network enrollment is reopened. The Contractor must notify DCH sixty (60) days prior to closing a provider panel.

4.8.1.4 The Contractor shall not include any Providers who have been excluded from participation by the Department of Health and Human Services, Office of Inspector General, or who are on the State's list of excluded Providers. The Contractor is responsible for routinely checking the exclusions list and shall immediately terminate any Provider found to be excluded and notify the Member per the requirements outlined in this Contract.

4.8.1.5 In accordance with 45 CFR 162.410, the Contractor shall require that each Provider have a National Provider Identifier (NPI).

4.8.1.6 The Contractor shall have written Selection and Retention Policies and Procedures. These policies shall be submitted to DCH for review and approval as updated. In selecting and retaining Providers in its network the Contractor shall consider the following:

- The anticipated GF Enrollment;
- The expected Utilization of services, taking into consideration the characteristics and Health Care needs of its Members;
- The numbers and types (in terms of training, experience and specialization) of Providers required to furnish the Covered Services;
- The numbers of network Providers who are not accepting new GF patients; and

- The geographic location of Providers and Members, considering distance, travel time, the means of transportation ordinarily used by Members, and whether the location provides physical access for Members with disabilities.

4.8.1.7 If the Contractor declines to include individual Providers or groups of Providers in its network, the Contractor shall give the affected Providers written notice of the reason(s) for the decision. These provisions shall not be construed to:

- Require the Contractor to contract with Providers beyond the number necessary to meet the needs of its Members;

- Preclude the Contractor from establishing measures that are designed to maintain quality of services and control costs and are consistent with its responsibilities to Members.

4.8.1.8 The Contractor shall ensure that all network Providers have knowingly and willfully agreed to participate in the Contractor's network. The Contractor shall be prohibited from acquiring established networks without contacting each individual Provider to ensure knowledge of the requirements of this Contract and the Provider's complete understanding and agreement to fulfill all terms of the Provider Contract, as outlined in section 4.10. The Contractor shall send all newly contracted Providers a written network participation welcome letter that includes a contract effective date for which Providers are approved to begin providing medical services to Georgia Families members. DCH reserves the right to confirm and validate, through both the collection of information and documentation from the Contractor and on-site visits to network Providers, the existence of a direct relationship between the Contractor and the network Providers.

4.8.1.8.1 The Contractor shall submit an up-dated version of the Provider Network Listing spreadsheet for all requested Provider types (as outlined under Required Attachments in 5.1.2.8 in the RFP). DCH may require the Contractor to include executed Signature Pages of Provider Contracts and written acknowledgements from all Providers part of a Preferred Health Organization (PHO), IPA, or other network stating that they know they are in the CMO's network, know they are accepting Medicaid patients, and that they are accepting the terms and conditions.

4.8.1.8.2 The Contractor shall identify in its Network Listing data that reports or indicates which providers are accepting new members; providers are not accepting new patients; providers that have full-time practice hour locations; and providers that have part-time practice hour locations.

4.8.1.9 The Contractor shall at least quarterly validate provider demographic data to ensure that current, accurate, and clean data is on file for all contracted providers. Failure to do so may result in liquidation damages up to $5,000 per day against the Contractor.

4.8.1.10 The Contractor shall ensure that all provider network data files are tested and validated for accuracy prior to deliverable submissions. The Contractor shall scrub data to identify inconsistencies such as addresses duplicates; mismatched cities, counties, and regions; and incorrect assigned specialties. The Contractor shall be responsible for submission of attestations for each network report. All reports are to be submitted in the established DCH format with all required data elements. Failure to do so may result in liquidated damages up to $5,000 per day against the Contractor.

4.8.1.11 The Contractor shall ensure that all members have timely access to quality care.

4.8.1.12 The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented in record. The Contractor will emphasize to Providers the need for a unique GA Medicaid number for each practice location.

4.8.2 Primary Care Providers (PCPs)

4.8.2.1 The Contractor shall offer its Members freedom of choice in selecting a PCP. The Contractor shall have written PCP Selection Policies and Procedures describing how Members select their PCP.

4.8.2.1.1 The Contractor shall offer its P4HB Participants in the IPC component of the Demonstration freedom of choice in selecting a PCP. The Contractor shall have written PCP selection policies and procedures describing how IPC P4HB Participants select their PCPs.

4.8.2.2 The Contractor shall submit these PCP Selection Policies and Procedures policies to DCH for review and approval as updated.

4.8.2.3 PCP assignment policies shall be in accordance with Section 4.1.2 of this Contract.

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

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

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

- The PCP no longer meets the geographic access standards as defined in Section 4.8.14;

- The PCP does not, because of moral or religious objections, provide the Covered Service(s) the Member seeks; and

- The Member or IPC Participant requests to be assigned to the same PCP as other family members.

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

4.8.2.5 The PCP is responsible for supervising, coordinating, and providing all Primary Care to each assigned Member. In addition, the PCP is responsible for coordinating and/or initiating Referrals for specialty care (both in and out of network), maintaining continuity of each Member's Health Care and maintaining the Member's Medical Record, which includes documentation of all services provided by the PCP as well as any specialty services. The Contractor shall require that PCPs fulfill these responsibilities for all Members.

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

4.8.2.6 The Contractor shall include in its network as PCPs the following:

4.8.2.6.1 Physicians who routinely provide Primary Care services in the areas of:

- Family Practice;

- General Practice;

- Pediatrics; or

- Internal Medicine.

4.8.2.6.2 Nurse Practitioners Certified (NP-C) specializing in:

- Family Practice; or

- Pediatrics.

4.8.2.7 NP-Cs in independent practice must also have a current collaborative agreement with a licensed physician who has hospital admitting privileges.

4.8.2.8 FQHCs and RHCs may be included as PCPs. The Contractor shall maintain an accurate list of all Providers rendering care at these facilities.

4.8.2.9 Primary Care Public Health Department Clinics and Primary Care Hospital Outpatient Clinics may be included as PCPs if they agree to the requirements of the PCP role, including the following conditions:

- The practice must routinely deliver Primary Care as defined by the majority of the practice devoted to providing continuing comprehensive and coordinated medical care to a population undifferentiated by disease or organ system. If deemed necessary, a Medical Record audit of the practice will be performed. Any exceptions to this requirement will be considered on a case-by-case basis.

- Any Referrals for specialty care to other Providers of the same practice may be reviewed for appropriateness.

4.8.2.10 Physician's assistants (PAs) may participate as a PCP as a Member of a physician's practice.

4.8.2.11 The Contractor may allow female Members to select a gynecologist or obstetrician-gynecologist (OB-GYN) as their Primary Care Provider.

4.8.2.12 The Contractor may allow Members with Chronic Conditions to select a specialist with whom he or she has an on-going relationship to serve as a PCP.

4.8.3 Direct Access

4.8.3.1 The Contractor shall provide female Members with direct in-network access to a women's health specialist for covered care necessary to provide her routine and preventive Health Care services. This is in addition to the Member's designated source of Primary Care if that Provider is not a women's health specialist.

4.8.3.2 The Contractor shall have a process in place that ensures that Members determined to need a course of treatment or regular care monitoring have direct access to a specialist as appropriate for the Member's condition and identified needs. The Medical Director shall be responsible for over-seeing this process.

4.8.3.3 The Contractor shall ensure that Members who are determined to need a course of treatment or regular care monitoring have a treatment plan. This treatment plan shall be developed by the Member's PCP with Member participation, and in consultation with any specialists caring for the Member. This treatment plan shall be approved in a timely manner by the Medical Director and in accord with any applicable State quality assurance and utilization review standards.

4.8.4 Pharmacies

The Contractor shall maintain a comprehensive Provider network of pharmacies that ensures pharmacies are available and accessible to all Members or P4HB Participants.

4.8.5 Hospitals

4.8.5.1 The Contractor shall have a comprehensive Provider network of hospitals such that they are available and accessible to all Members. This includes, but is not limited to tertiary care facilities and facilities with neo-natal, intensive care, burn, and trauma units.

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

4.8.5.2 The Contractor shall include in its network Critical Access Hospitals (CAHs) that are located in its Service Region.

4.8.5.3 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include CAHs in its network. This documentation shall be provided to DCH upon request.

4.8.5.4 A critical access hospital must provide notice to a care management organization and DCH of any alleged breaches in its contract by such care management organization (Title 33 of the Official Code of Georgia Annotated as amended pursuant to O.C.G.A. 33-21-1, et seq. known as the "Medicaid Care Management Organizations Act." (HB1234)

4.8.6 Laboratories

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

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

4.8.7 Mental Health/Substance Abuse

4.8.7.1 The Contractor shall include in its network Core Service Providers (CSP's) that meet the requirements of the Department of Human Services and are located in its Service Region, provided they agree to the Contractor's terms and conditions as well as rates; and presuming they meet the credentialing requirements established by the Contractor for that provider type.

4.8.7.2 The Contractor shall maintain copies of all letters and other correspondence related to the inclusion of CSP's in its network. This documentation shall be provided to DCH upon request.

4.8.8 Federally Qualified Health Centers (FQHCs)

4.8.8.1 The Contractor shall include in its Provider network all FQHCs in its Service Region based on PPS rates.

4.8.8.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include FQHCs in its network. This documentation shall be provided to DCH upon request.

4.8.8.3 The FQHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for FQHC (the Manual). Services and supplies deemed necessary for the provision of a Core services as described in §901.2 of the Manual are considered part of the FQHC service. In addition, an FQHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:

- Health Check (COS 600),
- Mental Health (COS 440),
- Dental Services (COS 450 and 460),
- Refractive Vision Care services (COS 470),
- Podiatry (COS 550),
- Pregnancy Related services (COS 730), and

4.8.9 Rural Health Clinics (RHCs)

4.8.9.1 The Contractor shall include in its Provider network all RHCs in its Service Region based on PPS rates.

4.8.9.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include FQHCs and RHCs in its network. This documentation shall be provided to DCH upon request.

4.8.9.3 The RHC must agree to provide those primary care services typically included as part of a physician's medical practice, as described in §901 of State Medicaid Manual Part II for RHC (the Manual). Services and supplies deemed necessary for the provision of a Core services as described in §901.2 of the Manual are considered part of the RHC service. In addition, an RHC can provide other ambulatory services of the following state Medicaid Program, once enrolled in the programs:

- Health Check (COS 600),
- Mental Health (COS 440),
- Dental Services (COS 450 and 460),
- Refractive Vision Care services (COS 470),
- Podiatry (COS 550),
- Pregnancy Related services (COS 730), and
- Perinatal Case Management (COS 761).

4.8.10 Family Planning Clinics

4.8.11.1 The Contractor shall make a reasonable effort to subcontract with all family planning clinics, including those funded by Title X of the Public Health Services Act.

4.8.11.2 The Contractor shall maintain copies of all letters and other correspondence related to its efforts to include Title X Clinics in its network. This documentation shall be provided to DCH upon request.

4.8.11 Nurse Practitioners Certified (NP-Cs) and Certified Nurse Midwives (CNMs)

The Contractor shall ensure that Members have appropriate access to NP-Cs and CNMs, through either Provider contracts or Referrals. This provision shall in no way be interpreted as requiring the Contractor to provide any services that are not Covered Services.

4.8.12 Dental Practitioners

4.8.12.1 The Contractor shall not deny any dentist from participating in the Medicaid and PeachCare for Kids® dental program administered by such care management organization if:

- such dentist has obtained a license to practice in this state and is an enrolled Provider who has met all of the requirements of DCH for participation in the Medicaid and PeachCare for Kids® program; and
- licensed dentist will provide dental services to members pursuant to a state or federally funded educational loan forgiveness program that requires such services; provided, however, each care management organization shall be required to offer dentists wishing to participate through such loan forgiveness programs the same contract terms offered to other dentists in the service region who participate in the care management organization's Medicaid and PeachCare for Kids® dental programs;

- the geographic area in which the dentist intends to practice has been designated as having a dental professional shortage as determined by DCH, which may be based on the designation of the Health Resources and Services Administration of the United States Department of Health and Human Services;

4.8.12.2 The Contractor must establish a sufficient number of general dentists and specialists as specified by 4.8.13 - Geographic Access Requirements to provide covered dental services to members in the geographic region.

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

4.8.12.3 The Contractor must report the total number of dental provider applications received, the number of applications pending a determination, and the total number of both approved and denied applications on a monthly basis.

4.8.12.4 The Contractor must process completed dental applications within 30 days from receipt.

4.8.12.5 The Contractor must include specific documentation that supports the decision to accept or decline a provider including a decision tool such as a checklist.

4.8.12.6 The Contractor's denial letter of a provider's application must include specific information regarding how to file an appeal.

4.8.12.7 The Contractor must report the number of dental application appeals, and appeal outcomes on a monthly basis.

4.8.13 Geographic Access Requirements

4.8.13.1 In addition to maintaining in its network a sufficient number of Providers to provide all services to its Members and P4HB Participants, the Contractor shall meet the following geographic access standards for all Members or P4HB Participants:

	Urban	Rural
PCPs	Two (2) within eight (8) miles	Two (2) within fifteen (15) miles
Specialists	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
General Dental Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Dental Subspecialty Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Hospitals	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Mental Health Providers	One (1) within thirty (30) minutes or thirty (30) miles	One within forty-five (45) minutes or forty-five (45) miles
Pharmacies	One (1) twenty-four (24) hours a day, seven (7) days a week within fifteen (15) minutes or fifteen (15) miles	One (1) twenty-four (24) hours a day (or has an after hours emergency phone number and pharmacist on call), seven (7) days a week within thirty (30) minutes or thirty (30) miles

4.8.13.2 All travel times are maximums for the amount of time it takes a Member or P4HB Participant, using usual travel means in a direct route to travel from their home to the Provider. DCH recognizes that transportation with NET vendors may not always follow direct routes due to multiple passengers.

4.8.13.3 The Contractor shall only include in its Geographic Access data reports those Providers that operate a full-time practice location. For purposes of this section, a full-time practice location is defined as a location operating for 16 or more hours in an office location each week. In addition to the Geographic Access data reports, the Contractor shall submit a separate report of those Providers and associated locations with closed panels (any Provider which the Contractor recognizes as no longer accepting new Members) and those Providers and associated locations with less than full-time practice hours. The separate reports must include a listing of the Providers by name and location, Provider type and an analysis of the total number of Providers with closed panels or less than full-time practice hours expressed as a percentage of the Contractor's total contracted Providers for the state and then for each Service Region. The Contractor must also provide any plans or corrective actions to enhance access of the Providers included in these separate reports. If enhanced access is not possible (i.e., no Providers available for contracting or available Providers only practice part-time) the Contractor must describe the limitations. The Contractor may indicate whether a Provider's office is a primary, secondary, tertiary, etc. location.

4.8.13.4 The Contractor shall be required to utilize the most recent GeoAccess program versions available and update periodically as appropriate. GeoCoder software is required to be used along with the GeoAccess application package.

4.8.13.5 The Contractor shall be required to report monthly the total number of provider applications received, the total number of applications pending a determination, and the total of each of the approved and denied applications.

4.8.13.6 The Contractor shall be required to ensure that all complete provider applications are processed and loaded within **30 days** of receipt by the Contractor or its designated subcontracted vendor.

4.8.14 Waiting Maximums and Appointment Requirements

4.8.14.1 The Contractor shall require that all network Providers offer hours of operation that are no less than the hours of operation offered to commercial and Fee-for-Service patients. The Contractor shall encourage its PCPs to offer After-Hours office care in the evenings and on weekends.

4.8.14.2 The Contractor shall have in its network the capacity to ensure that waiting times for appointments do not exceed the following:

PCPs (routine visits)	Not to exceed 14 calendar days
PCP (adult sick visit)	Not to exceed 24 hours
PCP (pediatric sick visit)	Not to exceed 24 hours
Specialists	Not to exceed 30 Calendar Days
Dental Providers (routine visits)	Not to exceed 21 Calendar Days
Dental Providers (urgent care)	Not to exceed 48 hours
Elective Hospitalizations	30 Calendar Days
Mental health Providers	14 Calendar Days
Urgent Care Providers	Not to exceed 24 hours
Emergency Providers	Immediately (24 hours a day, 7 days a week) and without prior authorization

4.8.14.3 The Contractor shall have in its network the capacity to ensure that waiting times in the provider office does not exceed the following for pediatrics and adults:

Scheduled Appointments	Waiting times shall not exceed 60 minutes. After 30 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting times shall not exceed 90 minutes. After 45 minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment

4.8.14.4 The Contractor shall ensure that provider response times for returning calls after-hours are as follows:

Urgent Calls	Shall not exceed 20 minutes
Other Calls	Shall not exceed one hour

4.8.14.5 The Contractor shall provide adequate capacity for initial visits for pregnant women within fourteen (14) Calendar Days and visits for Health Check eligible children within ninety (90) Calendar Days of Enrollment into the CMO plan.

4.8.14.6 The Contractor shall take corrective action if there is a failure to comply with these waiting times.

4.8.15 Credentialing

4.8.15.1 The Contractor shall maintain written policies and procedures for the Credentialing and Re-Credentialing of network Providers, using standards established by National Committee Quality Assurance (NCQA), Joint Commission on Accreditation Healthcare Organization (JCAHO), or American Accreditation Healthcare Commission/URAC. At a minimum, the Contractor shall require that each Provider be credentialed in accordance with State law and Federal regulations. The Contractor may impose more stringent Credentialing criteria than the State requires. The Contractor shall Credential all completed applications packets within 120 calendar days of receipt.

4.8.15.2 Credentialing policies and procedures shall include: the verification of the existence and maintenance of credentials, licenses, certificates, and insurance coverage of each Provider from a primary source; a methodology and process for Re-Credentialing Providers; a description of the initial quality assessment of private practitioner offices and other patient care settings; and procedures for disciplinary action, such as reducing, suspending, or terminating Provider privileges.

4.8.15.3 Upon the request of DCH, the Contractor shall make available all licenses, insurance certificates, and other documents of network Providers. The Contractor shall also make available to DCH each quarter the total number of provider applications by date that have been received, the number of applications pending a determination, credentialed, and approved and denied. These reports should be catalogued date in such a way to allow age tracking of each provider application submitted and the specific reason that credentialing for any of the applications was delayed beyond 120 days.

4.8.15.4 Contractors shall submit its Provider Credentialing and re-Credentialing Policies and Procedures to DCH as updated.

4.8.15.5 The Contractor's application review decision must include specific documentation to support the decision to accept or decline a provider. The Contractor must include instructions regarding how a provider can

appeal a decision to deny the provider's application.

4.8.15.6 The Contractor shall notify DCH within ten (10) days of the Contractor's denial of a provider credentialing application either for program integrity-related reasons or due to limitations placed on the provider's ability to participate for program integrity-related reasons.

4.8.16 Mainstreaming

4.8.16.1 The Contractor shall encourage that all In-Network Providers accept Members and P4HB Participants for treatment, unless they have a full panel (2500 members and P4HB Participants) and are accepting no new GF or commercial patients. The Contractor shall ensure that In-Network Providers do not intentionally segregate Members and P4HB Participants in any way from other persons receiving services.

4.8.16.2 The Contractor shall ensure that Members and P4HB Participants are provided services without regard to race, color, creed, sex, religion, age, national origin, ancestry, marital status, sexual preference, health status, income status, or physical or mental disability.

4.8.17 Coordination Requirements

4.8.17.1 The Contractor shall coordinate and work collaboratively with all divisions within DCH, as well as with other State agencies, and with other CMO plans operating within the same Service Region for administration of the Georgia Families program.

4.8.17.2 The Contractor shall also coordinate with local education agencies in the Referral and provision of children's intervention services provided through the school to ensure Medical Necessity and prevent duplication of services.

4.8.17.3 The Contractor shall coordinate the services furnished to its Members and P4HB Participants with the service the Member and P4HB Participant receives outside the CMO plan, including services received through any other managed care entity.

4.8.17.4 The Contractor shall coordinate with all NET vendors.

4.8.17.5 DCH strongly encourages the Contractor to Contract with Providers of essential community services who would normally Contract with the State as well as other public agencies and with non-profit organizations that have maintained a historical base in the community.

4.8.17.6 The Contractor shall implement procedures to ensure that in the process of coordinating care each Member's or P4HB Participants privacy is protected consistent with the confidentiality requirements in 45 CFR 160 and 45 CFR 164.

4.8.18 Network Changes

4.8.18.1 The Contractor shall notify DCH within seven (7) Business Days of any significant changes to the Provider network or, if applicable, to any Subcontractors' Provider network. A significant change is defined as:

- A decrease in the total number of PCPs by more than five percent (5%);
- A loss of all Providers in a specific specialty where another Provider in that specialty is not available within sixty (60) miles;
- A loss of a hospital in an area where another contracted hospital of equal service ability is not available within thirty (30) miles; or
- Other adverse changes to the composition of the network, which impair or deny the Members' or P4HB Participants adequate access to In-Network Providers.

4.8.18.2 The Contractor shall have procedures to address changes in the health plan Provider network that negatively affect the ability of Members or P4HB Participants to access services, including access to a culturally diverse Provider network. Significant changes in network composition that negatively impact Member or P4HB Participant access to services may be grounds for Contract termination or State determined remedies.

4.8.18.3 If a PCP ceases participation in the Contractor's Provider network the Contractor shall send written notice to the Members and P4HB Participants who have chosen the Provider as their PCP. This notice shall be issued no less than thirty (30) Calendar Days prior to the effective date of the termination and no more than ten (10) Calendar Days after receipt or issuance of the termination notice.

4.8.18.4 If a Member or P4HB Participant is in a prior authorized ongoing course of treatment with any other participating Provider who becomes unavailable to continue to provide services, the Contractor shall notify the Member or P4HB Participant in writing within ten (10) Calendar Days from the date the Contractor becomes aware of such unavailability.

4.8.18.5 These requirements to provide notice prior to the effective dates of termination shall be waived in instances where a Provider becomes physically unable to care for Members due to illness, a Provider dies, the Provider moves from the Service Region and fails to notify the Contractor, or when a Provider fails Credentialing. Under these circumstances, notice shall be issued immediately upon the Contractor becoming aware of the circumstances.

4.8.18.6 Continuity of Care Plan is required to be submitted to DCH 60 days prior to anticipated mass Network changes (as defined in 4.8.18.1) that will impact membership.

4.8.19 Out-of-Network Providers

4.8.19.1 If the Contractor's network is unable to provide Medically Necessary Covered Services to a particular Member, the Contractor shall adequately and timely cover these services Out-of-Network for the Member. The Contractor must inform the Out-of Network Provider that the member cannot be balance billed.

4.8.19.2 The Contractor shall coordinate with Out-of-Network Providers regarding payment. For payment to Out-of-Network, or non-participating Providers, the following guidelines apply:

- If the Contractor offers the service through an In-Network Provider(s), and the Member chooses to access the service (i.e., it is not an emergency) from an Out-of-Network Provider, the Contractor is not responsible for payment.
- If the service is not available from an In-Network Provider, but the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
- If the service is available from an In-Network Provider, but the service meets the Emergency Medical Condition standard, and the Contractor has three (3) Documented Attempts to contract with the Provider, the Contractor is not required to pay more than Medicaid FFS rates for the applicable service, less ten percent (10%).
- When paying out of state providers in an emergency situation: Be advised that the CMOs shall not allow a member to be held accountable for payment under these circumstances.
- If the service is not available from an In-Network Provider and the Member requires the service and is referred for treatment to an Out-of-Network Provider, the payment amount is a matter between the CMO and the Out-of-Network Provider.

4.8.19.3 In the event that needed services are not available from an In-Network Provider and the Member must receive services from an Out-of-Network Provider, the Contractor must ensure that the Member is not charged more than it would have if the services were furnished within the network.

4.8.20 Shriners Hospitals for Children

4.8.20.1 The Contractor shall comply with the responsibilities outlined in the "Memorandum of Understanding for the PeachCare Partnership Program" executed on February 18, 2008.

4.8.20.2 The Contractor shall cooperate with DCH in making any updates or revisions to the Memorandum, as necessary.

4.8.21 Reporting Requirements

4.8.21.1 The Contractor shall submit to DCH quarterly Provider Network Adequacy and Capacity Reports (included Policies and Procedures) as described in Section 4.18.4.10.

4.8.21.2 The Contractor shall submit to DCH quarterly Timely Access Reports as described in Section 4.18.4.1.

4.9 PROVIDER SERVICES

4.9.1 General Provisions

4.9.1.1 The Contractor shall provide information to all Providers about GF in order to operate in full compliance with the GF Contract and all applicable federal and State regulations.

4.9.1.2 The Contractor shall monitor Provider knowledge and understanding of Provider requirements, and take corrective actions to ensure compliance with such requirements.

4.9.1.3 The Contractor shall submit to DCH for review and prior approval all materials and information to be distributed and/or made available.

4.9.1.4 All Provider Handbooks and bulletins must be in compliance with State and federal laws.

4.9.1.5 Contractor must proactively seek DCH's written approval of the Contractor's interpretation of policies in the Georgia Medicaid Policy Manual when such policies are referenced in Provider contracts or communications. DCH's review and response will be completed within sixty (60) calendar days of the Contractor's written request for approval of its policy interpretation. DCH's written response shall be final regarding any dispute of the meaning of that policy language. In the event the Contractor misinterprets a Medicaid policy which is communicated to Providers, the Contractor must submit a written corrective action plan to DCH within three (3) business days of notice from DCH. Contractor will be required to retroactively correct and adjust any previously adjudicated claims or correct any other actions resulting from the misinterpreted policy language within thirty (30) calendar days of approval of the corrective action plan.

4.9.2 Provider Handbooks

4.9.2.1 The Contractor shall issue a Provider Handbook to all network Providers at the time the Provider Contract is signed. The Contractor may choose not to distribute the Provider Handbook via mail, provided it submits a written notification to all Providers that explains how to obtain the Provider Handbook from the CMO's Web site. This notification shall also detail how the Provider can request a hard copy from the CMO at no charge to the Provider. All Provider Handbooks and bulletins shall be in compliance with State and federal laws. The Provider Handbook shall serve as a source of information regarding GF Covered Services, policies and procedures, statutes, regulations, telephone access and special requirements to ensure all Contract requirements are being met. At a minimum, the Provider Handbook shall include the following information:

- Description of the GF;
- Covered Services;
- Emergency Service responsibilities;
- Health Check/EPSDT program services and standards;
- Policies and procedures of the Provider complaint system;
- Information on the Member Grievance System, including the Member's right to a State Administrative Law Hearing, the timeframes and requirements, the availability of assistance in filing, the toll-free numbers and the Member's right to request continuation of Benefits while utilizing the Grievance System;
- Medical Necessity standards and practice guidelines;
- Practice protocols, including guidelines pertaining to the treatment of chronic and complex Conditions;
- PCP responsibilities;
- Other Provider or Subcontractor responsibilities;
- Prior Authorization, Pre-Certification, and Referral procedures;
- Protocol for Encounter Data element reporting/records;
- Medical Records standard;
- Claims submission protocols and standards, including instructions and all information necessary for a clean or complete Claim;
- Payment policies;
- The Contractor's Cultural Competency Plan; and
- Member rights and responsibilities.
- Description of the Demonstration;
- Practice protocols for the Demonstration;
- Other Provider responsibilities pertaining to the Demonstration;
- Coding requirements pertaining to the Demonstration;
- Prior Authorization, Pre-Certification, and Referral procedures pertaining to the Demonstration;
- P4HB Participants rights and responsibilities

4.9.2.2 The Contractor shall disseminate bulletins as needed to incorporate any needed changes to the Provider Handbook.

4.9.2.3 The Contractor shall submit the Provider Handbook to DCH for review and approval and as updated. Any updates or revisions shall be submitted to DCH for review and approval at least 30 days prior to distribution.

4.9.3 Education and Training

4.9.3.1 The Contractor shall provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The Contractor shall conduct initial training within thirty (30) Calendar Days of placing a newly Contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or DCH in order to ensure compliance with program standards and the GF Contract.

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

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

4.9.3.2 The Contractor shall submit the Provider Training Manual and Training Schedule to DCH for review and approval as updated.

4.9.3.3 The Contractor shall submit the Provider Rep Field Visit Report Ad-Hoc as described in Section 4.18.6.3.

4.9.4 Provider Relations

4.9.4.1 The Contractor shall establish and maintain a formal Provider relations function to timely and adequately respond to inquiries, questions and concerns from network Providers. The Contractor shall implement policies addressing the compliance of Providers with the requirements of GF, institute a mechanism for Provider dispute resolution and execute a formal system of terminating Providers from the network.

4.9.4.2 The Contractor shall provide for a Provider Relations Liaison to carry out the Provider Relations functions. There shall be at least one (1) Provider Relations Liaison in each Service Region.

4.9.5 Toll-free Provider Services Telephone Line

4.9.5.1 The Contractor shall operate a toll-free telephone line to respond to Provider questions, comments and inquiries.

4.9.5.2 The Contractor shall develop Telephone line Policies and Procedures that address staffing, personnel, hours of operation, access and response standards, monitoring of calls via recording or other means, and compliance with standards.

4.9.5.3 The Contractor shall submit these Telephone line Policies and Procedures, including performance standards, to DCH for review and approval as updated.

4.9.5.4 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment L.

4.9.5.5 Pursuant to OCGA 30-20A-7.1, the telephone line shall be staffed twenty-four (24) hours a day, seven (7) days a week to respond to Prior Authorization and Pre-certification requests. This telephone line shall have staff to respond to Provider questions in all other areas, including the Provider complaint system, Provider responsibilities, etc. between the hours of 7:00am and 7:00pm EST Monday through Friday, excluding State holidays.

4.9.5.6 The Contractor shall develop performance standards and monitor Telephone Line performance by recording calls and employing other monitoring activities. At a minimum, the standards shall require that, on a monthly basis, eighty percent (80%) of calls are answered by a person within thirty (30) seconds, the Blocked Call rate does not exceed one percent (1%), and the rate of Abandoned Calls does not exceed five percent (5%).

4.9.5.7 The Contractor shall insure that after regular business hours the non-Prior Authorization/Pre-certification line is answered by an automated system with the capability to provide callers with operating hour's information and instructions on how to verify Enrollment for a Member with an Emergency or Urgent Medical Condition. The requirement that the Contractor shall provide information to Providers on how to verify Enrollment for a Member with an Emergency or Urgent Medical Condition shall not be construed to mean that the Provider must obtain verification before providing Emergency Services.

4.9.5.8 The Contractor shall develop Call Center Quality Criteria and Protocols to measure and monitor the accuracy of responses and phone etiquette as it relates to the Toll-free Telephone Line. The Contractor shall submit the Call Center Quality Criteria and Protocols to DCH for review and approval as updated.

4.9.6 Internet Presence/Web Site

4.9.6.1 The Contractor shall dedicate a section of its Web Site to Provider services and provide at a minimum, the capability for Providers to make inquiries and receive responses through the Medicaid fiscal agent Web Site, (www.gbp.georgia.gov).

4.9.6.2 In addition to the specific requirements outlined above, the Contractor's Web Site shall be functionally equivalent, with respect to functions described in this Contract, to the Web Site maintained by the State's Medicaid fiscal agent (www.gbp.georgia.gov).

4.9.6.3 The Contractor shall submit Web site screenshots to DCH for review and approval as updated.

4.9.6.4 The Contractor shall maintain a website that allows Providers to submit, process, edit (only if original submission is in an electronic format), rebill, and adjudicate claims electronically. To the extent a Provider has the capability; each care management organization shall submit payments to Providers electronically and submit remittance advices to Providers electronically within one business day of when payment is made. To the extent that any of these functions involve covered transactions under 45 C.F.R. Section 162.900, et seq., then those transactions also shall be conducted in accordance with applicable federal requirements.

4.9.6.5 The Contractor shall post on its website a searchable list of all providers with which the care management organization has contracted. At a minimum, this list shall be searchable by provider name, specialty, and location. At a minimum, the list shall be updated once each month.

4.9.7 Provider Complaint System

4.9.7.1 The Contractor shall establish a Provider Complaint system that permits a Provider to dispute the Contractor's policies, procedures, or any aspect of a Contractor's administrative functions.

4.9.7.2 The Contractor shall submit its Provider Complaint System Policies and Procedures to DCH for review and approval quarterly and annually and as updated thereafter.

4.9.7.3 The Contractor shall include its Provider Complaint System Policies and Procedures in its Provider Handbook that is distributed to all network Providers. This information shall include, but not be limited to, specific instructions regarding how to contact the Contractor's Provider services to file a Provider complaint and which individual(s) have the authority to review a Provider complaint.

4.9.7.4 The Contractor shall distribute the Provider Complaint System Policies and Procedures to Out-of-Network Providers with the remittance advice of the processed Claim. The Contractor may distribute a summary of these Policies and Procedures if the summary includes information on how the Provider may access the full Policies and Procedures on the Web site. This summary shall also detail how the Provider can request a hard copy from the CMO at no charge to the Provider.

4.9.7.5 As a part of the Provider Complaint System, the Contractor shall:

- Allow Providers thirty (30) Calendar Days to file a written complaint;
- Allow Providers to consolidate complaints or appeals of multiple claims that involve the same or similar payment or coverage issues, regardless of the number of individual patients or payment claims included in the bundled complaint or appeal.
- Allow a Provider that has exhausted the care management organization's internal appeals process related to a denied or underpaid claim or group of claims bundled for appeal the option either to pursue the administrative review process described in O.C.G.A. § 49-4-153(e) or to select binding arbitration by a private arbitrator who is certified by a nationally recognized association that provides training and certification in alternative dispute resolution. If the care management organization and the Provider are unable to agree on an association, the rules of the American Arbitration Association shall apply. The arbitrator shall have experience and expertise in the health care field and shall be selected according to the rules of his or her certifying association. Arbitration conducted pursuant to this Code section shall be binding on the parties. The arbitrator shall conduct a hearing and issue a final ruling within 90 days of being selected, unless the care management organization and the Provider mutually agree to extend this deadline. All costs of arbitration, not including attorney's fees, shall be shared equally by the parties.
- For all claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from fifteen (15) business days after the date the claim was submitted. A care management organization shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment.
- All interest payments shall be accurately identified on the associated remittance advice submitted by the care management organization to the Provider.
- Require that the reason for the complaint is clearly documented;
- Require that Providers exhaust the Contractor's internal Provider Complaint process prior to requesting an Administrative Law Hearing (State Fair Hearing);
- Have dedicated staff for Providers to contact via telephone, electronic mail, or in person, to ask questions, file a Provider Complaint and resolve problems;
- Identify a staff person specifically designated to receive and process Provider Complaints;
- Thoroughly investigate each GF Provider Complaint using applicable statutory, regulatory, and Contractual provisions, collecting all pertinent facts from all parties and applying the Contractor's written policies and procedures; and
- Ensure that CMO plan executives with the authority to require corrective action are involved in the Provider Complaint process.

4.9.7.6 In the event the outcome of the review of the Provider Complaint is adverse to the Provider, the Contractor shall provide a written Notice of Adverse Action to the Provider. The Notice of Adverse Action shall state that Providers may request an Administrative Law Hearing in accordance with O.C.G.A. § 49-4-153, O.C.G.A. § 50-13-13 and O.C.G.A. § 50-13-15.

4.9.7.7 The Contractor shall notify the Providers that a request for an Administrative Law Hearing must include the following information:

- A clear expression by the Provider that he/she wishes to present his/her case to an Administrative Law Judge;
- Identification of the Action being appealed and the issues that will be addressed at the hearing;
- A specific statement of why the Provider believes the Contractor's Action is wrong; and
- A statement of the relief sought.

4.9.7.8 DCH has delegated its statutory authority to receive hearing requests to the Contractor. The Contractor shall include with the Notice of Adverse Action the Contractor's address where a Provider's request for an Administrative Law Hearing should be sent in accordance with O.C.G.A. § 49-4-153(e).

4.9.7.9 Claims Adjustment Requests

If the amount reimbursed by the Contractor to an enrolled Provider is not correct, a positive or negative adjustment may be necessary. Such request for claims adjustment shall be included in the Contractor's internal appeals process and shall not negate a Provider's right to appeal pursuant to O.C.G.A. §49-4-153(e). The Contractor shall develop a procedure to address claims adjustment requests that meet the following minimum requirements:

- **Positive Adjustments**: When a Provider can substantiate that additional reimbursement is appropriate, the Provider may adjust and resubmit a claim. Provider shall be given the option to submit the written request, Explanation of Payment and all claims related documentation either electronically or by U.S. mail. All documentation must be received within three (3) months from the end of the month of payment. The adjustment request must include sufficient documentation to identify each claim identified in the request. The Contractor may return incomplete requests without further action provided it notifies the Provider of the basis for the incomplete status and allows the Provider ten (10) calendar days to resubmit the adjustment request. The Provider shall be required to submit documentation that supports the requested claims adjustment. If a positive adjustment is warranted, the Contractor shall make additional reimbursement upon processing of the request. If an adjustment is not warranted, the Provider will be notified via written correspondence from the Contractor.
- **Negative Adjustments:** When a Provider believes a negative adjustment is appropriate, the Provider may adjust and resubmit a claim. Provider shall be given the option to submit the written request, Explanation of Payment and all claims related documentation either electronically or by U.S. mail. If a negative adjustment is warranted, Contractor may either deduct the payment from future reimbursement or request from the Provider and required by the Provider's contract with the Contractor.
- The Contractor shall respond to all adjustment requests within 30 days of receipt.

4.9.8 Reporting Requirements

4.9.8.1 The Contractor shall submit to DCH monthly Telephone and Internet Activity Reports as described in Section 4.18.3.1.

4.9.8.2 The Contractor shall submit to DCH monthly Provider Complaints Reports as described in Section 4.18.3.10.

4.10 PROVIDER CONTRACTS AND PAYMENTS

4.10.1 Provider Contracts

4.10.1.1 The Contractor shall comply with all DCH procedures for contract review and approval submission. Memoranda of Agreement (MOA) shall not be permitted. Letters of Intent shall only be permitted in accordance with Section 4.8.1.10.

4.10.1.2 The Contractor shall submit to DCH for review and approval a model for each type of Provider Contract as updated.

4.10.1.3 Any significant changes to the model Provider Contract shall be submitted to DCH for review and approval no later than thirty (30) Calendar Days prior to the Enrollment of Members and P4HB Participants into the CMO plan.

4.10.1.4 Upon request, the Contractor shall provide DCH with free copies of all executed Provider Contracts.

4.10.1.5 The Contractor shall not require Providers to participate or accept other plans or products offered by the care management organization unrelated to providing care to members and P4HB Participants, nor reduce the funding available for members and P4HB Participants as a result of payment of such penalties.. Any care management organization which violates this prohibition shall be subject to a penalty of $1,000.00 per violation.

4.10.1.6 The Contractor shall not enter into any exclusive contract agreements with providers that exclude other health care providers from contract agreements for network participation.

4.10.1.7 Health care providers may not, as a condition of contracting with a CMO, require the CMO to contract with or not contract with another health care provider. A provider who violates this probation will be subject to a $1,000 per violation penalty.

4.10.1.8 If a Provider has complied with all of DCH's published procedures for verifying a patient's eligibility for Medicaid benefits through the established common verification process, DCH must reimburse the Provider for all covered services provided to the patient within the 72 hours following the verification, if such services are denied by a CMO or DCH because the patient is not enrolled as shown in the verification process. DCH would be able to pursue a case of action against a person who had contributed to the incorrect verification.

4.10.1.9 In addition to addressing the CMO plan licensure requirements, the Contractor's Provider Contracts shall:

- Prohibit the Provider from seeking payment from the Member for any Covered Services provided to the Member and P4HB Participant within the terms of the Contract and require the Provider to look solely to the Contractor for compensation for services rendered, with the exception of nominal cost sharing pursuant to the Georgia State Medicaid Plan, the Georgia State Medicaid Policies and Procedures Manuals, and the GF Contract;
- Require the Provider to cooperate with the Contractor's quality improvement and Utilization Review and management activities;
- Include provisions for the immediate transfer to another PCP or Contractor if the Member's and P4HB Participants health or safety is in jeopardy;
- Not prohibit a Provider from discussing treatment or non-treatment options with Members and P4HB Participants that may not reflect the Contractor's position or may not be covered by the Contractor;
- Not prohibit a Provider from acting within the lawful scope of practice, from advising or advocating on behalf of a Member for the Member's and P4HB Participants health status, medical care, or treatment or non-treatment options, including any alternative treatments that might be self-administered;
- Not prohibit a Provider from advocating on behalf of the Member and P4HB Participant in any Grievance System or Utilization Review process, or individual authorization process to obtain necessary Health Care services;
- Require Providers to meet appointment waiting time standards pursuant to Section 4.8.14.2 of this Contract;
- Provide for continuity of treatment in the event a Provider's participation terminates during the course of a Member's or P4HB Participants treatment by that Provider;
- Prohibit discrimination with respect to participation, reimbursement, or indemnification of any Provider who is acting within the scope of his or her license or certification under applicable State law, solely based on such license or certification. This provision should not be construed as any willing provider law, as it does not prohibit Contractors from limiting Provider participation to the extent necessary to meet the needs of the Members. Additionally, this provision shall not preclude the Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty. This provision also does not interfere with measures established by the Contractor that are designed to maintain Quality and control costs;
- Prohibit discrimination against Providers serving high-risk populations or those that specialize in Conditions requiring costly treatments;
- Specify that CMS and DCH will have the right to inspect, evaluate, and audit any pertinent books, financial records, documents, papers, and records of any Provider involving financial transactions related to the GF Contract;
- Specify Covered Services and populations;
- Require Provider submission of complete and timely Encounter Data, pursuant to Section 4.17.4.2 of the GF Contract;
- Include the definition and standards for Medical Necessity, pursuant to the definition in Section 4.5.4 of this Contract;
- Specify rates of payment. The Contractor ensures that Providers will accept such payment as payment in full for Covered Services provided to Members and P4HB Participants, as deemed Medically Necessary and appropriate under the Contractor's Quality Improvement and Utilization Management program, less any applicable Member and P4HB Participants cost sharing pursuant to the GF Contract;
- Provide for timely payment to all Providers for Covered Services to Members and P4HB Participants. Pursuant to O.C.G.A. 33-24-59.5(b) (1) once a clean claim has been received, the CMO(s) will have 15 Business Days within which to process and either transmit funds for payment electronically for the claim or mail a letter or notice denying it, in whole or in part giving the reasons for such denial.
- Specify acceptable billing and coding requirements;
- Require that Providers comply with the Contractor's Cultural Competency plan;
- Require that any marketing materials developed and distributed by Providers be submitted to the Contractor to submit to DCH for approval;
- Specify that in the case of newborns the Contractor shall be responsible for any payment owed to Providers for services rendered prior to the newborn's Enrollment with the Contractor;
- Specify that the Contractor shall not be responsible for any payments owed to Providers for services rendered prior to a Member's or P4HB Participants Enrollment with the Contractor, even if the services fell within the established period of retroactive eligibility;
- Comply with 42 CFR 434 and 42 CFR 438.6;
- Require Providers to collect Member and P4HB Participant co-payments as specified in Attachment K;
- Not employ or subcontract with individuals on the State or Federal Exclusions list;
- Prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a Member or P4HB Participant of the Provider's family has a Financial Relationship.
- Require Providers of transitioning Members and P4HB Participants to cooperate in all respects with Providers of other CMO plans to assure maximum health outcomes for Members and P4HB Participants;
- Not require that Providers sign exclusive Provider Contracts with the Contractor if the Provider is a CAH, FQHC, or RHC;
- Contain a provision stating that in the event DCH is due funds from a Provider; who has exhausted or waived the administrative review process, if applicable, the Contractor shall reduce payment by one hundred percent (100%) to that Provider until such time as the amount owed to DCH is recovered;
- Contain a provision giving notice that the Contractor's negotiated rates with Providers shall be adjusted in the event the Commissioner of DCH directs the Contractor to make such adjustments in order to reflect budgetary changes to the Medical Assistance program; and
- Require the Contractor to notify the Provider in writing no less than thirty (30) calendar days prior to any adjustments to the Provider's contracted reimbursement rates.

4.10.2 Provider Termination

4.10.2.1 The Contractor shall comply with all State and federal laws regarding Provider termination. In its Provider Contracts the Contractor shall:

- Specify that in addition to any other right to terminate the Provider Contract, and notwithstanding any other provision of this Contract, DCH may request Provider termination immediately, or the Contractor may immediately terminate on its own, a Provider's participation under the Provider Contract if a Provider fails to abide by the terms and conditions of the Provider Contract, as determined by DCH, or, in the sole discretion of DCH, fails to come into compliance within fifteen (15) Calendar Days after a receipt of notice from the Contractor specifying such failure and requesting such Provider to abide by the terms and conditions hereof;

- Specify that any Provider whose participation is terminated under the Provider Contract for any reason shall utilize the applicable appeals procedures outlined in the Provider Contract. No additional or separate right of appeal to DCH or the Contractor is created as a result of the Contractor's act of terminating, or decision to terminate any Provider under this Contract. Notwithstanding the termination of the Provider Contract with respect to any particular Provider, this Contract shall remain in full force and effect with respect to all other Providers;

4.10.2.2 The Contractor shall notify DCH at least forty-five (45) Calendar Days prior to the effective date of the suspension, termination, or withdrawal of a Provider from participation in the Contractor's network. If the termination was "for cause", the Contractor may terminate, suspend, or withdraw the Provider immediately and shall notify DCH in writing within one business day of the termination with the reasons for termination.

4.10.2.3 The Contractor shall notify the Members pursuant to Section 4.10.2 of this Contract.

4.10.3 Provider Insurance

4.10.3.1 The Contractor shall require each Provider (with the exception of Section 4.10.3.2 below, and FQHCs that are section 330 grantees) to maintain, throughout the terms of the Contract, at its own expense, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written Contract with the Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars ($1,000,000) per occurrence, and three million dollars ($3,000,000) annual aggregate. Providers may be allowed to self-insure if the Provider establishes an appropriate actuarially determined reserve. DCH reserves the right to waive this requirement if necessary for business need.

4.10.3.2 The Contractor shall require allied mental health professionals to maintain, throughout the terms of the Contract, professional and comprehensive general liability, and medical malpractice, insurance. Such comprehensive general liability policy of insurance shall provide coverage in an amount established by the Contractor pursuant to its written Contract with Provider. Such professional liability policy of insurance shall provide a minimum coverage in the amount of one million dollars ($1,000,000) per occurrence, and one million dollars ($1,000,000) annual aggregate. These Providers may also be allowed to self insure if the Provider establishes an appropriate actuarially determined reserve.

4.10.3.3 In the event any such insurance is proposed to be reduced, terminated or canceled for any reason, the Contractor shall provide to DCH and Department of Insurance (DOI) at least thirty (30) Calendar Days prior written notice of such reduction, termination or cancellation. Prior to the reduction, expiration and/or cancellation of any insurance policy required hereunder, the Contractor shall require the Provider to secure replacement coverage upon the same terms and provisions so as to ensure no lapse in coverage, and shall furnish DCH and DOI with a Certificate of Insurance indicating the receipt of the required coverage at the request of DCH or DOI.

4.10.3.4 The Contractor shall require Providers to maintain insurance coverage (including, if necessary, extended coverage or tail insurance) sufficient to insure against claims arising at any time during the term of the GF Contract, even though asserted after the termination of the GF Contract. DCH or DOI, at its discretion, may request that the Contractor immediately terminate the Provider from participation in the program upon the Provider's failure to abide by these provisions. The provisions of this Section shall survive the expiration or termination of the GF Contract for any reason.

4.10.4 Provider Payment

4.10.4.1 With the exceptions noted below, the Contractor shall negotiate rates with Providers and such rates shall be specified in the Provider Contract. DCH prefers that Contractors pay Providers on a Fee for Service basis, however if the Contractor does enter into a capitated arrangement with Providers, the Contractor shall continue to require all Providers to submit detailed Encounter Data, including those Providers that may be paid a Capitation Payment.

4.10.4.2 The Contractor shall be responsible for issuing an IRS Form (1099) in accordance with all federal laws, regulations and guidelines.

4.10.4.3 When the Contractor negotiates a contract with a Critical Access Hospital (CAH), pursuant to Section 4.8.5.2 of the GF Contract, the Contractor shall pay the CAH a payment rate based on 101% allowable costs incurred by the CAH. DCH may require the Contractor to adjust the rate paid to CAHs if so directed by the State of Georgia's Appropriations Act.

- A critical access hospital must provide notice to a care management organization and DCH of any alleged breaches in its contract by such care management organization.

- If a critical access hospital satisfies the requirement of Title 33 of the Official Code of Georgia Annotated (Medicaid Care Management Organizations Act), and if DCH concludes, after notice and hearing, that a care management organization has substantively and repeatedly breached a term of its contract with a critical access hospital, the department is authorized to require the care management organization to pay damages to the critical access hospital in an amount not to exceed three times the amount owed. Notwithstanding the foregoing, nothing in Title 33 of the Official Code of Georgia Annotated (Medicaid Care Management Organizations Act) shall be interpreted to limit the authority of DCH to establish additional penalties or fines against a care management organization for failure to comply with the contract between a care management organization and DCH.

4.10.4.4 When the Contractor negotiates a contract with a FQHC and/or a RHC, as defined in Section 1905(a)(2)(B) and 1905(a)(2)(C) of the Social Security Act, the Contractor shall pay the PPS rates for Core Services and other ambulatory services per encounter. The rates are established as described in §1001.1 of the Manual. At Contractor's discretion, it may pay more than the PPS rates for these services.

4.10.4.4.1 Payment Reports must consist of all covered service claim types each month, inclusive of all of the below claims data:

- Early and Periodic Screening, Diagnosis and Treatment
- Physician Services
- Office Visits
- Laboratory Diagnostics
- Radiology Diagnostics
- Obstetrical Services
- Family Planning Services
- Injectable Drugs and Immunizations
- Visiting Nurse Services
- Newborn Hearing Screening
- Hospitals
- Nursing Homes
- Other Clinics
- Residential
- Dental Services
- Mental Health Clinic Services
- Refractive Services
- Pharmaceutical Services
- Psychology Services
- Podiatry Services
- Pediatric Preventive Health Screening/Newborn Metabolic
- Supplies incident to core services
- Demonstration related Services as a separate report

(FOR ADDITIONAL FQHC AND RHC REQUIREMENTS, ACCESS THE DCH PART II, POLICIES AND PROCEDURES FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES AND PART II, POLICIES AND PROCEDURES FOR RURAL HEALTH CLINIC SERVICES AT GHP.GA.GOV.)

4.10.4.5 Upon receipt of notice from DCH that it is due funds from a Provider, who has exhausted or waived the administrative review process, if applicable, the Contractor shall reduce payment to the Provider for all claims submitted by that Provider by one hundred percent (100%), or such other amount as DCH may elect, until such time as the amount owed to DCH is recovered. The Contractor shall promptly remit any such funds recovered to DCH in the manner specified by DCH. To that end, the Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to DCH.

4.10.4.6 The Contractor shall adjust its negotiated rates with Providers to reflect budgetary changes to the Medical Assistance program, as directed by the Commissioner of DCH; to the extent, such adjustments can be made within funds appropriated to DCH and available for payment to the Contractor. The Contractor's Provider Contracts shall contain a provision giving notice of this obligation to the Provider, such that the Provider's execution of the Contract shall constitute agreement with the Contractor's obligation to DCH.

4.10.5 Reporting Requirements

The Contractor shall submit to DCH monthly FQHC and RHC Reports as described in Section 4.18.3.9.

4.10.6 **Provider Payment Agreement**

4.10.6.1 The Contractor shall increase benefit payments to Providers in an amount consistent with the provider rate increases included in the State of Georgia's fiscal year 2011 budget. This enhanced rate shall be effective for dates of service beginning July 1, 2010 until repealed or modified by legislative action or DCH policy changes.

4.10.6.2 The Contractor will provide reports as requested by DCH to enable DCH to determine the amount of the increase in benefit payments to Providers as referenced in Section 4.10.6.1. The report will include, but not be limited to monthly reports, by hospital, that provide the following data for each claim paid:

- Claim Number
- Date of Service
- Date of Payment
- Base Paid amount
- Add-on Paid amount
- Interest Paid Amount
- Total Paid amount

4.11 UTILIZATION MANAGEMENT AND CARE COORDINATION RESPONSIBILITIES

4.11.1 Utilization Management

4.11.1.1 The Contractor shall provide assistance to Members and Providers to ensure the appropriate Utilization of resources, using the following program components: Prior Authorization and Pre-Certification, prospective review, concurrent review, retrospective review, ambulatory review, second opinion, discharge planning and case management. Specifically, the Contractor shall have written Utilization Management Policies and Procedures that:

- Include protocols and criteria for evaluating Medical Necessity, authorizing services, and detecting and addressing over-Utilization and under-Utilization. Such protocols and criteria shall comply with federal and State laws and regulations.
- Address which services require PCP Referral; which services require Prior-Authorization and how requests for initial and continuing services are processed, and which services will be subject to concurrent, retrospective or prospective review.
- Describe mechanisms in place that ensure consistent application of review criteria for authorization decisions.
- Require that all Medical Necessity determinations be made in accordance with DCH's Medical Necessity definition as stated in Section 4.5.4.

4.11.1.1 The Contractor shall submit the Utilization Management Policies and Procedures to DCH for review and prior approval within quarterly and as changed.

4.11.1.2 Network Providers may participate in Utilization Review activities in their own Service Region to the extent that there is not a conflict of interest. The Utilization Management Policies and Procedures shall define when such a conflict may exist and shall describe the remedy.

4.11.1.3 The Contractor shall have a Utilization Management Committee comprised of network Providers within each Service Region. The Contractor may have one (1) independent Utilization Management Committee for all of the Service Regions in which it is operating, if there is representation from each Service Region on the Committee. The Utilization Management committee is accountable to the Medical Director and governing body of the Contractor. The Utilization Management Committee shall meet on a regular basis and maintain records of activities, findings, recommendations, and actions. Reports of these activities shall be made available to DCH upon request.

4.11.1.4 The Contractor, and any delegated Utilization Review agent, shall not permit or provide compensation or anything of value to its employees, agents, or contractors based on:

- Either a percentage of the amount by which a Claim is reduced for payment or the number of Claims or the cost of services for which the person has denied authorization or payment; or
- Any other method that encourages the rendering of a Proposed Action.

4.11.2 Prior Authorization and Pre-Certification

4.11.2.1 The Contractor shall not require Prior Authorization or Pre-Certification for Emergency Services, Post-Stabilization Services, or Urgent Care services, as described in Section 4.6.1, 4.6.2, and 4.6.3.

4.11.2.2 The Contractor shall require Prior Authorization and/or Pre-Certification for all non-emergent and non-urgent inpatient admissions except for normal newborn deliveries.

4.11.2.3 The Contractor may require Prior Authorization and/or Pre-Certification for all non-emergent, Out-of-Network services.

4.11.2.4 Prior Authorization and Pre-Certification shall be conducted by a currently licensed, registered or certified Health Care Professional who is appropriately trained in the principles, procedures and standards of Utilization Review.

4.11.2.5 The Contractor shall notify the Provider of Prior Authorization determinations in accordance with the following timeframes:

4.11.2.5.1 Standard Service Authorizations. Prior Authorization decisions for non-urgent services shall be made within fourteen (14) Calendar Days of receipt of the request for services. An extension may be granted for an additional fourteen (14) Calendar Days if the Member, P4HB Participant or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's or P4HB Participant's interest.

4.11.2.5.2 Expedited Service Authorizations. In the event a Provider indicates, or the Contractor determines, that following the standard timeframe could seriously jeopardize the Member's or P4HB Participant's life or health the Contractor shall make an expedited authorization determination and provide notice within twenty-four (24) hours. The Contractor may extend the twenty-four (24) hour period for up to five (5) Business Days if the Member, P4HB Participant or the Provider requests an extension, or if the Contractor justifies to DCH a need for additional information and the extension is in the Member's or P4HB Participant's interest.

4.11.2.5.3 Authorization for services that have been delivered. Determinations for authorization involving health care services that have been delivered shall be made within thirty (30) Calendar Days of receipt of the necessary information.

4.11.2.6 The Contractor's policies and procedures for authorization shall include consulting with the requesting Provider when appropriate.

4.11.3 Referral Requirements and P4HB Participants

4.11.3.1 The Contractor may require that Members obtain a Referral from their PCP prior to accessing non-emergency specialized services.

4.11.3.2 In the Utilization Management Policies and Procedures discussed in Section 4.11.1.1, the Contractor shall address:

- When a Referral from the Member's PCP is required;
- How a Member obtains a Referral to an In-Network Provider or an Out-of-Network Provider when there is no Provider within the Contractor's network that has the appropriate training or expertise to meet the particular health needs of the Member;
- How a Member with a Condition which requires on-going care from a specialist may request a standing Referral; and
- How a Member with a life-threatening Condition or disease, which requires specialized medical care over a prolonged period of time, may request and obtain access to a specialty care center.

4.11.3.3 The Contractor shall prohibit Providers from making Referrals for designated health services to Health Care entities with which the Provider or a Member of the Provider's family has a Financial Relationship.

4.11.3.4 DCH strongly encourages the Contractor to develop electronic, web-based Referral processes and systems. In the event a Referral is made via the telephone, the Contractor shall ensure that the Contractor, the Provider and DCH maintain Referral data, including the final decision, in a data file that can be accessed electronically.

4.11.3.5 In conjunction with the other Utilization Management policies, the Contractor shall submit the Referral processes to DCH for review and approval.

4.11.4 Transition of Members

4.11.4.1 Contractors shall identify and facilitate transitions for Members that are moving from one CMO to another or from a CMO to a fee-for service provider and require additional or distinctive assistance during a period of transition. When relinquishing Members, the Contractor shall cooperate with the receiving CMO plan or FFS Medicaid regarding the course of on-going care with a specialist or other Provider. Priority will be given to members who have medical conditions or circumstances such as:

- Members who are currently hospitalized.
- Pregnancy; women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date
- Major organ or tissue transplantation services which are in process, or have been authorized
- Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities, and/or

- Members who are in treatment such as Chemotherapy, radiation therapy, or Dialysis.
- Members with ongoing needs such as Specialized Durable medical equipment including ventilators and other respiratory assistance equipment
- Current Home health services
- Medically necessary transportation on a scheduled basis and
- Prescription medications requiring prior authorizations
- The Contractor will monitor Providers to ensure transition of care from one entity to another to include discharge planning as appropriate. Procedures that are scheduled to occur after their new CMO effective date, but that have been authorized by either DCH or the patients original CMO prior to their new CMO effective date will be covered by the patients new CMO for 30 days.
- Members that are in ongoing outpatient treatment or that are receiving medication that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by the new CMO for at least 30 days to allow time for clinical review, and if necessary transition of care. The CMO will not be obligated to cover services beyond 30 days, even if the DCH authorization was for a period greater than 30 days.

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

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

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

4.11.4.2 Inpatient Acute Coverage Responsibility

4.11.4.2.1 Members enrolled in a CMO that are hospitalized in an acute inpatient hospital facility will remain the responsibility of that CMO until they are discharged from the facility, even if they change to a different CMO, or they become eligible for coverage under FFS Medicaid during their inpatient stay. The CMO is not required to cover services for a member that has no Medicaid benefits, if the member remains an acute inpatient and loses Medicaid eligibility during the stay; the CMO is only responsible for payment until the last day of Medicaid eligibility.

4.11.4.2.1.1 Inpatient care for newborns born on or after their mother's effective date will be the responsibility of the mother's assigned CMO.

4.11.4.2.1.2 Members that become eligible and enrolled in any retro-active program (such as SSI) after the date of an inpatient hospitalization shall remain the responsibility of the CMO until they are discharged from inpatient acute hospital care. These members will remain the responsibility of the CMO for all covered services, even if the start date for SSI eligibility is made retroactive to a date prior to the inpatient acute hospitalization.

4.11.4.2.1.3 The admitting CMO will continue to receive capitation payment for every month that the member continues to be hospitalized and enrolled in a CMO and will be responsible for all medical claims during the period that they are receiving capitation. At discharge, and upon notice of such discharge, DCH will reassign the member to FFS or the new CMO following the normal monthly process.

4.11.4.2.1.4 Upon notification that a hospitalized member will be transitioning to a new CMO, or to FFS Medicaid, the current CMO will work with the new CMO or FFS Medicaid to ensure that coordination of care and appropriate discharge planning occurs.

4.11.4.2.1.5 When relinquishing Members, the Contractor shall cooperate with the receiving CMO plan regarding the course of on-going care with a specialist or other Provider.

4.11.4.2.1.6 Contractors must identify and facilitate coordination of care for all Georgia Families members during changes or transitions between Contractors, as well as transitions to FFS Medicaid. Members with special circumstances (such as those listed below) may require additional or distinctive assistance during a period of transition. Policies or protocols must be developed to address these situations. Special circumstances include members designated as having "special health care needs", as well as members who have medical conditions or circumstances such as:

- Pregnancy (especially women who are high risk and in third trimester, or are within 30 days of their anticipated delivery date)
- Major organ or tissue transplantation services which are in process, or have been authorized
- Chronic illness, which has placed the member in a high-risk category and/or resulted in hospitalization or placement in nursing, or other, facilities, and/or
- Significant medical conditions, (e.g., diabetes, hypertension, pain control or orthopedics) that require ongoing care of specialist appointments.
- Members who are in treatment such as:
    - Chemotherapy and/or radiation therapy, or
    - Dialysis.
- Members with ongoing needs such as:
    - Durable medical equipment including ventilators and other respiratory assistance equipment
    - Home health services
    - Medically necessary transportation on a scheduled basis
    - Prescription medications, and/or
- Other services not indicated in the State Plan, but covered by Title XIX for Early and Periodic Screening, Diagnosis and Treatment eligible members.
- Members who are currently hospitalized.

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

4.11.4.3 Long-Term Care Coverage Responsibility

4.11.4.3.1 Members enrolled in a CMO that are receiving services in a long-term care facility will remain the responsibility of the admitting CMO until disenrolled from the CMO by DCH.

4.11.4.3.2 For the purposes of this requirement, long-term care facilities include Nursing Homes, Skilled Nursing Facilities, Psychiatric Residential Treatment Facilities and other facilities that provide long-term non-acute care.

4.11.4.3.3 Upon disenrollment from the CMO, the financial responsibility for services provided to the member transitions to the member's new CMO or FFS.

4.11.4.3.4 Members that are in ongoing non acute treatment in an inpatient facility that has been covered by DCH or another CMO prior to their new CMO effective date will be covered by the new CMO for at least 30 days to allow time for clinical review, and if necessary transition of care. The CMO will not be obligated to cover services beyond 30 days, even if the DCH authorization was for a period greater than 30 days.

4.11.4.4 Discharge Planning

4.11.4.4.1 The Contractor shall maintain and operate a formalized discharge-planning program that includes a comprehensive evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

4.11.5 Back Transfers

4.11.5.1 Effective January 01, 2009, DCH will permit transfers from a higher level of care, back to a lower level (referred to as a back transfer). The transfer is subject to medical necessity review and the payment policies outlined in the contract with the payer.

4.11.5.2 Each request will be reviewed on an individual basis to determine if the transfer is appropriate. The length of stay for the transferring hospital and for the return to the originating hospital will also be evaluated to determine if the transfer is appropriate.

4.11.5.3 If a transfer back to a hospital provides a lower level of care does occur, the facility receiving the back-transfer will be eligible for reimbursement if prior authorization is obtained from the applicable payer and according to the payment agreement of that payer.

4.11.5.4 That hospital Providers fully understand this policy; each CMO will document provider education bulletins that will outline their CMO "back transfer" pre certification requirements along with the billing procedures.

4.11.5.5 It is the responsibility of the Contractor to review policy updates that are made periodically made to the Georgia Medicaid Manuals.

4.11.6 Court-Ordered Evaluations and Services

In the event a Member requires Medicaid-covered services ordered by a State or federal court, the Contractor shall fully comply with all court orders while maintaining appropriate Utilization Management practices.

4.11.7 Second Opinions

4.11.7.1 The Contractor shall provide for a second opinion in any situation when there is a question concerning a diagnosis or the options for surgery or other treatment of a health Condition when requested by any Member of the Health Care team, a Member, parent(s) and/or guardian (s), or a social worker exercising a custodial responsibility.

4.11.7.2 The second opinion must be provided by a qualified Health Care Professional within the network, or the Contractor shall arrange for the Member to obtain one outside the Provider network.

4.11.7.3 The second opinion shall be provided at no cost to the Member.

4.11.8 Care Coordination Responsibilities

4.11.8.1 The Contractor is responsible for care coordination – a set of member-centered, goal-oriented, culturally relevant and logical steps to assure that a member receives needed services in a supportive, effective, efficient, timely and cost-effective manner. Care Coordination includes Case Management, Disease Management, Transition of Care and Discharge Planning.

4.11.8.2 The Contractor shall develop and implement a Care Coordination system to ensure and promote:

- Timely access and delivery of Health Care and services required by Members;
- Continuity of Members' care; and
- Coordination and integration of Members' care.

4.11.8.3 Policies and procedures are designed to accommodate the specific cultural and linguistic needs of the Contractor's Members and include, at a minimum, the following elements:

- The provision of an individual needs assessment and diagnostic assessment; the development of an individual treatment plan, as necessary, based on the needs assessment; the establishment of treatment objectives; the monitoring of outcomes; and a process to ensure that treatment plans are revised as necessary.
- A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning
- Procedures and criteria for making Referrals to specialists and sub-specialists;
- Procedures and criteria for maintaining care plans and Referral Services when the Member changes PCPs; and
- Capacity to implement, when indicated, case management functions such as individual needs assessment, including establishing treatment objectives, treatment follow-up, monitoring of outcomes, or revision of treatment plan.

4.11.8.4 The Contractor shall submit the Care Coordination Policies and Procedures to DCH for review and approval within ninety (90) Calendar Days of Contract Award and as updated thereafter.

4.11.9 Case Management

4.11.9.1 The Contractor's Case Management system shall emphasize prevention, continuity of care, and coordination of care. The system will advocate for, and link Members to, services.

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

4.11.9.2 Case Management functions include:

- Early identification of Members who have or may have special needs;
- Assessment of a Member's risk factors;
- Development of a plan of care;
- Referrals and assistance to ensure timely access to Providers;
- Coordination of care actively linking the Member to Providers, medical services, residential, social and other support services where needed;
- Monitoring;
- Continuity of care;
- Follow up and;
- Documentation

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

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

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

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

4.11.9.3 The Contractor shall be responsible for the Case Management of their Members and shall make special effort to identify Members who have the greatest need for Case Management, including those who have

catastrophic or other high-cost or high-risk Conditions including pregnant women under 21, high risk pregnancies and infants and toddlers with established risk for developmental delays.

4.11.9.4 The Contractor will submit quarterly reports to DCH which include specified Case Management Program data as described in Section 4.18.4.12.

4.11.10 Disease Management

4.11.10.1 The Contractor shall develop disease management programs for individuals with Chronic Conditions. These programs must target the prevalent chronic diseases within the Contractor's population.

4.11.10.2 The Contractor must notify DCH of the disease management programs it initiates and terminates and provide evidence, on an annual basis of the effectiveness of such programs for its enrolled members.

4.11.10.3 The Contractor must submit Quarterly status reports to DCH which include specified Disease Management Program data as described in Section 4.18.4.13 in addition to the annual report.

4.11.10.4 The Contractor will submit Quarterly reports to DCH which include specified Disease Management Program data as described in Section 4.18.4.13.

4.11.11 Discharge Planning

4.11.11.1 The Contractor shall maintain and operate a formalized discharge-planning program that includes a comprehensive evaluation of the Member's health needs and identification of the services and supplies required to facilitate appropriate care following discharge from an institutional clinical setting.

4.11.12 Reporting Requirements

4.11.12.1 The Contractor shall submit to DCH quarterly Case Management and Disease Management Reports as described in 4.18.4.12 and 4.18.4.13.

4.11.12.2 The Contractor shall submit to DCH quarterly Prior Authorization and Pre-Certification Reports as described in Section 4.18.4.9.

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

4.12 QUALITY IMPROVEMENT

4.12.1 General Provisions

4.12.1.1 The Contractor shall provide for the delivery of Quality care with the primary goal of improving the health status of Members and, where the Member's Condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in Condition or deterioration of health status. This shall include the identification of Members at risk of developing Conditions, the implementation of appropriate interventions and designation of adequate resources to support the intervention(s).

4.12.1.2 The Contractor shall seek input from, and work with, Members, Providers and community resources and agencies to actively improve the Quality of care provided to Members.

4.12.1.3 The Contractor shall establish a multi-disciplinary Quality Oversight Committee to oversee all Quality functions and activities. This committee shall meet at least quarterly, but more often if warranted.

4.12.2 Quality Strategic Plan Requirements

4.12.2.1 The Contractor shall support and comply with Georgia Families Quality Strategic Plan. The Quality Strategic Plan is designed to improve the Quality of Care and Service rendered to GF members (as defined in Title 42 of the Code of Federal Regulations (42 CFR) 431.300 et seq. (Safeguarding Information on Applicants and Recipients); 42 CFR 438.200 et seq. (Quality Assessment and Performance Improvement Including Health Information Systems), and 45 CFR Part 164 (HIPAA Privacy Requirements).

4.12.2.2 The GF Quality Strategic Plan promotes improvement in the quality of care provided to enrolled members through established processes. DCH Managed Care & Quality staff' oversight of the Contractor includes:

- Monitoring and evaluating the Contractor's service delivery system and provider network, as well as its own processes for quality management and performance improvement;
- Implementing action plans and activities to correct deficiencies and/or increase the quality of care provided to enrolled members,
- Initiating performance improvement projects to address trends identified through monitoring activities, reviews of complaints and allegations of abuse, provider credentialing and profiling, utilization management reviews, etc.;
- Monitoring compliance with Federal, State and Georgia Families requirements;
- Ensuring the Contractor's coordination with State registries;
- Ensuring Contractor executive and management staff participation in the quality management and performance improvement processes;
- Ensure that the development and implementation of quality management and performance improvement activities include contracted provider participation and information provided by members, their families and guardians, and
- Identifying the Contractor's best practices for performance and quality improvement.

4.12.3 Performance Measures

4.12.3.1 The Contractor shall comply with the Georgia Families Quality Management requirements to improve the health outcomes for all Georgia Families members. Improved health outcomes will be documented using established performance measures. Georgia Families uses the Healthcare Effectiveness Data and Information Set (HEDIS) and the Agency for Healthcare Research and Quality (AHRQ) technical specifications for some of the quality and health improvement performance measures.

4.12.3.2 Several of the HEDIS measures utilize hybrid methodology, that is, they require a medical record review in addition to the administrative data requirement for measurement reporting. The number of required record reviews is determined by the specifications for each HEDIS measure.

4.12.3.3 While the Contractor must meet the Georgia Families Performance Measure Targets for each measure, it is equally important that the Contractor continually improve health outcomes from year to year. The Contractor shall strive to meet the performance measure targets established by Georgia Families. The performance measure targets for each performance measure are defined in Attachment M. Performance targets for the HEDIS measures are based on national Medicaid Managed Care HEDIS audit means and percentiles as reported by NCQA.

4.12.3.4 Georgia Families may also require a CAPA/PC form that addresses the lack of performance measure target achievements and identifies steps that will lead toward improvements. This evidence-based CAPA/PC form must be received by Georgia Families within 30 days of receipt of notification of lack of achievement of performance targets from Georgia Families. The CAPA/PC form must be approved by Georgia Families prior to implementation. Georgia Families may conduct follow up on-site reviews to verify compliance with a CAPA/PC form. Georgia Families may impose Category 3 Liquidated Damages on Contractors who do not meet the performance measure targets for any one performance measure.

4.12.3.5 The performance measures apply to the member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure. Performance Measures, benchmarks, and/or specifications may change annually to comply with industry standards and updates.

4.12.3.6 Each contractor must validate each performance measure and submit to DCH no later than June 30 of each year.

4.12.4 Reporting Requirements

Contractors must submit the following data reports as indicated.

REPORT	DUE DATE	REPORTS DIRECTED TO:
Performance Improvement Project Proposal(s)	Annually June 30	Georgia Families/ Quality Management Unit
Quality Assurance Performance Improvement Plan	Annually June 30	Georgia Families/ Quality Management Unit
Quality Assessment Performance Improvement Program Evaluation	Annually June 30	Georgia Families/ Quality Management Unit
Performance Improvement Project Baseline Report	Annually June 30	Georgia Families/ Quality Management Unit
Performance Improvement Project Final Evaluation Report (including any new QM/PI activities implemented as a result of the project)	Annually June 30	Georgia Families/ Quality Management Unit
Corrective Action Preventive Action Plan/Performance Concerns for deficiencies noted in: 1. An Operations Field Review 2. A Focused Review 3. QM/PI Plan 4. Performance related to Quality Measures	30 days after receipt of notice to submit a Corrective Action Preventive Action Plan (CAPA) unless otherwise stated.	Georgia Families/ Quality Management Unit
Performance Measures Report	Annually June 30	Georgia Families/ Quality Management Unit

If an extension of time is needed to complete a report, the Contractor may submit a request in writing to the Georgia Families/Quality Management

4.12.5 Quality Assessment Performance Improvement (QAPI) Program

4.12.5.1 The Contractor shall have in place an ongoing QAPI program consistent with 42 CFR 438.240.

4.12.5.2 The Contractor's QAPI program shall be based on the latest available research in the area of Quality assurance and at a minimum must include:

- A method of monitoring, analysis, evaluation and improvement of the delivery, Quality and appropriateness of Health Care furnished to all Members (including under and over Utilization of services), including those with special Health Care needs;
- Written policies and procedures for Quality assessment, Utilization Management and continuous Quality improvement that are periodically assessed for efficacy;
- A health information system sufficient to support the collection, integration, tracking, analysis and reporting of data;
- Designated staff with expertise in Quality assessment, Utilization Management and continuous Quality improvement;
- Reports that are evaluated, indicated recommendations that are implemented, and feedback provided to Providers and Members;
- A methodology and process for conducting and maintaining Provider profiling;
- Ad-Hoc Reports to the Contractor's multi-disciplinary Quality oversight committee and DCH on results, conclusions, recommendations and implemented system changes;
- Annual performance improvement projects (PIPs) that focus on clinical and non-clinical areas; and
- Annual Reports on performance improvement projects and a process for evaluation of the impact and assessment of the Contractor's QAPI program.

4.12.5.3 The Contractor's QAPI Program Plan must be submitted to DCH for review and approval as updated.

4.12.5.4 The Contractor shall submit any changes to its QAPI Program Plan to DCH for review and prior approval sixty (60) Calendar Days prior to implementation of the change.

4.12.5.5 Upon the request of DCH, the Contractor shall provide any information and documents related to the implementation of the QAPI program.

4.12.6 Performance Improvement Projects

4.12.6.1 As part of its QAPI program, the Contractor shall conduct clinical and non-clinical performance improvement projects in accordance with DCH and federal protocols. In designing its performance improvement projects, the Contractor shall:

- Show that the selected area of study is based on a demonstration of need and is expected to achieve measurable benefit to the Member (rationale);
- Establish clear, defined and measurable goals and objectives that the Contractor shall achieve in each year of the project;
- Measure performance using Quality indicators that are objective, measurable, clearly defined and that allow tracking of performance and improvement over time;
- Implement interventions designed to achieve Quality improvements;
- Evaluate the effectiveness of the interventions;
- Establish standardized performance measures (such as HEDIS or another similarly standardized product);
- Plan and initiate activities for increasing or sustaining improvement; and
- Document the data collection methodology used (including sources) and steps taken to assure data is valid and reliable.

4.12.6.2 Each performance improvement project must be completed in a period determined by DCH, to allow information on the success of the project in the aggregate to produce new information on Quality of care each year.

4.12.6.3 The Contractor shall perform the following required performance improvement projects, as agreed upon by the Parties (see Section 4.12.6.5), beginning January 1, 2012, ongoing for the duration of the GF Contract period:

- Well-child visits;
- ADHD Medication follow up;
- Immunization rates;
- Dental-children
- Obesity-children
- Comprehensive Diabetes Care;
- Avoidable Emergency room utilization;
- Member satisfaction, and
- Provider satisfaction

4.12.6.4 Each PIP will use the calendar year as the study period.

4.12.6.5 Each PIP will use the study question and study indicators agreed upon by DCH and the CMOs.

4.12.6.6 Each CMO will submit the designated PIPs to DCH and/or the EQRO using the DCH specified template and format by June 30 of each contract year with the exception of the member satisfaction PIP which is due by August 1.

4.12.6.7 The EQRO will evaluate the CMOs' PIP performance on an annual basis. DCH reserves the right to request modification of the PIPs based on this evaluation. Modifications will be discussed with each CMO prior to implementation.

4.12.7 Practice Guidelines

4.12.7.1 The Contractor shall adopt a minimum of three (3) evidence-based clinical practice guidelines. Such guidelines shall:

- Be based on the health needs and opportunities for improvement identified as part of the QAPI program;
- Be based on valid and reliable clinical evidence or a consensus of Health Care Professionals in the particular field;
- Consider the needs of the Members;
- Be adopted in consultation with network Providers; and
- Be reviewed and updated periodically as appropriate.

4.12.7.2 The Contractor shall submit all Practice Guidelines in use, which shall include a methodology for measuring and assessing compliance, to DCH for review and prior approval as part of the QAPI program plan as updated.

4.12.7.3 The Contractor shall disseminate the guidelines to all affected Providers and, upon request, to Members.

4.12.7.4 The Contractor shall ensure that decisions for Utilization Management, Member education, coverage of services, and other areas to which the guidelines apply are consistent with the guidelines.

4.12.7.5 In order to ensure consistent application of the guidelines the Contractor shall encourage Providers to utilize the guidelines, and shall measure compliance with the guidelines, until ninety percent (90%) or more of the Providers are consistently in compliance. The Contractor may use Provider incentive strategies to improve Provider compliance with guidelines.

4.12.8 Focused Studies

4.12.8.1 Focus Studies examine a specific aspect of health care (such as prenatal care) for a defined point in time. These studies are usually based on information extracted from medical records or Contractor administrative data such as enrollment files and encounter/claims data. Steps that may be taken by the Contractor when conducting focus studies are:

- Selecting the Study Topic(s)
- Defining the Study Question(s)
- Selecting the Study Indicator(s)
- Identifying a representative and generalizable study population
- Documenting sound sampling techniques utilized (if applicable)
- Collecting reliable data
- Analyzing data and interpreting study results

4.12.8.2 The Contractor may perform, at DCH discretion, a Focused Study to examine a specific aspect of health care (such as prenatal care) for a defined point in time. The Focused Study will have a calendar year study period and the results will be reported to DCH by June 30th following the year of the study.

4.12.9 Patient Safety Plan

4.12.9.1 The Contractor shall have a structured Patient Safety Plan to address concerns or complaints regarding clinical care. This plan must include written policies and procedures for processing of Member complaints regarding the care they received. Such policies and procedures shall include:

- A system of classifying complaints according to severity;
- A review by the Medical Director and a mechanism for determining which incidents will be forwarded to Peer Review and Credentials Committees; and
- A summary of incident(s), including the final disposition, included in the Provider profile.

4.12.9.2 The Contractor shall submit the Patient Safety Plan to DCH for review and approval as updated.

4.12.10 Reserved.

4.12.11 External Quality Review

DCH will contract with an External Quality Review Organization (EQRO) to conduct annual, external, independent reviews of the Quality outcomes, timeliness of, and access to, the services covered in this Contract. The Contractor shall collaborate with DCH's EQRO to develop studies, surveys and other analytic activities to assess the Quality of care and services provided to Members and to identify opportunities for CMO plan improvement. To facilitate this process the Contractor shall supply data, including but not limited to Claims data and Medical Records, to the EQRO.

4.12.12 Reporting Requirements

4.12.12.1 The Contractor's Quality Oversight Committee shall submit to DCH Quality Oversight Committee Reports - Ad Hoc as described in Section 4.12.5.2

4.12.12.2 The Contractor shall submit to DCH Performance Improvement Project Reports no later than June 30 of the contract year as described in Section 4.12.6.

4.12.12.3 The Contractor shall submit to DCH annual Focused Studies Reports no later than June 30 of the contract year as described in Section 4.12.8.

4.12.12.4 The Contractor shall submit to DCH annual Patient Safety Plan Reports no later than June 30 of the contract year as described in Section 4.12.9.

4.13 FRAUD AND ABUSE

4.13.1 Program Integrity

4.13.1.1 The Contractor shall have a Program Integrity Program, including a mandatory compliance plan, designed to guard against Fraud and Abuse. This Program Integrity Program shall include policies, procedures, and standards of conduct for the prevention, detection, reporting, and corrective action for suspected cases of Fraud and Abuse in the administration and delivery of services under this Contract.

4.13.1.2 The Contractor shall submit its Program Integrity Policies and Procedures, which include the compliance plan and pharmacy lock-in program described below, to DCH for approval as updated.

4.13.2 Compliance Plan

4.13.2.1 The Contractor's compliance plan shall include, at a minimum, the following:

- The designation of a Compliance Officer who is accountable to the Contractor's senior management and is responsible for ensuring that policies to establish effective lines of communication between the Compliance Officer and the Contractor's staff, and between the Compliance Officer and DCH staff, are followed;
- Provision for internal monitoring and auditing of reported Fraud and Abuse violations, including specific methodologies for such monitoring and auditing;
- Policies to ensure that all officers, directors, managers and employees know and understand the provisions of the Contractor's Fraud and Abuse compliance plan;
- Policies to establish a compliance committee that periodically meets and reviews Fraud and Abuse compliance issues;
- Policies to ensure that any individual who reports CMO plan violations or suspected Fraud and Abuse will not be retaliated against;
- Policies of enforcement of standards through well-publicized disciplinary standards;
- Provision of a data system, resources and staff to perform the Fraud and Abuse and other compliance responsibilities;
- Procedures for the detection of Fraud and Abuse that includes, at a minimum, the following:
    - Claims edits
    - Post-processing review of Claims;
    - Provider profiling and Credentialing;
    - Quality Control; and
    - Utilization Management.
- Written standards for organizational conduct;
- Effective training and education for the Compliance Officer and the organization's employees, management, board Members, and Subcontractors;
- Inclusion of information about Fraud and Abuse identification and reporting in Provider and Member materials;
- Provisions for the investigation, corrective action and follow-up of any suspected Fraud and Abuse reports; and
- Procedures for reporting suspected Fraud and Abuse cases to the State Program Integrity Unit, including timelines and use of State approved forms.

4.13.2.2 As part of the Program Integrity Program, the Contractor shall implement a pharmacy lock-in program. The policies, procedures and criteria for establishing a lock-in program shall be submitted to DCH for review and approval as part of the Program Integrity Policies and Procedures discussed in Section 4.13.1. The pharmacy lock-in program shall:

- Allow Members to change pharmacies for good cause, as determined by the Contractor after discussion with the Provider(s) and the pharmacist. Valid reasons for change should include recipient relocation or the pharmacy does not provide the prescribed drug;
- Provide Case management and education reinforcement of appropriate medication use;
- Annually assess the need for lock-in for each Member; and
- Require that the Contractor's Compliance Officer report on the program on a monthly basis to DCH.
- A member will not be allowed to transfer to another pharmacy, PCP, or CMO while enrolled in their existing CMO's pharmacy lock-in program.

4.13.3 Coordination with DCH and Other Agencies

4.13.3.1 The Contractor shall cooperate and assist any State or federal agency charged with the duty of identifying, investigating, or prosecuting suspected Fraud and Abuse cases, including permitting access to the Contractor's place of business during normal business hours, providing requested information, permitting access to personnel, financial and Medical Records, and providing internal reports of investigative, corrective and legal actions taken relative to the suspected case of Fraud and Abuse.

4.13.3.2 The Contractor's Compliance Officer shall work closely, including attending quarterly meetings, with DCH's program integrity staff to ensure that the activities of one entity do not interfere with an ongoing investigation being conducted by the other entity.

4.13.3.3 The Contractor shall inform DCH immediately about known or suspected cases and it shall not investigate or resolve the suspicion without making DCH aware of, and if appropriate involved in, the investigation, as determined by DCH.

4.13.4 Reporting Requirements

4.13.4.1 The Contractor shall submit to DCH a monthly Fraud and Abuse Report, as described in Section 4.18.3.5. This Report shall include information on the pharmacy lock-in program described in Section 4.13.2.2. This report shall also include information on the prohibition of affiliations with individuals debarred and suspended described in Section 31.19.

4.14 INTERNAL GRIEVANCE/APPEALS SYSTEM

4.14.1 General Requirements

4.14.1.1 The Contractor's Grievance System shall include a process to address Grievances. The Contractor's Appeals Process shall include an Administrative Review process and access to the State's Administrative Law Hearing (State Fair Hearing) system. The Contractor's Appeals Process shall include an internal process that must be exhausted by the Member or P4HB Participant prior to accessing an Administrative Law Hearing.

4.14.1.2 The Contractor shall develop written Grievance System and Appeals Process Policies and Procedures that detail the operation of the Grievance System and the Appeals Process. The Contractor's policies and procedures shall be available in the Member's and P4HB Participants primary language. The Grievance System and Appeals Process Policies and Procedures shall be submitted to DCH for review and approval as updated.

4.14.1.3 The Contractor shall process each Grievance and Administrative Review using applicable State and federal statutory, regulatory, and GF Contractual provisions, and the Contractor's written policies and procedures. Pertinent facts from all parties must be collected during the investigation.

4.14.1.4 The Contractor shall give Members and P4HB Participants any reasonable assistance in completing forms and taking other procedural steps for both Grievances and Administrative Reviews. This includes, but is not limited to, providing interpreter services and toll-free numbers that have adequate TTD and interpreter capability.

4.14.1.5 The Contractor shall acknowledge receipt of each filed Grievance and Administrative Review in writing within ten (10) Business Days of receipt. The Contractor shall have procedures in place to notify all Members and P4HB Participant in their primary language of Grievance and Appeal resolutions.

4.14.1.6 The Contractor shall ensure that the individuals who make decisions on Grievances and Administrative Reviews were not involved in any previous level of review or decision-making; and are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member's and P4HB Participants Condition or disease if deciding any of the following:

- An Appeal of a denial that is based on lack of Medical Necessity;
- A Grievance regarding denial of expedited resolutions of an Administrative Review; and
- Any Grievance or Administrative Review that involves clinical issues.

4.14.1.7 **Member Medical Review Process for PeachCare for Kids®**

DCH also allows a state review on behalf of PeachCare for Kids® members. If the member or parent believes that a denied service should be covered, the parent must send a written request for review to the Care Management Organization (CMO) in which the affected child is enrolled. The CMO will conduct its review process in accordance with Section 4.14 of the contract.

4.14.1.7.1 If the decision of the CMO review maintains the denial of service, a letter will be sent to the parent detailing the reason for denial. If the parent elects to dispute the decision, the parent will have the option of having the decision reviewed by the Formal Appeals Committee. The request should be sent to:

Department of Community Health
PeachCare for Kids®
Administrative Review Request
2 Peachtree Street, NW, 37th floor
Atlanta, GA 30303-3159

4.14.1.7.2 The decision of the Formal Grievance Committee will be the final recourse available to the member. In reference to the Formal Grievance level, the State assures:

- Enrollees receive timely written notice of any documentation that includes the reasons for the determination, an explanation of applicable rights to review, the standard and expedited time frames for review, the manner in which a review can be requested, and the circumstances under which enrollment may continue, pending review.
- Enrollees have the opportunity for an independent, external review of a delay, denial, reduction, suspension, termination of health services, failure to approve, or provide payment for health services in a timely manner. The independent review is available at the Formal Grievance level.
- Decisions are written when reviewed by DCH and the Formal Grievance Committee.
- Enrollees have the opportunity to represent themselves or have representatives in the process at the Formal Grievance level.
- Enrollees have the opportunity to timely review their files and other applicable information relevant to the review of the decision. While this is assured at each level of review, members will be notified of the timeframes for the appeals process once an appeal is file with the Formal Grievance Committee.
- Enrollees have the opportunity to fully participate in the review process, whether the review is conducted in person or in writing.
- Reviews that are not expedited due to an enrollee's medical condition will be completed within 90 calendar days of the date of a request is made.
- Reviews that are expedited due to an enrollee's medical condition shall be completed within 72 hours of the receipt of the request.

4.14.2 Grievance Process

4.14.2.1 A Member, Member's Authorized Representative, or P4HB Member may file a Grievance to the Contractor either orally or in writing. A Grievance may be filed about any matter other than a Proposed Action. A Provider cannot file a Grievance on behalf of a Member or P4HB Member.

4.14.2.2 The Contractor shall ensure that the individuals who make decisions on Grievances that involve clinical issues are Health Care Professionals who have the appropriate clinical expertise, as determined by DCH, in treating the Member or P4HB Member's Condition or disease and who were not involved in any previous level of review or decision-making.

4.14.2.3 The Contractor shall provide written notice of the disposition of the Grievance as expeditiously as the Member or P4HB Member's health Condition requires but must be completed within ninety (90) days but shall not exceed ninety (90) Calendar Days of the filing date.

4.14.3 Proposed Action

4.14.3.1 All Proposed Actions shall be made by a physician, or other peer review consultant, who has appropriate clinical expertise in treating the Member or P4HB Member's Condition or disease.

4.14.3.2 In the event of a Proposed Action, the Contractor shall notify the Member or P4HB Member in writing. The Contractor shall also provide written notice of a Proposed Action to the Provider. This notice must meet the language and format requirements in accordance with Section 4.3.2 of this Contract and be sent in accordance with the timeframes described in Section 4.14.3.4.

4.14.3.3 The notice of Proposed Action must contain the following:

- The Action the Contractor has taken or intends to take, including the service or procedure that is subject to the Action.
- Additional information, if any, that could alter the decision.
- The specific reason used as the basis of the action.
- The reasons for the Action must have a factual basis and legal/policy basis.
- The Member or P4HB Member's right to file an Administrative Review through the Contractor's internal Grievance System as described in Section 4.14.
- The Provider's right to file a Provider Complaint as described in Section 4.9.7;
- The requirement that a Member or P4HB Member exhaust the contractor's internal Administrative Review Process;
- The circumstances under which expedited review is available and how to request it; and
- The Member or P4HB Member's right to have Benefits continue pending resolution of the Administrative Review with the Contractor, Member or P4HB Member instructions on how to request that Benefits be continued, and the circumstances under which the Member or P4HB Member may be required to pay the costs of these services.

4.14.3.4 The Contractor shall mail the Notice of Proposed Action within the following timeframes:

4.14.3.4.1 For termination, suspension, or reduction of previously authorized Covered Services at least ten (10) Calendar Days before the date of Proposed Action or not later than the date of Proposed Action in the event of one of the following exceptions:

- The Contractor has factual information confirming the death of a Member or P4HB Member.
- The Contractor receives a clear written statement signed by the Member or P4HB Member that he or she no longer wishes services or gives information that requires termination or reduction of services and indicates that he or she understands that this must be the result of supplying that information.
- The post office returns Contractor mail directed to the Member or P4HB Member indicating no forwarding address and the Member's whereabouts are unknown and (refer to 42 CFR 431.231(d) for procedures if the Member or P4HB Member's whereabouts become known).
- The Member or P4HB Member's Provider prescribes an immediate change in the level of medical care.

4.14.3.4.2 The date of action will occur in less than ten (days), in accordance with 42 C.F.R. §483.12(a) (5) (ii), which provides exceptions to the 30 days' notice requirements of 42 C.F.R. § 483.12(a) (5) (i).

4.14.3.4.3 The Contractor may shorten the period of advance notice to five (5) Calendar Days before date of action if the Contractor has facts indicating that action should be taken because of probable Member or P4HB Member Fraud and the facts have been verified, if possible, through secondary sources.

4.14.3.4.5 For denial of payment, at the time of any Proposed Action affecting the Claim.

4.14.3.4.6 For standard Service Authorization decisions that deny or limit services, within the timeframes required in Section 4.11.2.5.1.

4.14.3.4.7 If the Contractor extends the timeframe for the decision and issuance of notice of Proposed Action according to Section 4.11.2.5, the Contractor shall give the Member or P4HB Member written notice of the reasons for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he or she disagrees with that decision. The Contractor shall issue and carry out its determination as expeditiously as the Member or P4HB Member's health requires and no later than the date the extension expires.

4.14.3.4.8 For authorization decisions not reached within the timeframes required in Section 4.11.2.5 for either standard or expedited Service Authorizations, Notice of Proposed Action shall be mailed on the date the timeframe expires, as this constitutes a denial and is thus a Proposed Action.

4.14.4 Administrative Review Process

4.14.4.1 An Administrative Review is the request for review of a "Proposed Action". The Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review either orally or in writing. Unless the Member or Provider requests expedited review, the Member, the Member's Authorized Representative, or the Provider acting on behalf of the Member with the Member's written consent, must follow an oral filing with a written, signed, request for Administrative Review.

4.14.4.2 The Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, may file an Administrative Review with the Contractor within thirty (30) Calendar Days from the date of the notice of Proposed Action.

4.14.4.3 Administrative Reviews shall be filed directly with the Contractor, or its delegated representatives. The Contractor may delegate this authority to an Administrative Review committee, but the delegation must be in writing.

4.14.4.4 The Contractor shall ensure that the individuals who make decisions on Administrative Reviews are individuals who were not involved in any previous level of review or decision-making; and who are Health Care Professionals who have the appropriate clinical expertise in treating the Member's Condition or disease if deciding any of the following:

- An Administrative Review of a denial that is based on lack of Medical Necessity.
- An Administrative Review that involves clinical issues.

4.14.4.5 The Administrative Review process shall provide the Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, a reasonable opportunity to present evidence and allegations of fact or law, in person, as well as in writing. The Contractor shall inform the Member or P4HB Member of the limited time available to provide this in case of expedited review.

4.14.4.6 The Administrative Review process must provide the Member, the Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, opportunity, before and during the Administrative Review process, to examine the Member or P4HB Member's case file, including Medical Records, and any other documents and records considered during the Administrative Review process.

4.14.4.7 The Administrative Review process must include as parties to the Administrative Review the Member, the Member's Authorized Representative, the Provider acting on behalf of the Member with the Member's written consent, P4HB Member or the legal representative of a deceased Member's estate.

4.14.4.8 The Contractor shall resolve each Administrative Review and provide written notice of the resolution, as expeditiously as the Member or P4HB Member's health Condition requires but shall not exceed forty-five (45) Calendar Days from the date the Contractor receives the Administrative Review. For expedited reviews and notice to affected parties, the Contractor has no longer than three (3) working days or as expeditiously as the Member or P4HB Member's physical or mental health condition requires, whichever is sooner. If the Contractor denies a Member or P4HB Member's request for expedited review, it must transfer the Administrative Review to the timeframe for standard resolution specified herein and must make reasonable efforts to give the Member or P4HB Member prompt oral notice of the denial, and follow up within two (2) Calendar Days with a written notice. The Contractor shall also make reasonable efforts to provide oral notice for resolution of an expedited review of an Administrative Review.

4.14.4.9 The Contractor may extend the timeframe for standard or expedited resolution of the Administrative Review by up to fourteen (14) Calendar Days if the Member, Member's Authorized Representative, P4HB Member or the Provider acting on behalf of the Member with the Member's written consent, requests the extension or the Contractor demonstrates (to the satisfaction of DCH, upon its request) that there is need for additional information and how the delay is in the Member or P4HB Member's interest. If the Contractor extends the timeframe, it must, for any extension not requested by the Member or P4HB Member, give the Member or P4HB Member written notice of the reason for the delay.

4.14.5 Notice of Adverse Action

4.14.5.1 If the Contractor upholds the Proposed Action in response to an Administrative Review filed by the Member or P4HB Member, the Contractor shall issue a Notice of Adverse Action within the timeframes described in Section 4.14.4.8 and 4.14.4.9.

4.14.5.2 The Notice of Adverse Action shall meet the language and format requirements as specified in 4.3 and include the following:

- The results and date of the Adverse Action including the service or procedure that is subject to the Action.
- Additional information, if any, that could alter the decision.

- The specific reason used as the basis of the action.
- The right to request a State Administrative Law Hearing within thirty (30) Calendar Days. The time for filing will begin when the filing is date stamped;
- The right to continue to receive Benefits pending a State Administrative Law Hearing;
- How to request the continuation of Benefits;
- Information explaining that the Member or P4HB Member may be liable for the cost of any continued Benefits if the Contractor's action is upheld in a State Administrative Law Hearing.
- Circumstances under which expedited resolution is available and how to request it.

4.14.6 Administrative Law Hearing

4.14.6.1 The State will maintain an independent Administrative Law Hearing process as defined in O.C.G.A. §49-4-153 and as required by federal law, 42 CFR 431.200. The Administrative Law Hearing process shall provide Members or P4HB Members an opportunity for a hearing before an impartial Administrative Law Judge. The Contractor shall comply with decisions reached as a result of the Administrative Law Hearing process.

4.14.6.2 The Contractor is responsible for providing counsel to represent its interests. DCH is not a party to case and will only provide counsel to represent its own interests.

4.14.6.3 A Member, Member's Authorized Representative, or P4HB Member may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Action is mailed by the Contractor. The parties to the Administrative Law Hearing shall include the Contractor as well as the Member, Member's Authorized Representative, P4HB Member or representative of a deceased Member's estate. A Provider cannot request an Administrative Law Hearing on behalf of a Member or P4HB Member. DCH reserves the right to intervene on behalf of the interest of either party.

4.14.6.4 The hearing request and a copy of the adverse action letter must be received by the Contractor within 30 days or less from the date that the notice of action was mailed.

4.14.6.5 A Member may request a Continuation of Benefits as described in Section 4.14.7 while an Administrative Law Hearing is pending.

4.14.6.6 The Contractor shall make available any records and any witnesses at its own expense in conjunction with a request pursuant to an Administrative Law Hearing.

4.14.7 Continuation of Benefits while the Contractor Appeal and Administrative Law Hearing are Pending

4.14.7.1 As used in this Section, "timely" filing means filing on or before the later of the following:

- Within ten (10) Calendar Days of the Contractor mailing the Notice of Adverse Action.
- The intended effective date of the Contractor's Proposed Action.

4.14.7.2 The Contractor shall continue the Member or P4HB Member's Benefits if the Member, P4HB Member or the Member's Authorized Representative files the Appeal timely; the Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment; the services were ordered by an authorized Provider; the original period covered by the original authorization has not expired; and the Member or P4HB Member requests extension of the Benefits.

4.14.7.3 If, at the Member or P4HB Member's request, the Contractor continues or reinstates the Member or P4HB Member's benefit while the Appeal or Administrative Law Hearing is pending, the Benefits must be continued until one of the following occurs:

- The Member or P4HB Member withdraws the Appeal or request for the Administrative Law Hearing.
- Ten (10) Calendar Day pass after the Contractor mails the Notice of Adverse Action, unless the Member or P4HB Member, within the ten (10) Calendar Day timeframe, has requested an Administrative Law Hearing with continuation of Benefits until an Administrative Law Hearing decision is reached.
- An Administrative Law Judge issues a hearing decision adverse to the Member or P4HB Member.
- The time period or service limits of a previously authorized service has been met.

4.14.7.4 If the final resolution of Appeal is adverse to the Member or P4HB Member, that is, upholds the Contractor action, the Contractor may recover from the Member the cost of the services furnished to the Member or P4HB Member while the Appeal is pending, to the extent that they were furnished solely because of the requirements of this Section.

4.14.7.5 If the Contractor or the Administrative Law Judge reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the Contractor shall authorize or provide these disputed services promptly, and as expeditiously as the Member or P4HB Member's health condition requires.

4.14.7.6 If the Contractor or the Administrative Law Judge reverses a decision to deny authorization of services, and the Member or P4HB Member received the disputed services while the Appeal was pending, the Contractor shall pay for those services.

4.14.8 Reporting Requirements

4.14.8.1 The Contractor shall log and track all Grievances, Proposed Actions, Appeals and Administrative Law Hearing requests, as described in Section 4.18.4.5.

4.14.8.2 The Contractor shall maintain records of Grievances, whether received verbally or in writing, that include a short, dated summary of the problems, name of the grievant, date of the Grievance, date of the decision, and the disposition.

4.14.8.3 The Contractor shall maintain records of Appeals, whether received verbally or in writing, that include a short, date summary of the issues, name of the appellant, date of Appeal, date of decision, and the resolution.

4.14.8.4 DCH may publicly disclose summary information regarding the nature of Grievances and Appeals and related dispositions or resolutions in consumer information materials.

4.14.8.5 The Contractor shall submit quarterly Grievance System Reports to DCH as described in Section 4.18.4.5.

4.15 ADMINISTRATION AND MANAGEMENT

4.15.1 General Provisions

4.15.1.1 The Contractor shall be responsible for the administration and management of all requirements of this Contract. All costs related to the administration and management of this Contract shall be the responsibility of the Contractor.

4.15.2 Place of Business and Hours of Operation

4.15.2.1 The Contractor shall maintain a central business office within the Service Region in which it is operating. If the Contractor is operating in more than one (1) Service Region, there must be one (1) central business office and an additional office in each Service Region. If a Contractor is operating in two (2) or more contiguous Service Regions, the Contractor may establish one (1) central business office for all Service Regions. This business office must be centrally located within the contiguous Service Regions and in a location accessible for foot and vehicle traffic. The Contractor may establish more than one (1) business office within a Service Region, but must designate one (1) of the offices as the central business office.

4.15.2.2 All documentation must reflect the address of the location identified as the legal, duly licensed, central business office. This business office must be open at least between the hours of 8:30 a.m. and 5:30 p.m. EST, Monday through Friday. The Contractor shall ensure that the office(s) are adequately staffed to ensure that Members and Providers receive prompt and accurate responses to inquiries.

4.15.2.3 The Contractor shall ensure that all business offices and all staff that perform functions and duties, related to this Contract are located within the United States.

4.15.2.4 The Contractor shall provide live access, through its telephone hot line as described in Section 4.3.7 and Section 4.9.5. The Contractor shall provide access twenty-four (24) hours a day, seven (7) days per week to its Web site.

4.15.3 Training

4.15.3.1 The Contractor shall conduct on-going training for its entire staff, in all departments, to ensure appropriate functioning in all areas and to ensure that staff is aware of all programmatic changes.

4.15.3.2 The Contractor shall submit a staff-training plan to DCH for review and approval as updated.

4.15.3.3 The Contractor designated staff are required to attend DCH in-service training on an Ad-Hoc basis. DCH will determine the type and scope of the training.

4.15.4 Data and Report Certification

4.15.4.1 The Contractor shall certify all data pursuant to 42 CFR 438.606. The data that must be certified include, but are not limited to, Enrollment information, Encounter Data, Contractual Reports and other information required by the State and contained in Contracts, proposals and related documents. The data must be certified by one of the following: the Contractor's Chief Executive Officer, the Contractor's Chief Financial Officer, or an individual who has delegated authority to sign for, and who Reports directly to the Contractor's Chief Executive Officer or Chief Financial Officer. The certification must attest, based on best knowledge, information, and belief, as follows:

- By virtue of submission, the Contractor attests to the accuracy, completeness, and truthfulness of the data, reports, and other documents provided to the State.
- Inaccurate data, reports, and other documents provided to the State by the Contractor are subject to applicable Liquidated Damages.

4.15.4.2 The Contractor shall submit the certification concurrently with the certified data.

4.16 CLAIMS MANAGEMENT

4.16.1 General Provisions

4.16.1.1 The Contractor shall utilize the same time frames and deadlines for submission, processing, payment, denial, adjudication, and appeal of Medicaid and Demonstration claims. Demonstration claims will be processed as all other Medicaid claims are processed using the time frames and deadlines that DCH uses on claims its pays directly. The Contractor shall administer an effective, accurate and efficient claims processing function that adjudicates and settles Provider Claims for Covered Services that are filed within the time frames specified by DCH (see Part I. Policy and Procedures for Medicaid/PeachCare for Kids® Manual) and in compliance with all applicable State and federal laws, rules and regulations.

4.16.1.2 The Contractor shall maintain a Claims management system that can identify date of receipt (the date the Contractor receives the Claim as indicated by the date-stamp), real-time-accurate history of actions taken on each Provider Claim (i.e. paid, denied, suspended, Appealed, etc.), and date of payment (the date of the check or other form of payment).

4.16.1.3 At a minimum, the Contractor shall run one (1) Provider payment cycle per week, on the same day each week, as determined by DCH.

4.16.1.4 The Contractor shall support an Automated Clearinghouse (ACH) mechanism that allows Providers to request and receive electronic funds transfer (EFT) of Claims payments.

4.16.1.5 The Contractor shall encourage that its Providers, as an alternative to the filing of paper-based Claims, submit and receive Claims information through electronic data interchange (EDI), i.e. electronic Claims. Electronic Claims must be processed in adherence to information exchange and data management requirements specified in Section 4.17. As part of this Electronic Claims Management (ECM) function, the Contractor shall also provide on-line and phone-based capabilities to obtain Claims processing status information.

4.16.1.6 The Contractor shall generate Explanation of Benefits and Remittance Advices in accordance with State standards for formatting, content and timeliness and will verify that recipients have received the services indicated on the Explanation of Benefits received and the Remittance Advices.

4.16.1.7 The Contractor shall not pay any Claim submitted by a Provider who is excluded or suspended from the Medicare, Medicaid or SCHIP programs for Fraud, abuse or waste or otherwise included on the Department of Health and Human Services Office of Inspector General exclusions list, or employs someone on this list. The Contractor shall not pay any Claim submitted by a Provider that is on payment hold under the authority of DCH or its Agent(s).

4.16.1.8 Not later than the fifteenth (15) business day after the receipt of a Provider Claim that does not meet Clean Claim requirements, the Contractor shall suspend the Claim and request in writing (notification via e-mail, the CMO plan Web Site/Provider Portal or an interim Explanation of Benefits satisfies this requirement) all outstanding information such that the Claim can be deemed clean. Upon receipt of all the requested information from the Provider, the CMO plan shall complete processing of the Claim within fifteen (15) Business Days.

4.16.1.9 If a Provider submits a claim to a responsible health organization for services rendered within 72 hours after the Provider verifies the eligibility of the patient with that responsible health organization, the responsible health organization shall reimburse the Provider in an amount equal to the amount to which the Provider would have been entitled if the patient had been enrolled as shown in the eligibility verification process. After resolving the Provider's claim, if the responsible health organization made payment for a patient for whom it was not responsible, then the responsible health organization may pursue a cause of action against any person who was responsible for payment of the services at the time they were provided but may not recover any payment made to the Provider.

4.16.1.10 The Contractor shall not apply any penalty for failure to file claims in a timely manner, for failure to obtain prior authorization, or for the provider not being a participating provider in the person's network, and the amount of reimbursement shall be that person's applicable rate for the service if the provider is under contract with that person or the rate paid by DCH for the same type of claim that it pays directly if the provider is not under contract with that person.

4.16.1.11 The Contractor shall inform all network Providers about the information required to submit a Clean Claim as a provision within the Contractor/Provider Contract. The Contractor shall make available to network Providers Claims coding and processing guidelines for the applicable Provider type. The Contractor shall notify Providers ninety (90) Calendar Days before implementing changes to Claims coding and processing guidelines.

4.16.1.12 The Contractor shall perform Quarterly scheduled Global Claims Analyses to ensure an effective, accurate, and efficient claims processing function that adjudicates and settles provider claims. In addition, the contractor shall assume all costs associated with Claim processing, including the cost of reprocessing/resubmission, due to processing errors caused by the Contractor or to the design of systems within the Contractor's span of control.

4.16.1.13 In addition to the specific Web site requirements outlined above, the Contractor's Web site shall be functionally equivalent to the Web site maintained by the State's Medicaid fiscal agent.

4.16.2 Other Considerations

4.16.2.1 An adjustment to a paid Claim shall not be counted as a Claim for the purposes of reporting.

4.16.2.2 Electronic Claims shall be treated as identical to paper-based Claims for the purposes of reporting.

4.16.3 Encounter Data Submission Requirements

4.16.3.1 The Georgia Families program utilizes encounter data to determine the adequacy of medical services and to evaluate the quality of care rendered to members. DCH will use the following requirements to establish the standards for the submission of data and to measure the compliance of the Contractor to provide timely and accurate information. Encounter data from the Contractor also allows DCH to budget available resources, set contractor capitation rates, monitor utilization, follow public health trends and detect potential fraud. Most importantly, it allows the Division of Managed Care and Quality to make recommendations that can lead to the improvement of healthcare outcomes.

4.16.3.2 The Contractor shall work with all contracted Providers to implement standardized billing requirements to enhance the quality and accuracy of the billing data submitted to the health plan.

4.16.3.3 The Contractor shall instruct contracted Providers that the Georgia State Medicaid ID number is mandatory, and must be documented in record. The Contractor will emphasize to Providers the need for a unique GA Medicaid number for each practice location.

4.16.3.4 The Contractor shall submit to Fiscal Agent weekly cycles of data files. All identified errors shall be submitted to the Contractor from the Fiscal Agent each week. The Contractor shall clean up and resubmit the corrected file to the Fiscal Agent within seven (7) Business Days of receipt.

4.16.3.5 The Contractor is required to submit 100% of Critical Data Elements such as state Medicaid ID numbers, NPI numbers, SSN numbers, Member Name, and DOB. These items must match the states eligibility and provider file.

4.16.3.6 The Contractor submitted claims must consistently include:

- Patient name
- Date of birth
- Place of service
- Date of service
- Type of service
- Units of service
- Diagnosis-primary & secondary
- Treating provider
- NPI number
- Tax Identification Number
- Facility code

- A unique TCN
- All additionally required CMS 1500 or UB 04 codes
- CMO Paid Amount

4.16.3.7 For each submission of claims per 4.16.3.5 and 4.16.3.6, Contractor must provide the following Cash Disbursements data elements:

- Provider/Payee Number
- Name
- Address
- City
- State
- Zip
- Check date
- Check number
- Check amount
- Check code (i.e. EFT, paper check, etc)

Contractor will assist DCH in reconciliation of Cash Disbursement check amounts totals to CMO Paid Amount totals for submitted claims.

4.16.3.8 The Contractor shall maintain an Encounter Error Rate of <5% weekly as monitored by the Fiscal Agent and DCH. The Encounter Error Rate is the occurrence of a single error in any Transaction Control Number (TCN) or encounter claim counts as an error for that encounter (this is regardless of how many other errors are detected in the TCN.)

4.16.3.9 The Contractors failure to comply with defined standard(s) will be subject to a CAPA/PC and may be liable for liquidated damages (LD's).

4.16.4 Reporting Requirements

The Contractor shall submit to DCH monthly Claims Processing Reports as described in section 4.18.3.4.

4.16.5 Emergency Health Care Services

4.16.5.1 The Contractor shall not deny or inappropriately reduce payment to a provider of emergency health care services for any evaluation, diagnostic testing, or treatment provided to a recipient of medical assistance for an emergency condition; or

4.16.5.2 Make payment for emergency health care services contingent on the recipient or provider of emergency health care services providing any notification, either before or after receiving emergency health care services.

4.16.5.3 In processing claims for emergency health care services, a care management organization shall consider, at the time that a claim is submitted, at least the following criteria:

- The age of the patient;
- The time and day of the week the patient presented for services;
- The severity and nature of the presenting symptoms;
- The patient's initial and final diagnosis; and
- Any other criteria prescribed by DCH, including criteria specific to patients less than 18 years of age.

4.16.5.4 The Contractor shall configure or program its automated claims processing system to consider at least the conditions and criteria described in this subsection for claims presented for emergency health care services.

4.16.5.5 If a provider that has not entered into a contract with a care management organization provides emergency health care services or post-stabilization services to that care management organization's member, the care management organization shall reimburse the non contracted provider for such emergency health care services and post-stabilization services at a rate equal to the rate paid by DCH for Medicaid claims that it reimburses directly.

4.17 INFORMATION MANAGEMENT AND SYSTEMS

4.17.1 General Provisions

4.17.1.1 The Contractor shall have Information management processes and Information Systems (hereafter referred to as Systems) that enable it to meet GF requirements, State and federal reporting requirements, all other Contract requirements and any other applicable State and federal laws, rules and regulations including HIPAA.

4.17.1.2 The Contractor is responsible for maintaining a system that shall possess capacity sufficient to handle the workload projected for the start of the program and will be scalable and flexible enough to adapt as needed, within negotiated timeframes, in response to program or Enrollment changes.

4.17.1.3 The Contractor shall provide a Web-accessible system hereafter referred to as the DCH Portal that designated DCH and other state agency resources can use to access Quality and performance management information as well as other system functions and information as described throughout this Contract. Access to the DCH Portal shall be managed as described in section 4.17.5.

4.17.1.4 The Contractor shall attend DCH's Systems Work Group meetings as scheduled by DCH. The Systems Work Group will meet on a designated schedule as agreed to by DCH, its agents and every Contractor.

4.17.1.5 The Contractor shall provide a continuously available electronic mail communication link (E-mail system) with the State. This system shall be:

- Available from the workstations of the designated Contractor contacts; and
- Capable of attaching and sending documents created using software products other than Contractor systems, including the State's currently installed version of Microsoft Office and any subsequent upgrades as adopted.

4.17.1.6 By no later than the 30th of April of each year, the Contractor will provide DCH with an annual progress/status report of the Contractor's system refresh plan for the upcoming State fiscal year. The plan will outline how Systems within the Contractor's Span of Control will be systematically assessed to determine the need to modify, upgrade and/or replace application software, operating hardware and software, telecommunications capabilities, information management policies and procedures, and/or systems management policies and procedures in response to changes in business requirements, technology obsolescence, staff turnover and other relevant factors. The systems refresh plan will also indicate how the Contractor will insure that the version and/or release level of all of its System components (application software, operating hardware, operating software) are always formally supported by the original equipment manufacturer (OEM), software development firm (SDF) or a third party authorized by the OEM and/or SDF to support the System component.

4.17.1.7 The Contractor is responsible for all costs associated with the Contractors system refresh plan.

4.17.2 Health Information Technology and Exchange

4.17.2.1 The Contractor shall have in place or develop initiatives towards electronic health information exchange and health care transparency that would encourage the use of qualified electronic health records, personal health records (PHRs), and make available to Providers and members increased information on cost and quality of care through health information technology.

4.17.2.2 The Contractor shall develop an incentive program for the adoption and utilization of electronic health records that result in improvements in the quality and cost of health care services.

4.17.2.3 The Contractor will work with DCH on the HITECH Act provisions as mandated by CMS.

4.17.3 Global System Architecture and Design Requirements

4.17.3.1 The Contractor shall comply with federal and State policies, standards and regulations in the design, development and/or modification of the Systems it will employ to meet the aforementioned requirements and in the management of Information contained in those Systems. Additionally, the Contractor shall adhere to DCH and State-specific system and data architecture preferences as indicated in this Contract.

4.17.3.2 The Contractor's Systems shall:

- Employ a relational data model in the architecture of its databases and relational database management system (RDBMS) to operate and maintain them;
- Be SQL and ODBC compliant;
- Adhere to Internet Engineering Task Force/Internet Engineering Standards Group standards for data communications, including TCP and IP for data transport;
- Conform to standard code sets detailed in Attachment L;
- Contain industry standard controls to maintain information integrity applicable to privacy and security, especially PHI. These controls shall be in place at all appropriate points of processing. The controls shall be tested in periodic and spot audits following a methodology to be developed jointly and mutually agreed upon by the Contractor and DCH; and
- Partner with the State in the development of future standard code sets, not specific to HIPAA or other federal effort and will conform to such standards as stipulated by DCH.

4.17.3.3 Where Web services are used in the engineering of applications, the Contractor's Systems shall conform to World Wide Web Consortium (W3C) standards such as XML, UDDI, WSDL and SOAP so as to facilitate integration of these Systems with DCH and other State systems that adhere to a service-oriented architecture.

4.17.3.4 Audit trails shall be incorporated into all Systems to allow information on source data files and documents to be traced through the processing stages to the point where the Information is finally recorded. The audit trails shall:

- Contain a unique log-on or terminal ID, the date, and time of any create/modify/delete action and, if applicable, the ID of the system job that effected the action;
- Have the date and identification "stamp" displayed on any on-line inquiry;
- Have the ability to trace data from the final place of recording back to its source data file and/or document shall also exist;
- Be supported by listings, transaction Reports, update Reports, transaction logs, or error logs;
- Facilitate auditing of individual Claim records as well as batch audits; and
- Be maintained for seven (7) years in either live and/or archival systems. The duration of the retention period may be extended at the discretion of and as indicated to the Contractor by the State as needed for ongoing audits or other purposes.

4.17.3.5 The Contractor shall house indexed images of documents used by Members and Providers to transact with the Contractor in the appropriate database(s) and document management systems to maintain the logical relationships between certain documents and certain data.

4.17.3.6 The Contractor shall institute processes to insure the validity and completeness of the data it submits to DCH. At its discretion, DCH will conduct general data validity and completeness audits using industry-accepted statistical sampling methods. Data elements that will be audited include but are not limited to: Member ID, date of service, Provider ID, category and sub category (if applicable) of service, diagnosis codes, procedure codes, revenue codes, date of Claim processing, and date of Claim payment.

4.17.3.7 Where a System is herein required to, or otherwise supports, the applicable batch or on-line transaction type, the system shall comply with HIPAA-standard transaction code sets as specified in Attachment L.

4.17.3.8 The Contractor System(s) shall conform to HIPAA standards for information exchange.

4.17.3.9 The layout and other applicable characteristics of the pages of Contractor Web sites shall be compliant with Federal "section 508 standards" and Web Content Accessibility Guidelines developed and published by the Web Accessibility Initiative.

4.17.3.10 Contractor Systems shall conform to any applicable Application, Information and Data, Middleware and Integration, Computing Environment and Platform, Network and Transport, and Security and Privacy policy and standard issued by GTA as stipulated in the appropriate policy/standard. These policies and standards can be accessed at: http://gta.georgia.gov/00/channel_modifieddate/0,2096,1070969_6947051,00.html

4.17.4 Data and Document Management Requirements By Major Information Type

In order to meet programmatic, reporting and management requirements, the Contractor's systems shall serve as either the Authoritative Host of key data and documents or the host of valid, replicated data and documents from other systems. Attachment L lays out the requirements for managing (capturing, storing and maintaining) data and documents for the major information types and subtypes associated with the aforementioned programmatic, reporting and management requirements.

4.17.5 System and Data Integration Requirements

4.17.5.1 All of the Contractor's applications, operating software, middleware, and networking hardware and software shall be able to interface with the State's systems and will conform to standards and specifications set by the Georgia Technology Authority and the agency that owns the system. These standards and specifications are detailed in Attachment L.

4.17.5.2 The Contractor's System(s) shall be able to transmit and receive transaction data to and from the MMIS as required for the appropriate processing of Claims and any other transaction that may be performed by either System.

4.17.5.2.1 The Contractor shall generate encounter data files no less than weekly (or at a frequency defined by DCH) from its claims management system(s) and/or other sources. The files will contain settled Claims and Claim adjustments and encounters from Providers with whom the Contractor has a capitation arrangement for the most recent month for which all such transactions were completed. The Contractor will provide these files electronically to DCH and/or its designated agent in adherence to the procedure and format indicated in Attachment L.

4.17.5.2.2 The Contractor's System(s) shall be capable of generating all required files in the prescribed formats (as referenced in Attachment L) for upload into state Systems used specifically for program integrity and compliance purposes.

4.17.5.3 The Contractor's System(s) shall possess mailing address standardization functionality in accordance with US Postal Service conventions.

4.17.6 System Access Management and Information Accessibility Requirements

4.17.6.1 The Contractor's System shall employ an access management function that restricts access to varying hierarchical levels of system functionality and Information. The access management function shall:

- Restrict access to Information on a "need to know" basis, e.g. users permitted inquiry privileges only will not be permitted to modify information;
- Restrict access to specific system functions and information based on an individual user profile, including inquiry only capabilities; global access to all functions will be restricted to specified staff jointly agreed to by DCH and the Contractor; and
- Restrict attempts to access system functions (both internal and external) to three (3), with a system function that automatically prevents further access attempts and records these occurrences.
- At a minimum, follow the GTA Security Standard and Access Management protocols.

4.17.6.2 The Contractor shall make System Information available to duly Authorized Representatives of DCH and other State and federal agencies to evaluate, through inspections or other means, the quality, appropriateness and timeliness of services performed.

4.17.6.3 The Contractor shall have procedures to provide for prompt electronic transfer of System Information upon request to In-Network or Out-of-Network Providers for the medical management of the Member in adherence to HIPAA and other applicable requirements.

4.17.6.4 All Information, whether data or documents, and reports that contain or make references to said Information, involving or arising out of this Contract is owned by DCH. The Contractor is expressly prohibited from sharing or publishing DCH information and reports without the prior written consent of DCH. In the event of a dispute regarding the sharing or publishing of information and reports, DCH's decision on this matter shall be final and not subject to change.

4.17.7 Systems Availability and Performance Requirements

4.17.7.1 The Contractor will ensure that Member and Provider portal and/or phone-based functions and information, such as confirmation of CMO Enrollment (CCE) and electronic claims management (ECM), Member services and Provider services, are available to the applicable System users twenty-four (24) hours a day, seven (7) Days a week, except during periods of scheduled System Unavailability agreed upon by DCH and the Contractor. Unavailability caused by events outside of a Contractor's span of control is outside of the scope of this requirement.

4.17.7.2 The Contractor shall ensure that at a minimum, all other System functions and Information are available to the applicable system users between the hours of 7:00 a.m. and 7:00 p.m. Monday through Friday.

4.17.7.3 The Contractor shall ensure that the average response time that is controllable by the Contractor is no greater than the requirements set forth below, between 7:00 am and 7:00 pm, Monday through Friday for all applicable system functions except a) during periods of scheduled downtime, b) during periods of unscheduled unavailability caused by systems and telecommunications technology outside of the Contractor's span of control or c) for Member and Provider portal and phone-based functions such as CCE and ECM that are expected to be available twenty-four (24) hours a day, seven (7) days a week:

- Record Search Time – The response time shall be within three (3) seconds for ninety-eight percent (98%) of the record searches as measured from a representative sample of DCH System Access Devices, as monitored by the Contractor;
- Record Retrieval Time – The response time will be within three (3) seconds for ninety-eight percent (98%) of the records retrieved as measured from a representative sample of DCH System Access Devices;
- On-line Adjudication Response Time – The response time will be within five (5) seconds ninety-nine percent (99%) of the time as measured from a representative sample of user System Access Devices.

4.17.7.4 The Contractor shall develop an automated method of monitoring the CCE and ECM functions on at least a thirty (30) minute basis twenty-four (24) hours a day, seven (7) Days per week. The monitoring method shall separately monitor for availability and performance/response time each component of the CCE and ECM systems, such as the voice response system, the PC software response, direct line use, the swipe box method and ECM on-line pharmacy system.

4.17.7.5 Upon discovery of any problem within its Span of Control that may jeopardize System availability and performance as defined in this Section of the Contract, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, in person, via phone, electronic mail and/or surface mail.

4.17.7.6 The Contractor shall deliver notification as soon as possible but no later than 7:00 pm if the problem occurs during the business day and no later than 9:00 am the following business day if the problem occurs after 7:00 pm.

4.17.7.7 Where the operational problem results in delays in report distribution or problems in on-line access during the business day, the Contractor shall notify the DCH Director, Contract Compliance and Resolution, within fifteen (15) minutes of discovery of the problem, in order for the applicable work activities to be rescheduled or be handled based on System Unavailability protocols.

4.17.7.8 The Contractor shall provide to the DCH Director, Contract Compliance and Resolution, information on System Unavailability events, as well as status updates on problem resolution. These up-dates shall be provided on an hourly basis and made available via electronic mail, telephone and the Contractor's Web Site/DCH Portal.

4.17.7.9 Unscheduled System Unavailability of CCE and ECM functions, caused by the failure of systems and telecommunications technologies within the Contractor's Span of Control will be resolved, and the restoration of services implemented, within thirty (30) minutes of the official declaration of System Unavailability. Unscheduled System Unavailability to all other Contractor System functions caused by systems and telecommunications technologies within the Contractor's Span of Control shall be resolved, and the restoration of services implemented, within four (4) hours of the official declaration of System Unavailability.

4.17.7.10 Cumulative System Unavailability caused by systems and telecommunications technologies within the Contractor's span of control shall not exceed one (1) hour during any continuous five (5) Day period.

4.17.7.11 The Contractor shall not be responsible for the availability and performance of systems and telecommunications technologies outside of the Contractor's Span of Control. Contractor is obligated to work with identified vendors to resolve and report system availability and performance issues. Reference Section 23.5.1.5 – (Liquidated Damages)

4.17.7.12 Full written documentation that includes a CAPA/PC that describes what caused the problem, how the problem will be prevented from occurring again, and within a set time frame for resolution must be submitted to DCH within five (5) Business Days of the problem's occurrence.

4.17.7.13 Regardless of the architecture of its Systems, the Contractor shall develop and be continually ready to invoke a business continuity and disaster recovery (BC-DR) plan that at a minimum addresses the following scenarios: (a) the central computer installation and resident software are destroyed or damaged, (b) System interruption or failure resulting from network, operating hardware, software, or operational errors that compromises the integrity of transactions that are active in a live system at the time of the outage, (c) System interruption or failure resulting from network, operating hardware, software or operational errors that compromises the integrity of data maintained in a live or archival system, (d) System interruption or failure resulting from network, operating hardware, software or operational errors that does not compromise the integrity of transactions or data maintained in a live or archival system but does prevent access to the System, i.e. causes unscheduled System Unavailability.

4.17.7.14 The Contractor shall periodically, but no less than annually, test its BC-DR plan through simulated disasters and lower level failures in order to demonstrate to the State that it can restore System functions per the standards outlined elsewhere in this Contract. The Contractor will prepare a report of the results of these tests and present to DCH staff within five (5) business days of test completion.

4.17.7.15 In the event that the Contractor fails to demonstrate in the tests of its BC-DR plan that it can restore system functions per the standards outlined in this Contract, the Contractor shall be required to submit to the State a CAPA/PC that describes how the failure will be resolved. The CAPA/PC will be delivered within five (5) Business Days of the conclusion of the test.

4.17.7.16 The Contractor shall submit monthly System Availability and Performance Report to DCH as described in section 4.18.3.3

4.17.8 System User and Technical Support Requirements

4.17.8.1 The Contractor shall provide Systems Help Desk (SHD) services to all DCH staff and the other agencies that may have direct access to Contractor systems.

4.17.8.2 The SHD shall be available via local and toll free telephone service and via e-mail from 7 a.m. to 7 p.m. EST Monday through Friday, with the exception of State holidays. Upon State request, the Contractor shall staff the SHD on a State holiday, Saturday, or Sunday at the Contractor's expense.

4.17.8.3 SHD staff shall answer user questions regarding Contractor System functions and capabilities; report recurring programmatic and operational problems to appropriate Contractor or DCH staff for follow-up; redirect problems or queries that are not supported by the SHD, as appropriate, via a telephone transfer or other agreed upon methodology; and redirect problems or queries specific to data access authorization to the appropriate State login account administrator.

4.17.8.4 The Contractor shall submit to DCH for review and approval its SHD Standards. At a minimum, these standards shall require that between the hours of 7 a.m. and 7 p.m. EST ninety percent (90%) of calls are answered by the fourth (4th) ring, the call abandonment rate is five percent (5%) or less, the average hold time is two (2) minutes or less, and the blocked call rate does not exceed one percent (1%).

4.17.8.5 Individuals who place calls to the SHD between the hours of 7 p.m. and 7 a.m. EST shall be able to leave a message. The Contractor's SHD shall respond to messages by noon the following Business Day.

4.17.8.6 Recurring problems not specific to System Unavailability identified by the SHD shall be documented and reported to Contractor management within one (1) Business Day of recognition so that deficiencies are promptly corrected.

4.17.8.7 Additionally, the Contractor shall have an IT service management system that provides an automated method to record, track, and report on all questions and/or problems reported to the SHD. The service management system shall:

- Assign a unique number to each recorded incident;
- Create State defined extract files that contain summary information on all problems/issues received during a specified time frame;
- Escalate problems based on their priority and the length of time they have been outstanding;
- Perform key word searches that are not limited to certain fields and allow for searches on all fields in the database;
- Notify support personnel when a problem is assigned to them and re-notify support personnel when an assigned problem has escalated to a higher priority;
- List all problems assigned to a support person or group;
- Perform searches for duplicate problems when a new problem is entered;
- Allow for entry of at least five hundred (500) characters of free form text to describe problems and resolutions; and
- Generate Reports that identify categories of problems encountered, length of time for resolution, and any other State-defined criteria.

4.17.8.8 The Contractor's call center systems shall have the capability to track call management metrics identified in Attachment L.

4.17.9 System Change Management Requirements

4.17.9.1 The Contractor shall absorb the cost of routine maintenance, inclusive of defect correction, System changes required to effect changes in State and federal statute and regulations, and production control activities, of all Systems within its Span of control.

4.17.9.2 The Contractor shall provide DCH, prior written notice of non-routine System changes excluding changes prompted by events described in Section 4.17.6 and including proposed corrections to known system defects, within ten (10) Calendar Days of the projected date of the change. As directed by the state, the Contractor shall discuss the proposed change in the Systems Work Group.

4.17.9.3 The Contractor shall respond to State reports of System problems not resulting in System Unavailability and shall perform the needed changes according to the following timeframes:

- Within five (5) Calendar Days of receipt, the Contractor shall respond in writing to notices of system problems.

- Within fifteen (15) Calendar Days, the correction will be made or a Requirements Analysis and Specifications document will be due.
- The Contractor will correct the deficiency by an effective date to be determined by DCH.
- Contractor systems will have a system-inherent mechanism for recording any change to a software module or subsystem.

4.17.9.4 The Contractor shall put in place procedures and measures for safeguarding the State from unauthorized modifications to Contractor Systems.

4.17.9.5 Unless otherwise agreed to in advance by DCH as part of the activities described in Section 4.17.8.3, scheduled System Unavailability to perform System maintenance, repair and/or upgrade activities shall take place between 11 p.m. on a Saturday and 6 a.m. on the following Sunday.

4.17.10 System Security and Information Confidentiality and Privacy Requirements

4.17.10.1 The Contractor shall provide for the physical safeguarding of its data processing facilities and the systems and information housed therein. The Contractor shall provide DCH with access to data facilities upon DCH request. The physical security provisions shall be in effect for the life of this Contract.

4.17.10.2 The Contractor shall restrict perimeter access to equipment sites, processing areas, and storage areas through a card key or other comparable system, as well as provide accountability control to record access attempts, including attempts of unauthorized access.

4.17.10.3 The Contractor shall include physical security features designed to safeguard processor site(s) through required provision of fire retardant capabilities, as well as smoke and electrical alarms, monitored by security personnel.

4.17.10.4 The Contractor shall ensure that the operation of all of its systems is performed in accordance with State and federal regulations and guidelines related to security and confidentiality and meet all privacy and security requirements of HIPAA regulations. Relevant publications are included in Attachment L.

4.17.10.5 The Contractor will put in place procedures, measures and technical security to prohibit unauthorized access to the regions of the data communications network inside of a Contractor's Span of Control.

4.17.10.6 The Contractor shall ensure compliance with:

- 42 CFR Part 431 Subpart F (confidentiality of information concerning applicants and Members of public medical assistance programs);
- 42 CFR Part 2 (confidentiality of alcohol and drug abuse records); and
- Special confidentiality provisions related to people with HIV/AIDS and mental illness.

4.17.10.7 The Contractor shall provide its Members with a privacy notice as required by HIPAA. The Contractor shall provide the State with a copy of its Privacy Notice for its filing.

4.17.11 Information Management Process and Information Systems Documentation Requirements

4.17.11.1 The Contractor shall ensure that written System Process and Procedure Manuals document and describe all manual and automated system procedures for its information management processes and information systems.

4.17.11.2 The Contractor shall develop, prepare, print, maintain, produce, and distribute distinct System Design and Management Manuals, User Manuals and Quick/Reference Guides, and any updates thereafter, for DCH and other agency staff that use the DCH Portal.

4.17.11.3 The System User Manuals shall contain information about, and instructions for, using applicable System functions and accessing applicable system data.

4.17.11.4 When a System change is subject to State sign off, the Contractor shall draft revisions to all appropriate manuals impacted by the system change i.e. user manuals, technical specifications etc. prior to State sign off the change.

4.17.11.5 All of the aforementioned manuals and reference guides shall be available in printed form and on-line via the DCH Portal. The manuals will be published in accordance to the applicable DCH and/or Georgia Technology Authority (GTA) standard.

4.17.11.6 Updates to the electronic version of these manuals shall occur in real time; updates to the printed version of these manuals shall occur within ten (10) Business Days of the update taking effect.

4.17.12 Reporting Requirements

The Contractor shall submit to DCH a monthly Systems Availability and Performance Report as described in Section 4.18.3.3.

4.18 REPORTING REQUIREMENTS

4.18.1 General Procedures

4.18.1.1 The Contractor shall comply with all the reporting requirements established by this Contract. The Contractor shall create Reports using the formats, including electronic formats, instructions, and timetables as specified by DCH, at no cost to DCH. **DCH may modify reports, specifications, templates, or timetables as necessary during the contract year.** Contractor changes to the format must be approved by DCH prior to implementation. The Contractor shall transmit and receive all transactions and code sets required by the HIPAA regulations in accordance with Section 21.2. The Contractor's failure to submit the Reports as specified may result in the assessment of liquidated damages as described in Section 23.0.

4.18.1.1.1 The Contractor shall submit the Deliverables and Reports for DCH review and approval according to the following timelines, unless otherwise indicated:

- Annual Reports shall be submitted within thirty (30) Calendar Days following the twelfth (12^{th}) month of the contract year ending June 30th.
- Quarterly Reports shall be submitted by April 30, July 30, October 30, and January 30, for the quarter immediately preceding the due date;
- Monthly Reports shall be submitted within fifteen (15) Calendar Days of the end of each month; and
- Weekly Reports shall be submitted on the same day of each week, as determined by DCH.

4.18.1.2 For reports required by DOI and DCH, the Contractor shall submit such reports according to the DOI schedule of due dates, unless otherwise indicated. While such schedule may be duplicated in this Contract, should the DOI schedule of due dates be amended at a future date, the due dates in this Contract shall automatically change to the new DOI due dates.

4.18.1.3 The Contractor shall, upon request of DCH, generate any additional data or reports at no additional cost to DCH within a time period prescribed by DCH. The Contractor's responsibility shall be limited to data in its possession.

4.18.2 Weekly Reporting

At this time, no weekly reports are due.

4.18.3 Monthly Reporting

4.18.3.1 Telephone and Internet Activity Report

4.18.3.1.1 This information may be submitted as a summary report, in a format to be determined by DCH. The Contractor shall maintain, and make available at the request of DCH, any and all supporting documentation. Each Telephone and Internet Activity Report shall include the following information:

- Call volume;
- E-mail volume;
- Average call length;
- Average hold time;
- Abandoned Call rate;
- Accuracy rate based on CMO's Call Center Quality Criteria and Protocols;

- Content of call or email and resolution; and
- Blocked Call rate.

4.18.3.2 Eligibility and Enrollment Reconciliation Report

4.18.3.2.1 Pursuant to Section 4.1.4.2, the Contractor shall submit an Eligibility and Enrollment Reconciliation Report that reconciles eligibility data to the Contractor's Enrollment records. The written report shall verify that the Contractor has an Enrollment record for all Members that are eligible for Enrollment in the CMO plan.

4.18.3.3 System Availability and Performance Report

4.18.3.3.1 Pursuant to Section 4.17.6, the Contractor shall submit a System Availability and Performance Report that shall report the following information:

- Record Search Time
- Record Retrieval Time
- Screen Edit Time
- New Screen/Page Time
- Print Initiation Time
- Confirmation of CMO Enrollment Response Time
- Online Claims Adjudication Response Time

4.18.3.4 Claims Processing Report

4.18.3.4.1 Pursuant to Section 4.16.4, the Contractor shall submit a Claims Processing Report that documents the claims processing activities for the following claim types:

- Physicians
- Institutional
- Professional
- Pharmacy
- Dental
- Vision
- Behavioral

4.18.3.4.2 Number and dollar value of Claims processed by Provider type and processing status (adjudicated and paid, adjudicated and not paid, suspended, appealed, denied);

- Aging of Claims: number, dollar value and status of Claims filed in most recent and prior months (defined as six (6) months previous) by Provider type and processing status; and
- Cumulative percentage for the current fiscal year of Clean Claims processed and paid within thirty (30) calendar and ninety (90) Calendar Days of receipt.

4.18.3.5 Fraud and Abuse Report

4.18.3.5.1 Pursuant to Section 4.13, the Contractor shall submit a Fraud and Abuse Report which shall include, at a minimum, the following:

- Source of complaint;
- Alleged persons or entities involved;
- Nature of complaint;
- Approximate dollars involved;
- Date of the complaint;
- Disciplinary action imposed;
- Administrative disposition of the case;
- Investigative activities, corrective actions, prevention efforts, and results; and
- Trending and analysis as it applies to: Utilization Management; Claims management; post-processing review of Claims; and Provider profiling.

4.18.3.5.2 Pursuant to Section 31.19, the Contractor shall submit, attached to the Fraud and Abuse Report, all disclosures required under Section 31.19.

4.18.3.6 Medical Loss Ratio Report

4.18.3.6.1 Pursuant to Section 8.6.2, the Contractor shall submit monthly, a Medical Loss Ratio report that captures medical expenses relative to capitation payments received on a cumulative year to date basis. The Medical Loss Ratio report shall include:

- Capitation payments received;
- Medical expenses by provider grouping including, but not limited to:
  - Direct payments to Providers for covered medical services;
  - Capitated payments to Providers; and
  - Payments to subcontractors for covered benefits and services.

4.18.3.6.2 An Estimate of incurred but not reported IBNR expenses;

4.18.3.6.3 Actuarial certification that the report, including the estimate of IBNR, has been reviewed for accuracy; and

4.18.3.6.4 Supporting claims lag tables by claim type.

4.18.3.7 Member Data Conflict Report

Pursuant to Section 4.1.4.1, the Contractor shall submit a Member Data Conflict Report. The report shall include data conflicts that may affect the Member's eligibility for Georgia Families including, but not limited to, name changes, date of birth, duplicate records, social security number or gender.

4.18.3.8 Dental Utilization Participation Report

Pursuant to Section 4.8.12.1, the Contractor shall submit a Dental Utilization Participation Report that maintains an appropriate number of Dental providers (both general and specialty) in network for the service area based on claims data which shall include, at a minimum, the following:

- Total number or unique enrolled providers
- Total number of unique participating providers

- Unique participating providers by county
- Provider listing of unique participating provider with claims paid/denied data included.

4.18.3.9 FQHC and RHC Report

Pursuant to 4.10.5, the Contractor shall submit monthly FQHC and RHC Payment Reports that identify Contractor payments made to each FQHC and RHC for each Covered Service provided to Members.

4.18.3.10 Provider Complaints Report

Pursuant to Section 4.9.8.2 the Contractor shall submit a Provider Complaints Report that includes, at a minimum, the following:

- Number of complaints by type;
- Type of assistance provided; and
- Administrative disposition of the case.

4.18.4 Quarterly Reporting

4.18.4.1 Timely Access Report

Pursuant to Section 4.8.14, the Contractor shall submit Timely Access Reports that monitor the time lapsed between a Member's initial request for an office appointment and the date of the appointment. These data for the Timely Access Reports may be collected using statistical sampling methods (including periodic Member and/or Provider surveys). The report shall include:

- Total number of appointment requests;
- Total number of requests that meet the waiting time standards;
- Total number of requests that exceed the waiting time standards; and
- Average waiting time for those requests that exceed the waiting time standards. Information for items iii and iv shall be provided for each provider type/class.

4.18.4.2 Reserved.

4.18.4.3 Contractor Notifications

Pursuant to Section 5.8, the Contractor shall submit a Contractor Notifications Report that includes all DCH requested updated information within 10 days of verification; subsequently a quarterly summary must be provided that includes but is not limited to:

- Relationship of Parties
- Criminal Background
- Confidentiality Requirements
- Insurance Coverage
- Payment Bond & Letter of Credit
- Compliance with Federal Laws
- Conflict of Interest and Contractor Independence
- Drug Free Workplace
- Business Associate Agreement
- System Status
- Key staff or Senior Level Management
- Current Corporate and Local Organization Chart
- Unclaimed Payments from the Prior Year

4.18.4.4 Utilization Management Report

4.18.4.4.1 Utilization Management Reports must include an analysis of data and identification of opportunities for improvement and follow up of the effectiveness of the intervention. Utilization data is to be reported based on claim data. The reports shall include specific data elements that are defined by DCH such that all CMOs are reporting a common data set.

4.18.4.4.2 The Contractor shall submit a Utilization Management Report on Utilization patterns and aggregate trend analysis. The Contractor shall also submit individual physician profiles to DCH, as requested. These Reports should provide to DCH analysis and interpretation of Utilization patterns, including but not limited to, high volume services, high risk services, services driving cost increases, including prescription drug utilization; Fraud and Abuse trends; and Quality and disease management. The Contractor shall provide ad hoc reports pursuant to the requests of DCH. The Contractor shall submit its proposed reporting mechanism, including but not limited to focus of study, data sources to DCH for approval.

4.18.4.4.3 The Contractor shall select three (3) of the following elements to monitor in its physician profiles. Each element should be measured against an established threshold.

- Member access (encounters per member per year, new patient visit within 6 months, ER use per member per year, etc.)
- Preventive care (EPSDT rates, breast cancer screening rates, immunizations, etc.)
- Disease management (asthma ER/IP encounters, HBA1C rates, etc.)
- Pharmacy utilization (generics, asthma medications, etc.)

4.18.4.5 Grievance System Report

Pursuant to Section 4.14.8.1 the Contractor shall submit a summary of Grievance, Appeals and Administrative Law Hearing requests. The report shall, at a minimum, include the following:

- Number of complaints by type;
- Type of assistance provided; and
- Administrative disposition of the case.

4.18.4.6 Reserved.

4.18.4.7 Independent Audit and Income Statement

The Contractor shall submit to DOI:

- A quarterly report on the form prescribed by the National Association of Insurance Commissioners (NAIC) for Health Maintenance Organizations (HMOs) pursuant to Section 8.6.6; and
- A quarterly income statement on the form prescribed by the NAIC for HMOs pursuant to Section 8.6.6.

4.18.4.8 Subcontractor Agreement Report

Pursuant to Section 16.0, the Contractor shall submit a Subcontractor Agreement Report. The Subcontractor Agreement Report shall include:

i. All signed agreements for services provided (direct or indirect) to or on behalf of the Contractor's assigned membership or contracted Providers that includes:

- Name of Subcontractor
- Services provided by Subcontractor
- Terms of the subcontracted agreement
- Subcontractor contact information

ii. Monitoring schedule (at least twice per year)

iii. Monitoring results

4.18.4.9 Prior Authorization and Pre-Certification Report

4.18.4.9.1 Pursuant to Section 4.11.1, the Contractor shall submit Prior Authorization and Pre-Certification Reports that summarize all requests in the preceding **quarter** for Prior Authorization and Pre-Certification. The Report shall include, at a minimum, the following information:

- Total number of completed requests for Standard Service Authorizations;
- Total number of completed requests for Expedited Service Authorizations;
- Percent of completed requests within timeliness standards by type of service;
- Total number of completed requests authorized by type of service;
- Total number or completed requests denied by type of service; and
- Percent of completed requests denied by type of service;
- Patterns and aggregate trend analysis

4.18.4.9.2 The Contractor must submit the Quality Management Report Analysis form to DCH with each submission of the quarterly Prior Authorization and Pre-Certification Report. In addition to providing an overall analysis of the data being submitted, the Contractor must also include the following:

- An explanation if less than 80% of the Standard Service Authorizations are approved within the contractual timeliness standards for each of the following services - Medical Inpatient, Medical Outpatient, Therapy, Behavioral Health including inpatient AND outpatient services, Vision, and Dental ;
- An explanation if less than 80% of the Expedited Service Authorizations are approved within the contractual timeliness standards for each of the following services – Pharmacy, Medical Inpatient, Medical Outpatient, Therapy, Behavioral Health including inpatient AND outpatient services, Vision, and Dental ;
- Reasons for denials (e.g., lack of medical necessity, required additional information, does not meet criteria, non-covered service, member not eligible, member exceeds age limit, etc.);
- An explanation if greater than or equal to 20% of the Standard Service Authorizations are denied for each of the following services - Medical Inpatient, Medical Outpatient, Therapy, Behavioral Health including inpatient AND outpatient services, Vision, and Dental; and
- An explanation if greater than or equal to 20% of the Expedited Service Authorizations are denied for each of the following services – Pharmacy, Medical Inpatient, Medical Outpatient, Therapy, Behavioral Health including inpatient AND outpatient services, Vision, and Dental.

4.18.4.10 Provider Network Adequacy and Capacity Report

4.18.4.10.1 Pursuant to Section 4.8.1, the Contractor shall submit a Provider Network Adequacy and Capacity Report quarterly that demonstrates that the Contractor offers an appropriate range of preventive, Primary Care and specialty services that is adequate for the anticipated number of Members for the service area and that its network of Providers is sufficient in number, mix and geographic distribution to meet the needs of the anticipated number of Members in the service area.

4.18.4.10.2 This Provider Network Adequacy and Capacity Report shall list all Providers enrolled in the Contractor's Provider network, including but not limited to, physicians, hospitals, FQHC/RHCs, home health agencies, pharmacies, Durable Medical Equipment vendors, behavioral health specialists, ambulance vendors, and dentists. Each Provider shall be identified by a unique identifying Provider number as specified in Section 4.8.1.5. This unique identifier shall appear on all Encounter Data transmittals. In addition to the listing, the Provider Network Adequacy and Capacity Report shall identify:

- Provider additions and deletions from the preceding month;
- All OB/GYN Providers participating in the Contractor's network, and those with open panels; and
- List of Primary Care Providers with open panels.

4.18.4.10.3 The Reports shall be submitted to DCH at the following times:

- Upon DCH request;
- Upon Enrollment of a new population in the Contractor's plan; and
- Any time there has been a significant change in the Contractor's operations that would affect adequate capacity and services. A significant change is defined as any of the following:
  - A decrease in the total number of PCPs by more than five percent (5%);
  - A loss of Providers in a specific specialty where another Provider in that specialty is not available within sixty (60) miles; or
  - A loss of a hospital in an area where another CMO plan hospital of equal service ability is not available within thirty (30) miles; or
  - Other adverse changes to the composition of the network, which impair or deny the Members' adequate access to CMO plan Providers.

4.18.4.11 Hospital Statistical and Reimbursement Report

4.18.4.11.1 The Contractor shall provide a Hospital Statistical and Reimbursement Report (HS&R) to a hospital provider upon request by the hospital or DCH using the same format that is used by DCH in completing HS&R reports within 30 days or receipt of such request.

4.18.4.11.2 Contractor will provide DCH with a quarterly report due thirty (30) days after the end of the quarter, indicating all HS&R reports requested, the requesting hospital, date requested by hospital and date provided to hospital.

4.18.4.11.3 Contractor must provide the HS&R report to the requesting hospital within thirty (30) days of request. If delinquent in providing the HS&R Report, Contractor is subject to an assessment of liquidated damages in the amount of $1,000 per day penalty starting on the thirty-first day after the request and continuing until the report is provided. Payment of the penalty will be to DCH to be deposited in the Indigent Care Trust Fund. Contractor shall not reduce the funding available for health care services for Members as a result of payment of such penalties.

4.18.4.11.4 It is the Contractor's responsibility to provide an HS&R Report that is accurate and includes the same data elements provided in the HS&R reports produced by DCH. DCH may, at its discretion, audit HS&R reports provided to hospitals. If these reports contain inaccuracies that would negatively impact a hospital's ability to produce accurate Medicare reports or if the Contractor is unable to provide cash records of payments to the requesting hospital that reconcile with payment amounts on the HS&R report, Contractor will be subject to a $1,000 penalty for each HS&R report containing inaccurate information. Payment of the penalty will be to DCH to be deposited in the Indigent Care Trust Fund. The Contractor will then have thirty (30) days to provide a corrected report to DCH and the requesting hospital. Contractor is subject to a $1,000 per day penalty starting on the thirty-first day after the request and continuing until the report is provided. Payment of the penalty will be to DCH to be deposited in the Indigent Care Trust Fund.

4.18.4.12 Case Management Report

Pursuant to Section 4.11.9.4, the Contractor shall submit a quarterly Case Management Report which includes specified data and utilization trends. The Contractor shall also conduct an annual evaluation of the effectiveness of the Case Management activities, with modification to program and policies as necessary, based on evaluation.

4.18.4.13 Disease Management Report

Pursuant to Section 4.11.10.4, the Contractor shall submit a quarterly Disease Management Report which includes specified data and utilization trends. The Contractor shall also conduct an annual evaluation of the effectiveness of the Disease Management activities, with modification to program and policies as necessary, based on evaluation.

4.18.4.14 Informing Activity

Pursuant to section 4.7.6.1, the Contractor shall submit all required Health Check Reports. The informing activity report includes specific data elements and measures that ensure the Contractor is in compliance with sections 4.7.2.2 and 4.7.2.3.

4.18.4.15 CMS 416

Pursuant to section 4.7.6.1 and in compliance with 1902(a) (43) of the Social Security Act (the Act), each State must report EPSDT activity annually, for each Federal fiscal year, on the CMS 416 form. The Contractor must submit to DCH on a quarterly basis cumulative CMS 416 reports utilizing the electronic CMS 416 form. Medicaid and PeachCare for Kids® data must be submitted on the CMS 416 forms.

4.18.4.16 Initial Screen Report

Pursuant to section 4.7.6.1, the Contractor shall submit all Health Check Reports. The quarterly initial screen report includes specific data elements and measures that ensure the Contractor is in compliance with section 4.7.3.7.

4.18.4.17 EPSDT Report

4.18.4.17.1 Pursuant to Section 4.7.6.1 the Contractor shall submit an EPSDT Report for Medicaid Members and PeachCare for Kids® members that identifies at a minimum the following:

- Number of live births;
- Number of initial newborn visits within twenty-four (24) hours of birth;
- Number of Members that received an initial health visit and screening within ninety (90) Calendar Days of Enrollment;

4.18.4.17.2 Reports shall capture Medicaid Members and PeachCare for Kids® Members.

4.18.4.17.3 DCH, at its sole discretion, may add additional data to the EPSDT Report if DCH determines that it is necessary for monitoring purposes.

4.18.4.18 Pharmacy Audit Reports

Pursuant to Section 4.13, the Contractor shall submit the following Pharmacy Audit Reports:

- Top 10 Pharmacies by Recovery
- Top 25 Drugs by Total Claims
- Top 25 Drugs by Recovery
- Top 10 Discrepancies by Recoupment

4.18.4.19 Pharmacy Cost Reports

- Paid cost per Member per month
- Average ingredient cost per prescription
- Number of scripts per Member per year
- Average cost of a brand prescription
- Average cost of a generic prescription

4.18.4.20 Health Check Record Review

Pursuant to Section 4.7.6.1 the Contractor shall submit all required Health Check Reports. The Health Check Record Review form is utilized to assess whether a medical record is maintained in an organized manner and whether the Provider's medical practices conform to the policies and procedures of the Health Check (EPSDT) program. Contractor shall submit the Health Check Record Review forms to DCH on a quarterly basis beginning January 1, 2011.

4.18.5 Annual Reports

4.18.5.1 Performance Improvement Projects Reports

Pursuant to Section 4.12.6, the Contractor shall submit a Performance Improvement Projects Report no later than June 30 of each contract year that includes the study design, analysis, status and results on performance improvement projects. Status Reports on Performance Improvement Projects may be requested more frequently by DCH.

4.18.5.2 Focused Studies Report

Pursuant to Section 4.12.8.1, the Contractor shall, by July 1, submit the Focus Studies proposal that includes study topics, study questions, study indicators, and the study population for each of the two required focused studies to DCH for approval. The Contractor shall submit annual Reports on the focused studies, which includes analysis and results, no later than the June 30 of each contract year.

4.18.5.3 Patient Safety Reports

Pursuant to Section 4.12.9, the Contractor shall submit a Patient Safety Report no later than June 30 of each contract year that includes, at a minimum, the following:

- A system of classifying complaints according to severity;
- Review by Medical Director and mechanism for determining which incidents will be forwarded to Peer Review and Credentials Committees; and
- Summary of incident(s) included in Provider Profile.

4.18.5.4 Systems Refresh Plan

Pursuant to Section 4.17.1.6, the Contractor shall submit to DCH a Systems Refresh Plan no later than April 30 of each contract year.

4.18.5.5 Independent Audit and Income Statement

The Contractor shall submit to DOI:

- An annual report on the form prescribed by the National Association of Insurance Commissioners (NAIC) for Health Maintenance Organizations (HMO) pursuant to Section 8.6.6;
- An annual income statement pursuant to Section 8.6.6; and
- An annual audit of its business transactions pursuant to Section 8.6.6.

4.18.5.6 "SAS 70" and "SSAE 16" Reports

4.18.5.6.1 Pursuant to Section 8.6.4.1, the Contractor shall submit to DCH an annual SAS 70 Report conducted by an independent auditing firm.

4.18.5.6.2 Pursuant to Section 8.6.4.1, each Contractor's Material Subcontractor shall submit to DCH an annual SAS 70 Report conducted by an independent auditing firm. For reporting periods ending on or after June 15, 2011, the Material Subcontractor shall submit to DCH an annual SSAE 16 Report in lieu of the SAS 70 Report.

4.18.5.6.3 SAS 70 or SSAE 16 Reports shall be due May 15 of each year and apply to the preceding twelve (12) month period April through March. The Contractor and its Material Subcontractors shall submit the first SSAE 16 Report (in lieu of the SAS 70 Report) to DCH on May 15, 2012 for the period April 2011 through March 2012.

4.18.5.7 Disclosure of Information on Annual Business Transactions

Pursuant to Section 8.6.5 and Section 31.20, the Contractor shall submit to DCH, in a format specified by DCH, an annual Disclosure of Information on Annual Business Transactions.

4.18.5.8 Unclaimed Property Report

Pursuant to Section 8.6.7, the Contractor shall submit an annual report on the form prescribed by the Section 8.6.7 to DCH and the Georgia Department of Revenue.

4.18.5.9 Unclaimed Payments Report

Under Georgia Code Title 44, Chapter 12, Article 5, all insurance companies must report annually on unclaimed payments from the prior year.

4.18.5.10 Performance Measures

The performance measures apply to the member populations as specified by the measures' technical specifications. Contractor performance is evaluated annually on the reported rate for each measure as referenced in Section 4.12.3.

4.18.6 Ad Hoc Reports

4.18.6.1 State Quality Monitoring Reports

Pursuant to Section 2.8, the Contractor shall report, upon request by DCH, information to support the State's Quality Monitoring Functions in accordance with 42 CFR 438.204. These Reports shall include information on:

- The availability of services;
- The adequacy of the Contractor's capacity and services;
- The Contractor's coordination and continuity of care for Members;
- The coverage and authorization of services;
- The Contractor's policies and procedures for selection and retention of Providers;
- The Contractor's compliance with Member information requirements in accordance with 42CFR 438.10;
- The Contractor's compliance with Title 45 of the Code of Federal Regulations relative to Member's confidentiality;
- The Contractor's compliance with Member Enrollment and Disenrollment requirements and limitations;
- The Contractor's Grievance System;
- The Contractor's oversight of all sub contractual relationships and delegations therein;
- The Contractor's adoption of practice guidelines, including the dissemination of the guidelines to Providers and Provider's application of them;
- The Contractor's quality assessment and performance improvement program; and
- The Contractor's health information systems.

4.18.6.2 Third Party Liability and Coordination of Benefits Report

Pursuant to Section 8.6.3, the Contractor shall submit a Third Party Liability and Coordination of Benefits Report that includes any Third Party Resources available to a Member discovered by the Contractor, in addition to those provided to the Contractor by DCH pursuant to Section 2.11.1, within ten (10) Business Days of verification of such information. The Contractor shall report any known changes to such resources in the same manner.

4.18.6.3 Provider Rep Field Visit Report

The Contractor shall submit the Provider Rep Field Visit Report on an as-needed-basis, according to the guidelines outlined under Section 4.9.3. The purpose of this report is to show that the CMOs conduct training within thirty (30) Calendar Days of placing a newly Contracted Provider on active status. The Contractor shall also conduct ongoing training as deemed necessary by the Contractor or DCH in order to ensure compliance with program standard and the GHF Contract.

4.18.6.4 Quality Oversight Committee Report

Pursuant to Section 4.12.12.1, the Contractor shall submit a Quality Oversight Committee Report that shall include a summary of results, conclusions, recommendations and implemented system changes for the QAPI program.

4.18.6.5 72 Hour Eligibility Rule Report

Pursuant to Section 4.16.1.9, the Contractor shall submit on an as needed basis, a 72 Hour Eligibility Rule Report demonstrating that the contracted Provider verified member eligibility within 72 hours of the service being rendered.

4.18.6.6 Cost Avoidance Report

Pursuant to Section 8.6.1, the Contractor shall submit a Cost Avoidance Report, within 20 calendar days of a written request from DCH that identifies all cost-avoided claims for Members with third party coverage from private insurance carriers and other responsible third parties.

5.0 DELIVERABLES

5.1 CONFIDENTIALITY

The Contractor shall ensure that any Deliverables that contain information about individuals that is protected by confidentiality and privacy laws shall be prominently marked as "CONFIDENTIAL" and submitted to DCH in a manner that ensures that unauthorized individuals do not have access to the information. The Contractor shall not make public such reports. Failure to ensure confidentiality may result in sanctions and liquidated damages as described in Section 23.

5.2 NOTICE OF APPROVAL/DISAPPROVAL

5.2.1 DCH will provide written notice of disapproval of a Deliverable to the Contractor within fourteen (14) Calendar Days of submission if it is disapproved. DCH may, at its sole discretion, elect to review a deliverable longer than fourteen (14) calendar days.

5.2.2 The notice of disapproval shall state the reasons for disapproval as specifically as is reasonably necessary and the nature and extent of the corrections required for meeting the Contract requirements.

5.3 RESUBMISSION WITH CORRECTIONS

Within fourteen (14) Calendar Days of receipt of a notice of disapproval, the Contractor shall make the corrections and resubmit the Deliverable.

5.4 NOTICE OF APPROVAL/DISAPPROVAL OF RESUBMISSION

Within thirty (30) Calendar Days following resubmission of any disapproved Deliverable, DCH will give written notice to the Contractor of approval, Conditional approval or disapproval.

5.5 DCH FAILS TO RESPOND

In the event that DCH fails to respond to a Contractor's submission or resubmission within the applicable time period, the Contractor should notify DCH of the outstanding request:

5.6 REPRESENTATIONS

5.6.1 By submitting a Deliverable or report, the Contractor represents that to the best of its knowledge, it has performed the associated tasks in a manner that will, in concert with other tasks, meet the objectives stated or referred to in the Contract.

5.6.2 By approving a Deliverable or report, DCH represents only that it has reviewed the Deliverable or report and detected no errors or omissions of sufficient gravity to defeat or substantially threaten the attainment of those objectives and to warrant the Withholding or denial of payment for the work completed. DCH'S acceptance of a Deliverable or report does not discharge any of the Contractor's Contractual obligations with respect to that Deliverable or report.

5.7 CONTRACT DELIVERABLES

Deliverable	Contract Section	Due Date
PCP Auto-assignment Policies	2.3.3	As updated
Member Handbook	4.3.3	As updated
Provider Directory	4.3.5	As updated
Sample Member ID card	4.3.6	As updated
Telephone Hotline Policies and Procedures (Member and Provider)	4.3.7 4.9.5	As updated
Call Center Quality Criteria and Protocols	4.3.7.9 4.9.5.8	As updated
Web site Screenshots	4.3.8 4.9.6	As updated
Cultural Competency Plan	4.3.9.3	As updated
Marketing Plan and Materials	4.4	As updated
Provider Marketing Materials	4.4.4	As updated
MH/SA Policies and Procedures	4.6.11	As updated
EPSDT policies and procedures	4.7	As updated
Provider Selection and Retention Policies and Procedures	4.8.1.6	As updated
Provider Network Listing spreadsheet for all requested Provider types and Provider Letters of Intent or executed Signature Pages of Provider Contracts not previously submitted as part of the RFP response	4.8	As updated
Final Provider Network Listing spreadsheet for all requested Provider types, Signature Pages for all Providers, and written acknowledgements from all Providers part of a PPO, IPO, or other network stating they know they are in the Contractor's network, know they are accepting Medicaid patients, and are accepting the terms and conditions of the Provider Contract.	4.8.1.8	As updated
Network Adequacy Policies and Procedures	4.18.4.10	As updated.
PCP Selection Policies and Procedures	4.8.2.2	As updated
Credentialing and Re-Credentialing Policies and Procedures	4.8.15	As updated
Provider Handbook	4.9.2	As updated
Provider Training Manuals	4.9.3.2	As updated
Provider Complaint System Policies and Procedures	4.9.7	As updated
Utilization Management Policies and Procedures	4.11	As updated
Care Coordination and Case Management Policies and Procedures	4.11	As updated
Quality Assessment and Performance Improvement Program Plan	4.12.5	As updated
Focused Studies	4.12.8.1	1st day of the 4th Quarter of the 1st year
Patient Safety Plan	4.12.9	As updated
Program Integrity Policies and Procedures	4.13	As updated
Grievance System Policies and Procedures	4.14	As updated
Staff Training Plan	4.15.3	As updated
Claims Management	4.16	As updated
Business Continuity Plan	4.17.7.13	As updated
System Users Manuals and Guides	4.17.7	As updated
Information Management Policies and Procedures	4.17	As updated
Subcontractor Agreements	16.0	As updated

5.8 CONTRACT REPORTS

Report	Contract Section	Due Date
Member Data Conflict Report	4.18.3.7	Monthly
Telephone and Internet Activity Report	4.18.3.1	Monthly
Eligibility and Enrollment Reconciliation Report	4.18.3.2	Monthly
Prior Authorization and Pre-Certification Report	4.18.4.9	Quarterly
Claims Processing Report	4.18.4	Monthly
System Availability and Performance Report	4.18.3.3	Monthly
Medical Loss Ratio Report	4.18.3.6	Monthly
EPSDT Report	4.18.4.17	Quarterly
Timely Access Report	4.18.4.1	Quarterly
Provider Complaints Report	4.18.3.10	Monthly
FQHC & RHC Report	4.18.3.9	Monthly
Quality Oversight Committee Report	4.12.5.2	Ad-Hoc
Contractor Information Report	14.1.3	Quarterly
Subcontractor Information Report	16.0	Quarterly
Fraud and Abuse Report	4.18.3.5	Monthly
Grievance System Report	4.18.4.5	Quarterly
Cost Avoidance and Post Payment Recovery Report	4.18.6.6	Ad Hoc
Independent Audit and Income Statement	4.18.5.5	Quarterly
Hospital Statistical and Reimbursement Report	4.18.4.11	Quarterly
Subcontractor Agreement Report	4.18.4.8	Quarterly
Performance Improvement Projects Report	4.18.5.1	Annually
Focused Studies Report	4.18.5.2	Annually
Patient Safety Report	4.18.5.3	Annually
System Refresh Plan	4.18.5.4	Annually
Independent Audit and Income Statement	4.18.5.5	Annually
"SAS 70" Report & "SSAE 16" Report	4.18.5.6	Annually
Disclosure of Information on Annual Business Transactions	4.18.5.7	Annually and any time there is a change.
State Quality Monitoring Report	4.18.6.1	Upon request by DCH
Provider Network Adequacy and Capacity Report	4.18.4.10	Quarterly; and Any time there is a significant change.
Third Party Liability and Coordination of Benefits Report	4.18.6.1.2	Ad-Hoc
Contractor Notifications	4.18.4.34	Within 10 Days of verifications, also a Quarterly summary report
Dental Utilization Report	4.18.3.8	Monthly
Case Management Report	4.18.4.12	Quarterly
Disease Management	4.18.4.13	Quarterly
Unclaimed Property Report	4.18.5.8	Annually
Unclaimed Payment Report	4.18.5.9	Annually
Health Check Record Review	4.18.4.20	Quarterly
Informing Activity	4.18.4.14	Quarterly
CMS 416	4.18.4.15	Quarterly
Initial Screen Report	4.18.4.16	Quarterly

Demonstration Reports	See Attachments O and Q	See Attachments O and Q
Disclosure of Ownership and Control Interest Statement	8.6.5 and 31.20	Annually and within 35 days of any change in ownership of the Contractor
Performance Measures	4.18.5.10	Annually
Utilization Management	4.18.4.4	Quarterly
Prior Authorization/Pre-Certification	4.18.4.9	Quarterly
Pharmacy Audit Report	4.18.4.18	Quarterly
Pharmacy Cost Report	4.18.4.19	Quarterly

6.0 TERM OF CONTRACT

The initial term of this Contract began on July 15, 2005 and continued until the close of the then current State fiscal year (i.e. June 30, 2006). At the time the Parties entered into this Contract on July 15, 2005, DCH was granted six (6) options to renew this Contract, each for an additional term of up to one (1) State fiscal year, which began on July 1, and ended at midnight on June 30, of the following year. DCH elected to exercise each of the six (6) renewal options, the last of which is set to expire on June 30, 2012.

DCH has obtained approval from the Georgia Department of Administrative Services (DOAS) to add two (2) renewal options covering State Fiscal Years 2013-2014. The Parties agree that DCH is granted an additional two (2) options to renew this Contract, each for an additional term of up to one (1) State fiscal year, which shall begin on July 1, and end at midnight on June 30 of the following year.

In the event DCH elects to exercise such additional renewal options, the first option shall begin on July 1, 2012 and continue until midnight on June 30, 2013. In the event DCH elects to exercise the second option, such option shall begin on July 1, 2013 and continue until midnight on June 30, 2014. Each additional term shall be upon the same terms, conditions and at Contractor's best price in effect at the time of renewal. Pursuant to O.C.G.A. § 50-5-64(a)(2), all renewal options shall be exercisable solely and exclusively by DCH. As to each term, the Contract shall be terminated absolutely at the close of the then current State fiscal year without further obligation by DCH.

7.0 PAYMENT FOR SERVICES

7.1 GENERAL PROVISIONS

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

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

7.1.2 The relevant Deliverables shall be mailed to the Project Leader named in the Notice provision of this Contract.

7.1.3 The total of all payments made by DCH to Contractor under this Contract shall not exceed the per Member per month Capitation payments agreed to under Attachment H, which has been provided for through the use of State or federal grants or other funds. With the exception of payments provided to the Contractor in accordance with Section 7.2 on Performance Incentives, DCH will have no responsibility for payment beyond that amount. Also as specified in Section 7.2.1.1, the total of all payments to the Contract will not exceed one hundred and five percent (105%) of the Capitation payment pursuant to 42 CFR 438.6 (hereinafter the "maximum funds"). It is expressly understood that the total amount of payment to the Contractor will not exceed the maximum funds provided above, unless Contractor has obtained prior written approval, in the form of a Contract amendment, authorizing an increase in the total payment. Additionally, the Contractor agrees that DCH will not pay or otherwise compensate the Contractor for any work that it performs in excess of the Maximum Funds.

7.2 Performance Incentives

7.2.1 The Contractor may be eligible for financial performance incentives subject to availability of funding. In order to be eligible for the financial performance incentives described below the Contractor must be fully compliant in all areas of the Contract. All incentives must comply with the federal managed care Incentive Arrangement requirements pursuant to 42 CFR 438.6 and the State Medicaid Manual 2089.3.

7.2.1.1 The total of all payments paid to the Contractor under this Contract shall not exceed one hundred and five percent (105%) of the Capitation payment pursuant to 42 CFR 438.6.

7.2.1.2 The amount of financial performance incentive and allocation methodology is developed solely by DCH.

7.2.2 Health Check Screening Initiative

- The Contractor could become eligible for a performance incentive payment if the Contractor's performance exceeds the minimum compliance standard for Health Check visits.
- The payment to the Contractor, if any, shall depend upon the percentage of Health Check well-child visits and screens achieved by the Contractor in excess of the minimum required compliance standard of eighty percent (80%). Payment shall be based on information obtained from Encounter Data.

8.0 FINANCIAL MANAGEMENT

8.1 GENERAL PROVISIONS

8.1.1 The Contractor shall be responsible for the sound financial management of the CMO plan.

8.2 SOLVENCY AND RESERVES STANDARDS

8.2.1 The Contractor shall establish and maintain such net worth, working capital and financial reserves as required pursuant to O.C.G.A. § 33-21.

8.2.2 The Contractor shall provide assurances to the State that its provision against the risk of insolvency is adequate such that its Members shall not be liable for its debts in the event of insolvency.

8.2.3 As part of its accounting and budgeting function, the Contractor shall establish an actuarially sound process for estimating and tracking incurred but not reported costs. As part of its reserving process, the Contractor shall conduct annual reviews to assess its reserving methodology and make adjustments as necessary.

8.3 REINSURANCE

8.3.1 DCH will not administer a Reinsurance program funded from capitation payment Withholding.

8.3.2 In addition to basic financial measures required by State law and discussed in section 8.2.1 and section 26, the Contractor shall meet financial viability standards. The Contractor shall maintain net equity (assets minus liability) equal to at least one (1) month's capitation payments under this Contract. In addition, the Contractor shall maintain a current ratio (current assets/current liabilities) of greater than or equal to 1.0.

8.3.3 In the event the Contractor does not meet the minimum financial viability standards outlined in 8.3.2, the Contractor shall obtain Reinsurance that meets all DOI requirements. While commercial Reinsurance is not required, DCH recommends that Contractors obtain commercial Reinsurance rather than self-insuring. The Contractor may not obtain a reinsurance policy from an offshore company; the insurance carrier, the insurance carrier's agents and the insurance carrier's subsidiaries must be domestic.

8.4 THIRD PARTY LIABILITY AND COORDINATION OF BENEFITS

8.4.1 Third party liability refers to any other health insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded, or commercial carrier, automobile insurance and worker's compensation) or program, that is, or may be, liable to pay all or part of the Health Care expenses of the Member.

8.4.1.1 Pursuant to Section 1902(a)(25) of the Social Security Act and 42 CFR 433 Subpart D, DCH hereby authorizes the Contractor as its agent to identify and cost avoid Claims for all CMO plan Members, including PeachCare for Kids® Members.

8.4.1.2 The Contractor shall make reasonable efforts to determine the legal liability of third parties to pay for services furnished to CMO plan Members. To the extent permitted by State and federal law, the Contractor shall use Cost Avoidance processes to ensure that primary payments from the liable third party are identified, as specified below.

8.4.1.3 If the Contractor is unsuccessful in obtaining necessary cooperation from a Member to identify potential Third Party Resources after sixty (60) Calendar Days of such efforts, the Contractor may inform DCH, in a format to be determined by DCH, that efforts have been unsuccessful.

8.4.2 Cost Avoidance

8.4.2.1 The Contractor shall cost avoid all Claims or services that are subject to payment from a third party health insurance carrier, and may deny a service to a Member if the Contractor is assured that the third party health insurance carrier will provide the service, with the exception of those situations described below in Section 8.4.2.2. However, if a third party health insurance carrier requires the Member to pay any cost-sharing amounts (e.g., co-payment, coinsurance, deductible), the Contractor shall pay the cost sharing amounts. The Contractor's liability for such cost sharing amounts shall not exceed the amount the Contractor would have paid under the Contractor's payment schedule for the service.

8.4.2.2 Further, the Contractor shall not withhold payment for services provided to a Member if third party liability, or the amount of third party liability, cannot be determined, or if payment will not be available within sixty (60) Calendar Days.

8.4.2.3 The requirement of Cost Avoidance applies to all Covered Services except Claims for labor and delivery, including inpatient hospital care and postpartum care, prenatal services, preventive pediatric services, and services provided to a dependent covered by health insurance pursuant to a court order. For these services, the Contractor shall ensure that services are provided without regard to insurance payment issues and must provide the service first. The Contractor shall then coordinate with DCH or it agent to enable DCH to recover payment from the potentially liable third party.

8.4.2.4 If the Contractor determines that third party liability exists for part or all of the services rendered, the Contractor shall:

- Notify Providers and supply third party liability data to a Provider whose Claim is denied for payment due to third party liability; and
- Pay the Provider only the amount, if any, by which the Provider's allowable Claim exceeds the amount of third party liability.

8.4.3 Compliance

8.4.3.1 DCH may determine whether the Contractor complies with this Section by inspecting source documents for timeliness of billing and accounting for third party payments.

8.5 PHYSICIAN INCENTIVE PLAN

8.5.1 The Contractor may establish physician incentive plans pursuant to federal and State regulations, including 42 CFR 422.208 and 422.210, and 42 CFR 438.6.

8.5.2 The Contractor shall disclose any and all such arrangements to DCH, and upon request, to Members. Such disclosure shall include:

- Whether services not furnished by the physician or group are covered by the incentive plan;
- The type of Incentive Arrangement;
- The percent of Withhold or bonus; and,
- The panel size and if patients are pooled, the method used.

8.5.3 Upon request, the Contractor shall report adequate information specified by the regulations to DCH in order that DCH will adequately monitor the CMO plan.

8.5.4 If the Contractor's physician incentive plan includes services not furnished by the physician/group, the Contractor shall: (1) ensure adequate stop loss protection to individual physicians, and must provide to DCH proof of such stop loss coverage, including the amount and type of stop loss; and (2) conduct annual Member surveys, with results disclosed to DCH, and to Members, upon request.

8.5.5 Such physician incentive plans may not provide for payment, directly or indirectly, to either a physician or physician group as an inducement to reduce or limit medically necessary services furnished to an individual.

8.6 REPORTING REQUIREMENTS

8.6.1 The Contractor shall submit to DCH the quarterly Cost Avoidance Reports as described in Section 4.18.6.6.

8.6.2 The Contractor shall submit to DCH monthly Medical Loss Ratio Reports that detail direct medical expenditures for Members and premiums paid by the Contractor, as described in Section 4.18.3.6.

8.6.3 The Contractor shall submit to DCH Third Party Liability and Coordination of Benefits Reports within ten (10) Business Days of verification of available Third Party Resources to a Member, as described in Section 4.18.6.2. The Contractor shall report any known changes to such resources in the same manner.

8.6.4 Effective for reporting periods ending on or after June 15, 2011, the Contractor, at its sole expense, shall submit by May 15 (or a later date if approved by DCH) of each year a "Reporting on Controls at a Service Organization", meeting all standards and requirements of the AICPA's SSAE 16 "type 2" report, for the Contractor's operations performed for DCH under this Contract. Such report shall cover a period of no less than nine (9) months, ending March 31 of that year (2012). Subsequent reports shall cover 12 months ending on March 31 of that year.

8.6.4.1 Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization, is an attestation standard developed by the American Institute of Certified Public Accountants (AICPA) which shall replace the SAS 70 and is effective for such auditors' reports for periods ending on or after June 15, 2011.

8.6.4.2 For more information on the AICPA's "Statement on Standards for Attestation Engagements No. 16, *Reporting on Controls at a Service Organization*," Contractor may refer to this AICPA website: http://www.aicpa.org/News/FeaturedNews/Pages/SASNo70Transformed%E2%80%93ChangesAheadforStandardonServiceOrganizations.aspx

8.6.4.3 The audit shall be conducted by an independent auditing firm, which has SAS 70 and SSAE No. 16 audit experience. The auditor must meet all AICPA standards for independence. The selection of, and contract with the independent auditor shall be subject to the approval of DCH and the State Auditor. Since such audits are not intended to fully satisfy all auditing requirements of DCH, the State Auditor reserves the right to fully and completely audit at their discretion the Contractor's operation, including all aspects, which will have effect upon the DCH account, either on an interim audit basis or at the end of the State's fiscal year. DCH also reserves the right to designate other auditors or reviewers to examine the Contractor's operations and records for monitoring and/or stewardship purposes.

8.6.4.4 The independent auditing firm shall simultaneously deliver identical reports of its findings and recommendations to the Contractor and DCH within forty-five (45) Calendar Days after the close of each review period. The audit shall be conducted and the report shall be prepared in accordance with generally accepted auditing standards for such audits as defined in the publications of the AICPA, entitled Statement on Standards for Attestation Engagements (SSAE) Number 16 (SSAE 16), Reporting on Controls at a Service Organization.

8.6.4.5 The Contractor shall respond to the audit findings and recommendations within thirty (30) Calendar Days of receipt of the audit and shall submit an acceptable proposed corrective action to DCH. The Contractor shall implement the CAPA/PC within forty (40) Calendar Days of its approval by DCH. Such response shall address, at minimum, any opinion other than a clean opinion; any testing exception; and any other exception, deficiency, weakness, opportunity for improvement, or recommendation reported by the independent auditor.

8.6.5 The Contractor shall submit to DCH a "Disclosure of Ownership and Control Interest Statement.

8.6.5.1 The Contractor shall disclose to DCH full and complete information regarding ownership, financial transactions and persons convicted of criminal activity related to Medicare, Medicaid, or the federal Title XX programs in the time and manner set forth in accordance with federal and state requirements, including 42 CFR §455.104.

8.6.5.2 The Contractor and its subcontractors shall collect the disclosure of health care-related criminal conviction information as required by 42 CFR§ 455.106 and establish policies and procedures to ensure that applicable criminal convictions are reported timely to the State. The Contractor shall screen their employees and contractors initially and on an ongoing monthly basis to determine whether any of them has been excluded from participation in Medicare, Medicaid, CHIP, or any Federal health care programs (as defined in Section 1128B(f) of the Social Security Act) and not employ or contract with an individual or entity that has been excluded. The results of said screenings shall be provided to the DCH on a monthly basis. The word "contractors" in this section shall refer to all individuals listed on the disclosure form including providers and non-providers such as board members, owners, agents, managing employees, etc.

8.6.5.3 Definition of A Party in Interest – As defined in section 1318(b) of the Public Health Service Act, a party in interest is:

- Any director, officer, partner, or employee responsible for management or administration of an HMO; any person who is directly or indirectly the beneficial owner of more than five percent (5%) of the equity of the HMO; any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than five percent (5%) of the HMO; or, in the case of an HMO organized as a nonprofit corporation, an incorporator or Member of such corporation under applicable State corporation law;
- Any organization in which a person as described in the above section is a director, officer or partner; has directly or indirectly a beneficial interest of more than five percent (5%) of the equity of the HMO; or has a mortgage, deed of trust, note, or other interest valuing more than five percent (5%) of the assets of the HMO;
- Any person directly or indirectly controlling, controlled by, or under common control with a HMO; or
- Any spouse, child, or parent of an individual as described in section 8.6.5.1.

8.6.5.4 The Contractor shall disclose the name and address of each person with an ownership or control interest in the disclosing entity or in any Provider, subcontractor or fiscal agent in which the disclosing entity has direct or indirect ownership of five percent (5%) or more and whether any of the persons named pursuant to this requirement is related to another as spouse, parent, child, or sibling. This disclosure shall include the name of any other disclosing entity in which a person with an ownership or control interest in the disclosing entity also has an ownership or control interest.

8.6.5.5 The Contractor shall disclose the identity of any Provider or subcontractor with whom the Contractor has had significant business transactions, defined as those totaling more than twenty-five thousand dollars ($25,000) during the twelve (12) month period ending on the date of the disclosure, and any significant business transactions between the Contractor, any wholly owned supplier, or between the Contractor and any Provider or subcontractor, during the five (5) year period ending on the date of the disclosure.

8.6.5.6 The Contractor shall disclose the identity of any person who has an ownership or control interest in the Contractor, or is an agent or managing employee of the Contractor and who has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the federal Title XX services program since the inception of those programs.

8.6.5.7 Types of Transactions Which Must Be Disclosed – Business transactions which must be disclosed include:

- Any sale, exchange or lease of any property between the Contractor and a party in interest;
- Any lending of money or other extension of credit between the Contractor and a party in interest; and

- Any furnishing for consideration of goods, services (including management services) or facilities between the Contractor and the party in interest. This does not include salaries paid to employees for services provided in the normal course of their employment;

8.6.5.3 The information which must be disclosed in the transactions listed in Section 8.6.5.7 between the Contractor and a party of interest includes:

- The name of the party in interest for each transaction;
- A description of each transaction and the quantity or units involved;
- The accrued dollar value of each transaction during the fiscal year; and
- Justification of the reasonableness of each transaction.

8.6.6 The Contractor shall submit all necessary reports, documentation, to DOI as required by State law, which may include, but is not limited to the following:

- Pursuant to State law and regulations, an annual report on the form prescribed by the National Association of Insurance Commissioners (NAIC) for HMOs, on or before March 1 of each calendar year.
- An annual income statement detailing the Contractor's fourth quarter and year to date earned revenue and incurred expenses as a result of this Contract on or before March 1 of each year. This annual income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and a reconciliation of the Medical Loss Ratio report to the annual NAIC filing on an accrual basis.
- Pursuant to state law and regulations, a quarterly report on the form prescribed by the NAIC for HMOs filed on or before May 15 for the first quarter of the year, August 15 for the second quarter of the year, and November 15, for the third quarter of the year.
- A quarterly income statement detailing the Contractor's quarterly and year to date earned revenue and incurred expenses because of this contract filed on or before May 15, for the first quarter of the year, August 15, for the second quarter of the year, and November 15, for the third quarter of the year. Each quarterly income statement shall be accompanied by a Medical Loss Ratio report for the corresponding period and reconciliation of the Medical Loss Ratio report to the quarterly NAIC filing on an accrual basis.
- An annual independent audit of its business transactions to be performed by a licensed and certified public accountant, in accordance with National Association of Insurance Commissioners Annual Statement Instructions regarding the Annual Audited Financial Report, including but not limited to the financial transactions made under this contract.

8.6.7 The Contractor shall submit all necessary reports, documentation, to the Department of Revenue as required by State law, which may include, but is not limited to the following for Unclaimed Property Reports:

- Pursuant to State law and regulations, an annual report on the form prescribed by the Georgia Department of Revenue for Unclaimed Property Reports for all Insurance Companies are due on or before May 1 of each calendar year.

9.0 PAYMENT OF TAXES

9.1 Contractor will forthwith pay all taxes lawfully imposed upon it with respect to this Contract or any product delivered in accordance herewith. DCH makes no representation whatsoever as to the liability or exemption from liability of Contractor to any tax imposed by any governmental entity.

9.2 The Contractor shall remit the Quality Assessment fee, as provided for in O.C.G.A. §31-8-170 et seq., in the manner prescribed by DCH.

9.3 Furthermore, Contractor shall be responsible for payment of all expenses related to, based on, or arising from salaries, benefits, employment taxes (whether State or Federal) and insurance (whether health, disability, personal, or retirement) for its employees, designees, or assignees.

10.0 RELATIONSHIP OF PARTIES

Neither Party is an agent, employee, assignee or servant of the other. It is expressly agreed that the Contractor and any subcontractors and agents, officers, and employees of Contractor or any subcontractor in the performance of this Contract shall act as independent contractors and not as officers or employees of DCH. DCH shall not be responsible for withholding taxes with respect to the Contractor's compensation hereunder. The Parties acknowledge, and agree, that the Contractor, its agents, employees, and servants shall in no way hold themselves out as agents, employees, or servants of DCH. The parties also agree that the Contractor, its agents, employees, and servants shall have no claim against DCH hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind. It is further expressly agreed that this Contract shall not be construed as a partnership or joint venture between the Contractor or any subcontractor and DCH.

11.0 INSPECTION OF WORK

DCH, the State Department of Audits and Accounts, the U.S. Department of Health and Human Services, the General Accounting Office, the Comptroller General of the United States, if applicable, or their Authorized Representatives, shall have the right to enter into the premises of the Contractor and/or all Subcontractors, or such other places where duties under this Contract are being performed for DCH, to inspect, monitor or otherwise evaluate the services or any work performed pursuant to this Contract. All inspections and evaluations of work being performed shall be conducted with prior notice and during normal business hours. All inspections and evaluations shall be performed in such a manner as will not unduly delay work.

12.0 STATE PROPERTY

12.1 The Contractor agrees that any papers, materials and other documents that are produced or that result, directly or indirectly, from or in connection with the Contractor's provision of the services under this Contract shall be the property of DCH upon creation of such documents, for whatever use that DCH deems appropriate, and the Contractor further agrees to execute any and all documents, or to take any additional actions that may be necessary in the future to effectuate this provision fully. In particular, if the work product or services include the taking of photographs or videotapes of individuals, the Contractor shall obtain the written consent from such individuals authorizing the use by DCH of such photographs, videotapes, and names in conjunction with such use. Contractor shall also obtain necessary releases from such individuals, releasing DCH from any and all Claims or demands arising from such use.

12.2 The Contractor shall be responsible for the proper custody and care of any State-owned property furnished for the Contractor's use in connection with the performance of this Contract. The Contractor will also reimburse DCH for its loss or damage, normal wear and tear excepted, while such property is in the Contractor's custody or use.

12.3 The Parties agree that access to or review of documents or materials by DCH or any other agency of State Government for informational or educational purposes shall not be regarded as having been "received" by DCH or such other agency within the meaning of O.C.G.A. Section 50-18-70 (a), except insofar as (1) copies of such documents or materials are retained and maintained by a State agency for future reference or use in the performance of State functions, or (2) the creation of such documents or materials, and approval of the specific content of such documents or materials, is expressly required by this Contract or any amendment thereto. The Parties further agree that Manuals, instructions, or other documents or materials created by Contractor for the use, information, and /or direction of its own employees, and that describe Contractor's internal procedures, policies, staffing, systems, operations, methodologies, or the like, shall not be regarded as records received or maintained by Contractor in the performance of a service or function for or on behalf of DCH, notwithstanding that such documents or materials may describe procedures, policies, systems, methodologies, operations, or the like that are applied or followed by Contractor in the course of fulfilling its obligations under this Contract.

13.0 OWNERSHIP AND USE OF DATA

All data created from information, documents, messages (verbal or electronic), reports, or meetings involving or arising out of this Contract is owned by DCH, hereafter referred to as DCH Data. The Contractor shall make all data available to DCH, who will also provide it to CMS upon request. The Contractor is expressly prohibited from sharing or publishing DCH Data or any information relating to Medicaid data without the prior written consent of DCH. In the event of a dispute regarding what is or is not DCH Data, DCH's decision on this matter shall be final and not subject to Appeal.

If DCH consents to the publication of its data by Contractor, Contractor shall display the following statement within the publication in a clear and conspicuous manner:

"This publication is made possible by the Georgia Department of Community Health (DCH) through a contract managed by (Contractor's name). Neither DCH or (Contractor's name) is responsible for any misuse or copyright infringement with respect to the publication."

The statement shall not be considered clear and conspicuous if it is difficult to read or hear, or if the placement is easily overlooked.

The Contractor warrants that all deliverables provided by the Contractor do not and will not infringe or misappropriate any right of any third party based on copyright, patent, trade secret, or other intellectual property rights. In case the deliverables or any one or part thereof is held or alleged to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to the Contractor to be likely to be brought, the Contractor will, at its own expense, either:

- Procure for the Department the right to continue using the deliverables; or,
- **M**odify or replace the deliverables to comply with the specifications so that no violation of any intellectual property right occurs. If Contractor fails to comply with the terms and conditions set forth in this section, DCH shall have the option to terminate the Contract.

13.1 SOFTWARE AND OTHER UPGRADES

The Parties also understand and agree that any upgrades or enhancements to software programs, hardware, or other equipment, whether electronic or physical, shall be made at the Contractor's expense only, unless the upgrade or enhancement is made at DCH's request and solely for DCH's use. Any upgrades or enhancements requested by and made for DCH's sole use shall become DCH's property without exception or limitation. The Contractor agrees that it will facilitate DCH's use of such upgrade or enhancement and cooperate in the transfer of ownership, installation, and operation by DCH.

14.0 CONTRACTOR: STAFFING ASSIGNMENTS & CREDENTIALS

- The Contractor warrants and represents that all persons, including independent Contractors and consultants assigned by it to perform this Contract, shall be employees or formal agents of the Contractor and shall have the credentials necessary (i.e., licensed, and bonded, as required) to perform the work required herein. The Contractor shall include a similar provision in any contract with any Subcontractor selected to perform work hereunder. The Contractor also agrees that DCH may approve or disapprove the Contractor's Subcontractors or its staff assigned to this Contract prior to the proposed staff assignment. DCH's decision on this matter shall not be subject to Appeal.

- The Contractor shall insure that all personnel involved in activities that involve clinical or medical decision making have a valid, active, and unrestricted license to practice. On at least an annual basis, the CMO and its subcontractors will verify that staff has a current license that is in good standing and will provide a list to DCH of licensed staff and current licensure status.

- In addition, the Contractor warrants that all persons assigned by it to perform work under this Contract shall be employees or authorized Subcontractors of the Contractor and shall be fully qualified, as required in the RFP and specified in the Contractor's proposal and in this Contract, to perform the services required herein. Personnel commitments made in the Contractor's proposal shall not be changed unless approved by DCH in writing. Staffing will include the named individuals at the levels of effort proposed.

- The Contractor shall provide and maintain sufficient qualified personnel and staffing to enable the Deliverables to be provided in accordance with the RFP, the Contractor's proposal and this Contract. The Contractor shall submit to DCH a detailed staffing plan, including the employees and management for all CMO functions.

- At a minimum, the Contractor shall provide the following staff:

    - An Executive Administrator who is a full-time administrator with clear authority over the general administration and implementation of the requirements detailed in this Contract.

    - A Medical Director who is a licensed physician in the State of Georgia. The Medical Director shall be actively involved in all major clinical program components of the CMO plan, shall be responsible for the sufficiency and supervision of the Provider network, and shall ensure compliance with federal, State and local reporting laws on communicable diseases, child abuse, neglect, etc.

    - A Quality Improvement/Utilization Director.

    - A Chief Financial Officer who oversees all budget and accounting systems.

    - An Information Management and Systems Director and a complement of technical analysts and business analysts as needed to maintain the operations of Contractor Systems and to address System issues in accordance with the terms of this contract.

    - A Pharmacist who is licensed in the State of Georgia;

    - A Dental Consultant who is a licensed dentist in the State of Georgia.

    - A Mental Health Coordinator who is a licensed mental health professional in the State of Georgia.

    - A Member Services Director.

    - A Provider Services Director.

    - A Provider Relations Liaison.

    - A Grievance/Complaint Coordinator.

    - Compliance Officer.

    - A Prior Authorization/Pre-Certification Coordinator who is a physician, registered nurse, or physician's assistant licensed in the State of Georgia.

    - Sufficient staff in all departments, including but not limited to, Member services, Provider services, and prior authorization and concurrent review services to ensure appropriate functioning in all areas.

- The Contractor shall conduct on-going training of staff in all departments to ensure appropriate functioning in all areas.

- The Contractor shall comply with all staffing/personnel obligations set out in the RFP and this Contract, including but not limited to those pertaining to security, health, and safety issues.

14.1 **STAFFING CHANGES**

14.1.1 The Contractor shall notify DCH in the event of any changes to key staff, including the Executive Administrator, Medical Director, Quality Improvement/Utilization Director, Management Information Systems Director, and Chief Financial Officer. The Contractor shall replace any of the key staff with a person of equivalent experience, knowledge and talent. This notification shall take place within five (5) business days of the resignation/termination.

14.1.2 DCH also may require the removal or reassignment of any Contractor employee or Subcontractor employee that DCH deems to be unacceptable. DCH's decision on this matter shall not be subject to Appeal. Notwithstanding the above provisions, the Parties acknowledge and agree that the Contractor may terminate any of its employees designated to perform work or services under this Contract, as permitted by applicable law. In the event of Contractor termination of any key staff identified in Section 14.0.4, the Contractor shall provide DCH with immediate notice of the termination, the reason(s) for the termination, and an action plan for replacing the discharged employee.

14.1.3 The Contractor must submit to DCH quarterly the Contractor Information Report that includes but is not limited to the changes to Contractor's local staff information as well as local and corporate organizational charts.

14.2 **CONTRACTOR'S FAILURE TO COMPLY**

Should the Contractor at any time: 1) refuse or neglect to supply adequate and competent supervision; 2) refuse or fail to provide sufficient and properly skilled personnel, equipment, or materials of the proper quality or quantity; 3) fail to provide the services in accordance with the timeframes, schedule or dates set forth in this Contract; or 4) fail in the performance of any term or condition contained in this Contract, DCH may (in addition to any other contractual, legal or equitable remedies) proceed to take any one or more of the following actions after five (5) Calendar Days written notice to the Contractor:

- Withhold any monies then or next due to the Contractor;

- Obtain the services or their equivalent from a third party, pay the third party for same, and Withhold the amount so paid to third party from any money then or thereafter due to the Contractor; or

- Withhold monies in the amount of any damage caused by any deficiency or delay in the services.

15.0 **CRIMINAL BACKGROUND CHECKS**

15.1 The Contractor shall, upon request, provide DCH with a resume and satisfactory criminal background check or an attestation that a satisfactory criminal background check has been completed of any of its staff or Subcontractor's staff assigned to or proposed to be assigned to any aspect of the performance of this Contract.

16.0 **SUBCONTRACTS**

16.1 **USE OF SUBCONTRACTORS**

16.1.1 The Contractor will not subcontract or permit anyone other than Contractor personnel to perform any of the work, services, or other performances required of the Contractor under this Contract, or assign any of its rights or obligations hereunder, without the prior written consent of DCH. Prior to hiring or entering into an agreement with any Subcontractor, any and all Subcontractors shall be approved by DCH. DCH reserves the right to inspect all subcontract agreements at any time during the Contract period. Upon request from DCH, the Contractor shall provide in writing the names of all proposed or actual Subcontractors. The Contractor is solely accountable for all functions and responsibilities contemplated and required by this Contract, whether the Contractor performs the work directly or through a Subcontractor.

16.1.2 All contracts between the Contractor and Subcontractors must be in writing and must specify the activities and responsibilities delegated to the Subcontractor. The contracts must also include provisions for revoking delegation or imposing other sanctions if the Subcontractor's performance is inadequate.

16.1.3 All contracts must ensure that the Contractor evaluates the prospective Subcontractor's ability to perform the activities to be delegated; monitors the Subcontractor's performance on an ongoing basis and subjects it to formal review according to a periodic schedule established by DCH and consistent with industry standards or State laws and regulations; and identifies deficiencies or areas for improvement and that corrective action is taken.

16.1.4 The Contractor shall give DCH immediate notice in writing by registered mail or certified mail of any action or suit filed by any Subcontractor and prompt notice of any Claim made against the Contractor by any Subcontractor or vendor that, in the opinion of Contractor, may result in litigation related in any way to this Contract.

16.1.5 All Subcontractors must fulfill the requirements of 42 CFR 438.6 as appropriate.

16.1.6 All Provider contracts shall comply with the requirements and provisions as set forth in Section 4.10 of this Contract.

16.1.7 The Contractor shall submit a Subcontractor Information Report to include, but is not limited to: Subcontractor name, services provided, effective date of the subcontracted agreement.

16.1.8 The Contractor shall submit to DCH a written notification of any subcontractor terminations at least ninety (90) days prior to the effective date of the termination.

16.2 COST OR PRICING BY SUBCONTRACTORS

16.2.1 The Contractor shall submit, or shall require any Subcontractors hereunder to submit, cost or pricing data for any subcontract to this Contract prior to award. The Contractor shall also certify that the information submitted by the Subcontractor is, to the best of their knowledge and belief, accurate, complete and current as of the date of agreement, or the date of the negotiated price of the subcontract to the Contract or amendment to the Contract. The Contractor shall insert the substance of this Section in each subcontract hereunder.

16.2.2 If DCH determines that any price, including profit or fee negotiated in connection with this Contract, or any cost reimbursable under this Contract was increased by any significant sum because of the inaccurate cost or pricing data, then such price and cost shall be reduced accordingly and this Contract and the subcontract shall be modified in writing to reflect such reduction.

17.0 LICENSE, CERTIFICATE, PERMIT REQUIREMENT

17.1 Contractor shall have, obtain, and maintain in good standing any licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits that may be necessary, upon DCH's request.

17.2 The Contractor warrants that it is qualified to do business in the State and is not prohibited by its articles of incorporation, bylaws or any law of the State under which it is incorporated from performing the services under this Contract. The Contractor shall have and maintain a Certificate of Authority pursuant to O.C.G.A. §33-21, and shall obtain and maintain in good standing any Georgia-licenses, certificates and permits, whether State or federal, that are required prior to and during the performance of work under this Contract. Loss of the licenses, certificates, permits, or Certificate of Authority for health maintenance organizations shall be cause for termination of the Contract pursuant to Section 22 of this Contract. In the event the Certificate of Authority, or any other license or permit is canceled, revoked, suspended or expires during the term of this Contract, the Contractor shall inform the State immediately and cease all activities under this Contract, until further instruction from DCH. The Contractor agrees to provide DCH with certified copies of all licenses, certificates and permits necessary upon request.

17.2 The Contractor shall be accredited by the National Committee for Quality Assurance (NCQA) for MCO, URAC (Health Plan accreditation), Accreditation Association for Ambulatory Health Care (AAAHC) for MCO, or Joint Commission on Accreditation of Healthcare Organizations (JCAHO) for MCO, or shall be actively seeking and working towards such accreditation. The Contractor shall provide to DCH upon request any and all documents related to achieving such accreditation and DCH shall monitor the Contractor's progress towards accreditation. DCH may require that the Contractor achieve such accreditation by year three of this Contract.

17.3 The Contractor shall notify DCH within fifteen calendar days of any accrediting organization noted deficiencies as well as any accreditations that have been rescinded by a recognized accrediting organization.

17.4 The Contractor warrants that there is no claim, legal action, counterclaim, suit, arbitration, governmental investigation or other legal, administrative, or tax proceeding, or any order, decree or judgment of any court, governmental agency, or arbitration tribunal that is in progress, pending, or threatened against or relating to Contractor or the assets of Contractor that would individually or in the aggregate have a material adverse effect on Contractor's ability to perform the obligations contemplated by this Agreement. Without limiting the generality of the representation of the immediately preceding sentence, Contractor is not currently the subject of a voluntary or involuntary petition in bankruptcy, does not presently contemplate filing any such voluntary petition, and is not aware of any intention on the part of any other person, or entity, to file such an involuntary petition against it.

18.0 RISK OF LOSS AND REPRESENTATIONS

18.1 DCH takes no title to any of the Contractor's goods used in providing the services and/or Deliverables hereunder and the Contractor shall bear all risk of loss for any goods used in performing work pursuant to this Contract.

18.2 The Parties agree that DCH may reasonably rely upon the representations and certifications made by the Contractor, including those made by the Contractor in the Contractor's response to the RFP and this Contract, without first making an independent investigation or verification.

18.3 The Parties also agree that DCH may reasonably rely upon any audit report, summary, analysis, certification, review, or work product that the Contractor produces in accordance with its duties under this Contract, without first making an independent investigation or verification.

19.0 PROHIBITION OF GRATUITIES AND LOBBYIST DISCLOSURES

19.1 The Contractor, in the performance of this Contract, shall not offer or give, directly or indirectly, to any employee or agent of the State, any gift, money or anything of value, or any promise, obligation, or contract for future reward or compensation at any time during the term of this Contract, and shall comply with the disclosure requirements set forth in O.C.G.A. § 45-1-6.

19.2 The Contractor also states and warrants that it has complied with all disclosure and registration requirements for vendor lobbyists as set forth in O.C.G.A. § 21-5-1, et seq. and all other applicable law, including but not limited to registering with the State Ethics Commission. In addition, the Contractor states and warrants that no federal money has been used for any lobbying of State officials, as required under applicable federal law. For the purposes of this Contract, vendor lobbyists are those who lobby State officials on behalf of businesses that seek a contract to sell goods or services to the State or oppose such contract.

20.0 RECORDS REQUIREMENTS

The Contractor agrees to maintain books, records, documents, and other evidence pertaining to the costs and expenses of this Contract to the extent and in such detail as will properly reflect all costs for which payment is made under the provisions of this Contract and/or any document that is a part of this Contract by reference or inclusion. The Contractor's accounting procedures and practices shall conform to generally accepted accounting principles, and the costs properly applicable to the Contract shall be readily ascertainable.

20.1 RECORDS RETENTION REQUIREMENTS

The Contractor shall preserve and make available all of its records pertaining to the performance under this Contract for a period of seven (7) years from the date of final payment under this Contract, and for such period, if any, as is required by applicable statute or by any other section of this Contract. If the Contract is completely or partially terminated, the records relating to the work terminated shall be preserved and made available for period of seven (7) years from the date of termination or of any resulting final settlement. Records that relate to Appeals, litigation, or the settlements of Claims arising out of the performance of this Contract, or costs and expenses of any such agreements as to which exception has been taken by the State Contractor or any of his duly Authorized Representatives, shall be retained by Contractor until such Appeals, litigation, Claims or exceptions have been disposed of.

20.2 ACCESS TO RECORDS

- The State and federal standards for audits of DCH agents, contractors, and programs are applicable to this section and are incorporated by reference into this Contract as though fully set out herein.

- Pursuant to the requirements of 42 CFR 434.6(a) (5) and 42 CFR 434.38, the Contractor shall make all of its books, documents, papers, Provider records, Medical Records, financial records, data, surveys and computer databases available for examination and audit by DCH, the State Attorney General, the State Health Care Fraud Control Unit, the State Department of Audits, and/or authorized State or federal personnel. Any records requested hereunder shall be produced immediately for review at DCH or sent to the requesting authority by mail within fourteen (14) Calendar Days following a request. All records shall be provided at the sole cost and expense of the Contractor. DCH shall have unlimited rights to access, use, disclose, and duplicate all information and data in any way relating to this Contract in accordance with applicable State and federal laws and regulations. DCH shall not be restricted in the number of times it may audit, visit, inspect, review or otherwise monitor Contractor and any subcontractors during the term of this Contract. DCH will only conduct audits as determined reasonably necessary by the Department.

- The Department may issue subpoenas to Contractor, which require the Contractor or its agents (e.g. employees, subcontractors) to: produce and permit inspection and copying of designated books, papers, documents, or other tangible items; and/or attend and give testimony at a deposition or hearing. The Contractor agrees to comply with all subpoenas issued by the Department or parties acting on behalf of the Department. The Contractor understands that it is ultimately responsible for its agents' compliance with the subpoenas described herein.

- During the entire life of the Contract, the Contractor and all subcontractors shall provide DCH with copies of its annual report and all disclosure or reporting statements or forms filed with the State of Georgia and/or the Securities and Exchange Commission (SEC) as soon as they are prepared in final form and are otherwise available for distribution or filing. In the event that the Contractor is not required to or does not prepare either an annual report or SEC disclosure or reporting statements or forms by virtue of being a subsidiary of another corporation, it shall fulfill the requirements of this section, with respect to all such documents for any parent corporation, which reflect, report or include any of its operations on any basis. In addition, upon the written request of the Program Manager, the Contractor and all subcontractors shall furnish DCH with the most recent un-audited and audited copies of its current balance sheet within fourteen (14) calendar days of its receipt of such request.

20.3 MEDICAL RECORD REQUESTS

- The Contractor shall ensure a copy of the Member's Medical Record is made available, without charge, upon the written request of the Member or Authorized Representative within fourteen (14) Calendar Days of the receipt of the written request.

- The Contractor shall ensure that Medical Records are furnished at no cost to a new PCP, Out-of-Network Provider or other specialist, upon Member's request, no later than fourteen (14) Calendar Days following the written request.

21.0 CONFIDENTIALITY REQUIREMENTS

21.1 GENERAL CONFIDENTIALITY REQUIREMENTS

The Contractor shall treat all information, including Medical Records and any other health and Enrollment information that identifies a particular Member or that is obtained or viewed by it or through its staff and Subcontractors performance under this Contract as confidential information, consistent with the confidentiality requirements of 45 CFR parts 160 and 164. The Contractor shall not use any information so obtained in any manner, except as may be necessary for the proper discharge of its obligations. Employees or authorized Subcontractors of the Contractor who have a reasonable need to know such information for purposes of performing their duties under this Contract shall use personal or patient information, provided such employees and/or Subcontractors have first signed an appropriate non-disclosure agreement that has been approved and maintained by DCH. The Contractor shall remove any person from performance of services hereunder upon notice that DCH reasonably believes that such person has failed to comply with the confidentiality obligations of this Contract. The Contractor shall replace such removed personnel in accordance with the staffing requirements of this Contract. DCH, the Georgia Attorney General, federal officials as authorized by federal law or regulations, or the Authorized Representatives of these parties shall have access to all confidential information in accordance with the requirements of State and federal laws and regulations.

21.2 HIPAA COMPLIANCE

The Contractor shall assist DCH in its efforts to comply with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its amendments, rules, procedures, and regulations. To that end, the Contractor shall cooperate and abide by any requirements mandated by HIPAA or any other applicable laws. Contractor warrants that it will cooperate with DCH, including cooperation with DCH privacy officials and other compliance officers required by HIPAA and its regulations, in the course of performance of this Contract so that both parties will be in compliance with HIPAA. The Contractor acknowledges that HIPAA may require the Contractor and DCH to sign documents for compliance purposes, including but not limited to a Business Associate Agreement. The Contractor shall cooperate with DCH on these matters, sign whatever documents may be required for HIPAA compliance, and abide by their terms and conditions. Contractor also agrees to abide by the terms and conditions of DCH policies and procedures regarding privacy and security.

22.0 TERMINATION OF CONTRACT

22.1 GENERAL PROCEDURES

This Contract may terminate, or may be terminated, by DCH for any or all of the following reasons:

- Default by the Contractor, upon thirty (30) Calendar Days' notice;
- Convenience of DCH, upon thirty (30) Calendar Days' notice;
- Immediately, in the event of insolvency, Contract breach, or declaration of bankruptcy by the Contractor; or
- Immediately, when sufficient appropriated funds no longer exist for the payment of DCH's obligation under this Contract.

22.2 TERMINATION BY DEFAULT

22.2.1 In the event DCH determines that the Contractor has defaulted by failing to carry out the substantive terms of this Contract or failing to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act, DCH may terminate the Contract in addition to or in lieu of any other remedies set out in this Contract or available by law.

22.2.2 Prior to the termination of this Contract, DCH will:

- Provide written notice of the intent to terminate at least thirty (30) Calendar Days prior to the termination date, the reason for the termination, and the time and place of a hearing to give the Contractor an opportunity to Appeal the determination and/or cure the default;
- Provide written notice of the decision affirming or reversing the proposed termination of the Contract, and for an affirming decision, the effective date of the termination; and
- For an affirming decision, give Members or the Contractor notice of the termination and information consistent with 42 CFR 438.10 on their options for receiving Medicaid services following the effective date of termination.

22.3 TERMINATION FOR CONVENIENCE

DCH may terminate this Contract for convenience and without cause upon thirty (30) Calendar Days' written notice. Termination for convenience shall not be a breach of the Contract by DCH. The Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date Availability of funds shall be determined solely by DCH.

22.4 TERMINATION FOR INSOLVENCY OR BANKRUPTCY

The Contractor's insolvency, or the Contractor's filing of a petition in bankruptcy, shall constitute grounds for termination for cause. In the event of the filing of a petition in bankruptcy, the Contractor shall immediately advise DCH. If DCH reasonably determines that the Contractor's financial condition is not sufficient to allow the Contractor to provide the services as described herein in the manner required by DCH, DCH may terminate this Contract in whole or in part, immediately or in stages. The Contractor's financial condition shall be presumed not sufficient to allow the Contractor to provide the services described herein, in the manner required by DCH if the Contractor cannot demonstrate to DCH's satisfaction that the Contractor has risk reserves and a minimum net worth sufficient to meet the statutory standards for licensed health care plans. The Contractor shall cover continuation of services to Members for the duration of period for which payment has been made, as well as for inpatient admissions up to discharge.

22.5 TERMINATION FOR INSUFFICIENT FUNDING

In the event that federal and/or State funds to finance this Contract become unavailable, DCH may terminate the Contract in writing with thirty (30) Calendar Days' notice to the Contractor. The Contractor shall be entitled to receive, and shall be limited to, just and equitable compensation for any satisfactory authorized work performed as of the termination date. Availability of funds shall be determined solely by DCH.

22.6 TERMINATION PROCEDURES

22.6.1 DCH will issue a written notice of termination to the Contractor by certified mail, return receipt requested, or in person with proof of delivery. The notice of termination shall cite the provision of this Contract giving the right to terminate, the circumstances giving rise to termination, and the date on which such termination shall become effective. Termination shall be effective at 11:59 p.m. EST on the termination date.

22.6.2 Upon receipt of notice of termination or on the date specified in the notice of termination and as directed by DCH, the Contractor shall:

- Stop work under the Contract on the date and to the extent specified in the notice of termination;
- Place no further orders or Subcontract for materials, services, or facilities, except as may be necessary for completion of such portion of the work under the Contract as is not terminated
- Terminate all orders and Subcontracts to the extent that they relate to the performance of work terminated by the notice of termination;
- Assign to DCH, in the manner and to the extent directed by the Contract Administrator, all of the right, title, and interest of Contractor under the orders or subcontracts so terminated, in which case DCH will have the right, at its discretion, to settle or pay any or all Claims arising out of the termination of such orders and Subcontracts;
- With the approval of the Contract Administrator, settle all outstanding liabilities and all Claims arising out of such termination or orders and subcontracts, the cost of which would be reimbursable in whole or in part, in accordance with the provisions of the Contract;
- Complete the performance of such part of the work as shall not have been terminated by the notice of termination;
- Take such action as may be necessary, or as the Contract Administrator may direct, for the protection and preservation of any and all property or information related to the Contract that is in the possession of Contractor and in which DCH has or may acquire an interest;
- Promptly make available to DCH, or another CMO plan acting on behalf of DCH, any and all records, whether medical or financial, related to the Contractor's activities undertaken pursuant to this Contract. Such records shall be provided at no expense to DCH;
- Promptly supply all information necessary to DCH, or another CMO plan acting on behalf of DCH, for reimbursement of any outstanding Claims at the time of termination; and
- Submit a termination plan to DCH for review and approval that includes the following terms:
  - Maintain Claims processing functions as necessary for ten (10) consecutive months in order to complete adjudication of all Claims;
  - Comply with all duties and/or obligations incurred prior to the actual termination date of the Contract, including but not limited to, the Appeal process as described in Section 4.14;
  - File all Reports concerning the Contractor's operations during the term of the Contract in the manner described in this Contract;
  - Ensure the efficient and orderly transition of Members from coverage under this Contract to coverage under any new arrangement developed by DCH in accordance with procedures set forth in Section 4.11.4;
  - Maintain the financial requirements, and insurance set forth in this Contract until DCH provides the Contractor written notice that all continuing obligations of this Contract have been fulfilled; and
  - Submit Reports to DCH every thirty (30) Calendar Days detailing the Contractor's progress in completing its continuing obligations under this Contract until completion.

22.6.3 Upon completion of these continuing obligations, the Contractor shall submit a final report to DCH describing how the Contractor has completed its continuing obligations. DCH will advise, within twenty (20) Calendar Days of receipt of this report, if all of the Contractor's obligations are discharged. If DCH finds that the final report does not evidence that the Contractor has fulfilled its continuing obligations, then DCH will require the Contractor to submit a revised final report to DCH for approval.

22.7 TERMINATION CLAIMS

22.7.1 After receipt of a notice of termination, the Contractor shall submit to the Contract Administrator any termination claim in the form, and with the certification prescribed by, the Contract Administrator. Such claim shall be submitted promptly but in no event later than ten (10) months from the effective date of termination. Upon failure of the Contractor to submit its termination claim within the time allowed, the Contract Administrator may, subject to any review required by the State procedures in effect as of the date of execution of the Contract, determine, on the basis of information available, the amount, if any, due to the Contractor by reason of the termination and shall thereupon cause to be paid to the Contractor the amount so determined.

22.7.2 Upon receipt of notice of termination, the Contractor shall have no entitlement to receive any amount for lost revenues or anticipated profits or for expenditures associated with this Contract or any other contract. Upon termination, the Contractor shall be paid in accordance with the following:

- At the Contract price(s) for completed Deliverables and/or services delivered to and accepted by DCH; and/or
- At a price mutually agreed upon by the Contractor and DCH for partially completed Deliverables and/or services.

22.7.3 In the event the Contractor and DCH fail to agree in whole or in part as to the amounts with respect to costs to be paid to the Contractor in connection with the total or partial termination of work pursuant to this article, DCH will determine, on the basis of information available, the amount, if any, due to the Contractor by reason of termination and shall pay to the Contractor the amount so determined.

23.0 LIQUIDATED DAMAGES

23.1 GENERAL PROVISIONS

23.1.1 In the event the Contractor fails to meet the terms, conditions, or requirements of this Contract and financial damages are difficult or impossible to ascertain exactly, the Contractor agrees that DCH may assess liquidated damages, not penalties, against the Contractor for the deficiencies. The Parties further acknowledge and agree that the specified liquidated damages are reasonable and the result of a good faith effort by the Parties to estimate the actual harm caused by the Contractor's breach. The Contractor's failure to meet the requirements in this Contract will be divided into four (4) categories of events.

23.1.2 Notwithstanding any sanction or liquidated damages imposed upon the Contractor other than Contract termination, the Contractor shall continue to provide all Covered Services and care management.

23.2 CATEGORY 1

23.2.1 Liquidated damages up to $100,000 per violation may be imposed for Category 1 events. For Category 1 events, the Contractor shall submit a written CAPA/PC to DCH for review and approval prior to implementing the corrective action. Category 1 events are monitored by DCH to determine compliance and shall include and constitute the following:

- Acts that discriminate among Members on the basis of their health status or need for health care services; and
- Misrepresentation of actions or falsification of information furnished to CMS or the State.
- Failure to implement requirements stated in the Contractor's proposal, the RFP, this Contract, or other material failures in the Contractor's duties.
- Failure to participate in a readiness and/or annual review.
- Failure to provide an adequate provider network of physicians, pharmacies, hospitals, and other specified health care Providers in order to assure member access to all Covered Services.

23.3 CATEGORY 2

23.3.1 Liquidated damages up to $25,000 per violation may be imposed for the Category 2 events. For Category 2 events, the Contractor shall submit a written CAPA/PC to DCH for review and approval prior to implementing the corrective action. Category 2 events are monitored by DCH to determine compliance and include the following:

- Substantial failure to provide medically necessary services that the Contractor is required to provide under law, or under this Contract, to a Member covered under this Contract;
- Misrepresentation or falsification of information furnished to a Member, Potential Member, or health care Provider;
- Failure to comply with the requirements for physician incentive plans, as set forth in 42 CFR 422.208 and 422.210;
- Distribution directly, or indirectly, through any Agent or independent contractor, marketing materials that have not been approved by the State or that contain false or materially misleading information;
- Violation of any other applicable requirements of section 1903(m) or 1932 of the Social Security Act and any implementing regulations;
- Failure of the Contractor to assume full operation of its duties under this Contract in accordance with the transition timeframes specified herein;
- Imposition of premiums or charges on Members that are in excess of the premiums or charges permitted under the Medicaid program (the State will deduct the amount of the overcharge and return it to the affected Member).
- Failure to resolve Member Appeals and Grievances within the timeframes specified in this Contract;
- Failure to ensure client confidentiality in accordance with 45 CFR 160 and 45 CFR 164; and an incident of noncompliance will be assessed as per member and/or per HIPAA regulatory violation.
- Violation of a subcontracting requirement in the Contract.

23.4 CATEGORY 3

23.4.1 Liquidated damages up to $5,000.00 per day may be imposed for Category 3 events. For Category 3 events, a written CAPA/PC may be required and corrective action must be taken. In the case of Category 3 events, if corrective action is taken within four (4) Business Days, then liquidated damages may be waived at the discretion of DCH. Category 3 events are monitored by DCH to determine compliance and shall include the following:

- Failure to submit required Reports and Deliverables in the timeframes prescribed in Section 4.18 and Section 5.7;
- Submission of incorrect or deficient Deliverables or Reports as determined by DCH;
- Failure to comply with the Claims processing standards as follows:
  - Failure to process and finalize to a paid or denied status ninety-seven percent (97%) of all Clean Claims within fifteen (15) Business Days during a fiscal year;
  - Failure to pay Providers interest at an eighteen percent (18%) annual rate, calculated daily for the full period during which a clean, unduplicated Claim is not adjudicated within the claims processing deadlines. For all claims that are initially denied or underpaid by the Contractor but eventually determined or agreed to have been owed by the Contractor to a provider of health care services, the Contractor shall pay, in addition to the amount determined to be owed, interest of twenty percent (20%) per annum (based on simple interest calculations), calculated from 15 calendar days after the date the claim was submitted. A Contractor shall pay all interest required to be paid under this provision or Code Section 33-24-59.5 automatically and simultaneously whenever payment is made for the claim giving rise to the interest payment. All interest payments shall be accurately identified on the associated remittance advice submitted by the Contractor to the Provider. A Contractor shall not be responsible for the penalty described in this subsection if the health care provider submits a claim containing a material omission or inaccuracy in any of the data elements required for a complete standard health care claim form as prescribed under 45 C.F.R. Part 162 for electronic claims, a CMS Form 1500 for non-electronic claims, or any claim prescribed by DCH.

- Failure to comply with the eighty percent (80%) of screening ratio on the Contractor's CMS-416 Health Check as described Section 4.7.3.8.
- Failure to achieve the Performance Target for any one Quality Performance Measure.
- Failure to provide an initial visit within fourteen (14) Calendar Days for all newly enrolled women who are pregnant in accordance with Sections 4.6.9.1.
- Failure to comply with the Notice of Proposed Action and Notice of Adverse Action requirements as described in Sections 4.14.3 and 4.14.5.
- Failure to comply with any CAPA/PC as required by DCH.
- Failure to seek, collect and/or report third party information as described in Section 8.4.
- Failure to comply with the Contractor staffing requirements as described in Section 14.2.
- Failure of Contractor to issue written notice to Members upon Provider's notice of termination in the Contractor's plan as described in Section 4.10.2.3.
- Failure to comply with federal law regarding sterilizations, hysterectomies, and abortions and as described in Section 4.6.5.
- Failure to submit acceptable member and provider directed materials or documents in a timely manner, i.e., member and provider directories, handbooks, policies and procedures.
- Failure to comply with the required Demonstration Reports and Deliverables as prescribed in Attachments O and Q.
- Failure to achieve annual targeted reductions in the Pregnancy Rate as identified in Attachment O.
- Failure to deliver effective Demonstration services as evidenced by lack of achievement of annual targeted LBW and VLBW reduction targets as identified in Attachment O.

23.5 CATEGORY 4

23.5.1 Liquidated damages as specified below may be imposed for Category 4 events. Imposition of liquidated damages will not relieve the Contractor from submitting and implementing CAPA/PC or corrective action as determined by DCH. Category 4 events are monitored by DCH to determine compliance and include the following:

23.5.1.1 Failure to implement the business continuity-disaster recovery (BC-DR) plan as follows:

- Implementation of the (BC-DR) plan exceeds the proposed time by two (2) or less Calendar Days: five thousand dollars ($5,000) per day up to day 2;
- Implementation of the (BC-DR) plan exceeds the proposed time by more than (2) and up to five (5) Calendar Days: ten thousand dollars ($10,000) per each day beginning with Day 3 and up to Day 5;
- Implementation of the (BC-DR) plan exceeds the proposed time by more than five (5) and up to ten (10) Calendar Days, twenty-five thousand dollars ($25,000) per day beginning with Day 6 and up to Day 10; and
- Implementation of the (BC-DR) plan exceeds the proposed time by more than ten (10) Calendar Days: fifty thousand dollars ($50,000) per each day beginning with Day 11.

23.5.1.2 Unscheduled System Unavailability (other than CCE and ECM functions described below) occurring during a continuous five (5) Business Day period, may be assessed as follows:

- Greater than or equal to two (2) and less than twelve (12) hours cumulative: up to one hundred twenty-five dollars ($125) for each thirty (30) minutes or portions thereof;
- Greater than or equal to twelve (12) and less than twenty-four (24) hours cumulative: up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof; and
- Greater than or equal to twenty-four (24) hours cumulative: up to five hundred dollars ($500) for each thirty (30) minutes or portions thereof up to a maximum of twenty-five thousand dollars ($25,000) per occurrence.

23.5.1.3 Confirmation of CMO Enrollment (CCE) or Electronic Claims Management (ECM) system downtime. In any calendar week, penalties may be assessed as follows for downtime outside the State's control of any component of the CCE and ECM systems, such as the voice response system and PC software response system:

- Less than twelve (12) hours cumulative: up to two hundred fifty dollars ($250) for each thirty (30) minutes or portions thereof;
- Greater than or equal to twelve (12) and less than twenty-four (24) hours cumulative: up to five hundred ($500) for each thirty (30) minutes or portions thereof; and
- Greater than or equal to twenty-four (24) hours cumulative: up to one thousand dollars ($1,000) for each thirty (30) minutes or portions thereof up to a maximum of fifty thousand dollars ($50,000) per occurrence.

23.5.1.4 Failure to make available to the state and/or its agent readable, valid extracts of Encounter Information for a specific month within fifteen (15) Calendar Days of the close of the month: five hundred dollars ($500) per day. After fifteen (15) Calendar Days of the close of the month: two thousand dollars ($2000) per day.

23.5.1.5 Failure to correct a system problem not resulting in System Unavailability within the allowed timeframe, where failure to complete was not due to the action or inaction on the part of DCH as documented in writing by the Contractor:

- One (1) to fifteen (15) Calendar Days late: two hundred and fifty dollars ($250) per Calendar Day for Days 1 through 15;
- Sixteen (16) to thirty (30) Calendar Days late: five hundred dollars ($500) per Calendar Day for Days 16 through 30; and
- More than thirty (30) Calendar Days late: one thousand dollars ($1,000) per Calendar Day for Days 31 and beyond.

23.5.1.6 Failure to meet the Telephone Hotline performance standards:

- $1,000.00 for each percentage point that is below the target answer rate of eighty percent (80%) in thirty (30) seconds;
- $1,000.00 for each percentage point that is above the target of a one percent (1%) Blocked Call rate; and
- $1,000.00 for each percentage point that is above the target of a five percent (5%) Abandoned Call rate.

23.6 OTHER REMEDIES

In addition other liquidated damages described above for Category 1-4 events, DCH may impose the following other remedies:

- Appointment of temporary management of the Contractor as provided in 42 CFR 438.706, if DCH finds that the Contractor has repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Social Security Act;
- Granting Members the right to terminate Enrollment without cause and notifying the affected Members of their right to disenroll;
- Suspension of all new Enrollment, including default Enrollment, after the effective date of remedies;
- Suspension of payment to the Contractor for Members enrolled after the effective date of the remedies and until CMS or DCH is satisfied that the reason for imposition of the remedies no longer exists and is not likely to occur;
- Termination of the Contract if the Contractor fails to carry out the substantive terms of the Contract or fails to meet the applicable requirements in 1932 and 1903(m) of the Social Security Act;
- Civil Monetary Fines in accordance with 42 CFR 438.704; and
- Additional remedies allowed under State statute or State regulation that address areas of non-compliance specified in 42 CFR 438.700.

23.7 NOTICE OF REMEDIES

Prior to the imposition of either liquidated damages or other remedies, DCH will issue a written notice of remedies that will include the following:

- A citation to the law, regulation or Contract provision that has been violated;
- The remedies to be applied and the date the remedies will be imposed;
- The basis for DCH's determination that the remedies should be imposed;
- Request for a CAPA/PC, if applicable; and
- The time frame and procedure for the Contractor to dispute DCH's determination. A Contractor's dispute of a liquidated damage or remedies shall not stay the effective date of the proposed liquidated damage or remedies.

24.0 INDEMNIFICATION

The Contractor hereby releases and agrees to indemnify and hold harmless DCH, the State of Georgia and its departments, agencies and instrumentalities (including the State Tort Claims Trust Fund, the State Authority Liability Trust Fund, The State Employee Broad Form Liability Funds, the State Insurance and Hazard Reserve Fund, and other self-insured funds, all such funds hereinafter collectively referred to as the "Funds") from and against any and all claims, demands, liabilities, losses, costs or expenses, and attorneys' fees, caused by, growing out of, or arising from this Contract, due to any act or omission on the part of the Contractor, its agents, employees, customers, invitees, licensees or others working at the direction of the Contractor or on its behalf, or due to any breach of this Contract by the Contractor, or due to the application or violation of any pertinent federal, State or local law, rule or regulation. This indemnification extends to the successors and assigns of the Contractor, and this indemnification survives the termination of the Contract and the dissolution or, to the extent allowed by the law, the bankruptcy of the Contractor.

25.0 INSURANCE

25.1 The Contractor shall, at a minimum, prior to the commencement of work, procure the insurance policies identified below at the Contractor's own cost and expense and shall furnish DCH with proof of coverage at least in the amounts indicated. It shall be the responsibility of the Contractor to require any Subcontractor to secure the same insurance coverage as prescribed herein for the Contractor, and to obtain a certificate evidencing that such insurance is in effect. In the event that any such insurance is proposed to be reduced, terminated or cancelled for any reason, the Contractor shall provide to DCH at least thirty (30) Calendar Days written notice. Prior to the reduction, expiration and/or cancellation of any insurance policy required hereunder, the Contractor shall secure replacement coverage upon the same terms and provisions to ensure no lapse in coverage, and shall furnish, at the request of DCH, a certificate of insurance indicating the required coverage's. The Contractor shall maintain insurance coverage sufficient to insure against claims arising at any time

during the term of the Contract. The provisions of this Section shall survive the expiration or termination of this Contract for any reason. In addition, the Contractor shall indemnify and hold harmless DCH and the State from any liability arising out of the Contractor's or its Subcontractor's untimely failure in securing adequate insurance coverage as prescribed herein:

25.1.1 Workers' Compensation Insurance, the policy(ies) to insure the statutory limits established by the General Assembly of the State of Georgia. The Workers' Compensation Policy must include Coverage B – Employer's Liability Limits of:

- Bodily injury by accident: five hundred thousand dollars ($500,000) each accident;
- Bodily Injury by Disease: five hundred thousand dollars ($500,000) each employee; and
- One million dollars ($1,000,000) policy limits.

25.1.2 The Contractor shall require all Subcontractors performing work under this Contract to obtain an insurance certificate showing proof of Worker's Compensation Coverage.

25.1.3 The Contractor shall have commercial general liability policy(ies) as follows:

- Combined single limits of one million dollars ($1,000,000) per person and three million dollars ($3,000,000) per occurrence;
- On an "occurrence" basis; and
- Liability for property damage in the amount of three million dollars ($3,000,000) including contents coverage for all records maintained pursuant to this Contract.

26.0 PAYMENT BOND & IRREVOCABLE LETTER OF CREDIT

26.1 Within five (5) Business Days of Contract Execution, Contractor shall obtain and maintain in force and effect an irrevocable letter of credit in the amount representing one half of one month's Net Capitation Payment associated with the actual GF lives in the Atlanta and Central Service Regions enrolled in Contractor's plan. On or before July 2 each following year, Contractor shall modify the amount of the irrevocable letter of credit currently in force and effect to equal one-half of the average of the Net Capitation Payments paid to the Contractor for the months of January, February and March. If at any time during the year, the actual GF lives enrolled in Contractor's plan increases or decreases by more than twenty-five percent, DCH, at its sole discretion, may increase or decrease the amount required for the irrevocable letter of credit.

Notwithstanding the above, Contractor shall have the option, in its discretion, to obtain a surety bond in lieu of the irrevocable letter of credit for 15% of the total irrevocable letter of credit requirement, and such surety bond, together with an irrevocable letter of credit in the amount of 85% of the total irrevocable letter of credit requirement, shall satisfy Contractor's obligations under this Section 26.1.

With regard to the irrevocable letter of credit, DCH may recoup payments from the Contractor for liabilities or obligations arising from any act, event, omission or condition which occurred or existed subsequent to the effective date of the Contract and which is identified in a survey, review, or audit conducted or assigned by DCH.

26.2 DCH may also, at its discretion, redeem Contractor's irrevocable letter of credit in the amount(s) of actual damages suffered by DCH if DCH determines that the Contractor is (1) unable to perform any of the terms and conditions of the Contract or if (2) the Contractor is terminated by default or bankruptcy or material breach that is not cured within the time specified by DCH, or under both conditions described at one (1) and two (2).

26.3 During the Contract period, Contractor shall obtain and maintain a payment bond from an entity licensed to do business in the State of Georgia and acceptable to DCH with sufficient financial strength and creditworthiness to assume the payment obligations of Contractor in the event of a default in payment arising from bankruptcy, insolvency, or other cause. Said bond shall be delivered to DCH within five (5) Business Days of Contract Execution and shall be in the amount of Five Million Dollars ($5,000,000.00). On or before July 2, of each following year, Contractor shall modify the amount of the bond to equal the average of the Net Capitation Payments paid to the Contractor for the months of January, February and March.

26.4 If at any time during the year, the actual GF lives enrolled in Contractor's plan increases or decreases by more than twenty-five percent, DCH, at its sole discretion, may increase or decrease the amount required for the bond.

27.0 COMPLIANCE WITH ALL LAWS

27.1 NON-DISCRIMINATION

The Contractor agrees to comply with applicable federal and State laws, rules and regulations, and the State's policy relative to nondiscrimination in employment practices because of political affiliation, religion, race, color, sex, physical handicap, age, or national origin including, but not limited to, Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972 as amended; the Age Discrimination Act of 1975, as amended; Equal Employment Opportunity (45 CFR 74 Appendix A (1), Executive Order 11246 and 11375) and the Americans with Disability Act of 1993 (including but not limited to 28 C.F.R. § 35.100 et seq.). Nondiscrimination in employment practices is applicable to employees for employment, promotions, dismissal and other elements affecting employment.

27.2 DELIVERY OF SERVICE AND OTHER FEDERAL LAWS

27.2.1 The Contractor agrees that all work done as part of this Contract is subject to CMS approval and will comply fully with applicable administrative and other requirements established by applicable federal and State laws and regulations and guidelines, including but not limited to section 1902(a)(7) of the Social Security Act and DCH Medicaid and PeachCare for Kids® Policies and Procedures manuals, and assumes responsibility for full compliance with all such applicable laws, regulations, and guidelines, and agrees to fully reimburse DCH for any loss of funds or resources or overpayment resulting from non-compliance by Contractor, its staff, agents or Subcontractors, as revealed in subsequent audits. The provisions of the Fair Labor Standards Act of 1938 (29 U.S.C. § 201 et seq.) and the rules and regulations as promulgated by the United States Department of Labor in Title XXIX of the Code of Federal Regulations are applicable to this Contract. Contractor shall agree to conform with such federal laws as affect the delivery of services under this Contract including but not limited to the Titles VI, VII, XIX, XXI of the Social Security Act, the Federal Rehabilitation Act of 1973, the Davis Bacon Act (40 U.S.C. § 276a et seq.), the Copeland Anti-Kickback Act (40 U.S.C. § 276c), the Clean Air Act (42 U.S.C. 7401 et seq.) and the Federal Water Pollution Control Act as Amended (33 U.S.C. 1251 et seq.); the Byrd Anti-Lobbying Amendment (31 U.S.C. 1352); and Debarment and Suspension (45 CFR 74 Appendix A (8) and Executive Order 12549 and 12689); the Contractor shall agree to conform to such requirements or regulations as the United States Department of Health and Human Services may issue from time to time. Authority to implement federal requirements or regulations will be given to the Contractor by DCH in the form of a Contract amendment.

27.2.2 The Contractor shall include notice of grantor agency requirements and regulations pertaining to reporting and patient rights under any contracts involving research, developmental, experimental or demonstration work with respect to any discovery or invention which arises or is developed in the course of or under such contract, and of grantor agency requirements and regulations pertaining to copyrights and rights in data.

27.2.3 The Contractor shall recognize mandatory standards and policies relating to energy efficiency, which are contained in the State energy conservation plan issues in compliance with the Energy Policy and Conservation Act (Pub. L. 94-165).

27.3 COST OF COMPLIANCE WITH APPLICABLE LAWS

The Contractor agrees that it will bear any and all costs (including but not limited to attorneys' fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not limited to federal and State statutes, case law, precedent, regulations, policies, and procedures which exist at the time of the execution of this Contract. The Contractor further agrees that it will bear any and all costs (including but not limited to attorneys' fees, accounting fees, research costs, or consultant costs) related to, arising from, or caused by compliance with any and all laws, such as but not limited to federal and state statutes, case law, precedent, regulations, policies, and procedures which become effective or are amended throughout the life of the Contract. In the event of a disagreement on this matter, DCH's determination on this matter shall be conclusive and not subject to Appeal.

27.4 GENERAL COMPLIANCE

Additionally, the Contractor agrees to comply and abide by all laws, rules, regulations, statutes, policies, or procedures that may govern the Contract, the deliverables in the Contract, or either Party's responsibilities. To the extent that applicable laws, rules, regulations, statutes, policies, or procedures – either those in effect at the time of the execution of this Contract, or those which become effective or are amended during the life of the Contract – require the Contractor to take action or inaction, any costs, expenses, or fees associated with that action or inaction shall be borne and paid by the Contractor solely.

28.0 CONFLICT RESOLUTION

Any dispute concerning a question of fact or obligation related to or arising from this Contract that is not disposed of by mutual agreement shall be decided by the Contract Administrator who shall reduce his or her decision to writing and mail or otherwise furnish a copy to the Contractor. The written decision of the Contract Administrator shall be final and conclusive, unless the Contractor mails or otherwise furnishes a written Appeal to the Commissioner of DCH within ten (10) Calendar Days from the date of receipt of such decision. The decision of the Commissioner or a duly Authorized Representative for the determination of such Appeal shall be final and conclusive. In connection with any Appeal proceeding under this provision, the Contractor shall be afforded an opportunity to be heard and to offer evidence in support of its Appeal. Pending a final decision of a dispute hereunder, the Contractor shall proceed diligently with the performance of the Contract.

29.0 CONFLICT OF INTEREST AND CONTRACTOR INDEPENDENCE

29.1 No official or employee of the State of Georgia or the federal government who exercises any functions or responsibilities in the review or approval of the undertaking or carrying out of the GF program shall, prior to the completion of the project, voluntarily acquire any personal interest, direct or indirect, in this Contract or the proposed Contract.

29.2 The Contractor covenants that it presently has no interest and shall not acquire any interest, direct or indirect, that would conflict in any material manner or degree with, or have a material adverse effect on the performance of its services hereunder. The Contractor further covenants that in the performance of the Contract no person having any such interest shall be employed.

29.3 All of the parties hereby certify that the provisions of O.C.G.A. §45-10-20 through §45-10-28, which prohibit and regulate certain transactions between State officials and employees and the State of Georgia, have not been violated and will not be violated in any respect throughout the term.

29.4 In addition, it shall be the responsibility of the Contractor to maintain independence and to establish necessary policies and procedures to assist the Contractor in determining if the actual Contractors performing work under this Contract have any impairment to their independence. To that end, the Contractor shall submit a written plan to DCH within five (5) Business Days of Contract Award in which it outlines its Impartiality and Independence Policies and Procedures relating to how it monitors and enforces Contractor and Subcontractor impartiality and independence. The Contractor further agrees to take all necessary actions to eliminate threats to impartiality and independence, including but not limited to reassigning, removing, or terminating Contractors or Subcontractors.

30.0 NOTICE

30.1 All notices under this Contract shall be deemed duly given upon delivery, if delivered by hand, or three (3) Calendar Days after posting, if sent by registered or certified mail, return receipt requested, to a party hereto at the addresses set forth below or to such other address as a party may designate by notice pursuant hereto.

For DCH:

Contract Administration:
Lindsey C. Breedlove
Acting Director of Contracts Administration
Georgia Department of Community Health
2 Peachtree Street, NW – 40th Floor
Atlanta, GA 30303-3159
(404) 463-1020 – Phone
(404) 657-7200 – Fax
E-mail address: lbreedlove@dch.ga.gov

Peach State Health Plan
Clyde White, Jr.
VP Compliance
Peach State Health Plan
3200 Highland Parkway SE
Suite 300
Smyrna, GA 30082
(678) 556-2439 – Phone
(678) 556-2309 - Fax
E-mail address: CWHITE@CENTENE.COM

Project Leader:
Claudette V. Bazile, Esq., Deputy Director of Operations
Georgia Department of Community Health
Division of Medicaid
2 Peachtree Street, NW, 36th Floor
Atlanta, Georgia 30303-3159
(404) 656-7513 - office
(770) 344-3829 - fax
E-mail address: cbazile@dch.ga.gov

30.2 It shall be the responsibility of the Contractor to inform the Contract Administrator of any change in address in writing no later than five (5) Business Days after the change.

31.0 MISCELLANEOUS

31.1 CHOICE OF LAW OR VENUE

This Contract shall be governed in all respects by the laws of the State of Georgia. Any lawsuit or other action brought against DCH, the State based upon, or arising from this Contract shall be brought in a court or other forum of competent jurisdiction in Fulton County in the State of Georgia.

31.2 ATTORNEY'S FEES

In the event that either party deems it necessary to take legal action to enforce any provision of this Contract, and in the event DCH prevails, the Contractor agrees to pay all expenses of such action including reasonable attorney's fees and costs at all stages of litigation as awarded by the court, a lawful tribunal, hearing officer or administrative law judge. If the Contractor prevails in any such action, the court or hearing officer, at its discretion, may award costs and reasonable attorney's fees to the Contractor. The term legal action shall be deemed to include administrative proceedings of all kinds, as well as all actions at law or equity.

31.3 SURVIVABILITY

The terms, provisions, representations and warranties contained in this Contract shall survive the delivery or provision of all services or Deliverables hereunder.

31.4 DRUG-FREE WORKPLACE

The Contractor shall certify to DCH that a drug-free workplace shall be provided for the Contractor's employees during the performance of this Contract as required by the "Drug-Free Workplace Act", O.C.G.A. § 50-24-1, et seq. and applicable federal law. The Contractor will secure from any Subcontractor hired to work in a drug-free workplace such similar certification. Any false certification by the Contractor or violation of such certification, or failure to carry out the requirements set forth in the code, may result in the Contractor being suspended, terminated or debarred from the performance of this Contract.

31.5 CERTIFICATION REGARDING DEBARMENT, SUSPENSION, PROPOSED DEBARMENT AND OTHER MATTERS

The Contractor certifies that it is not presently debarred, suspended, proposed for debarment or declared ineligible for award of contracts by any federal or State agency.

31.6 WAIVER

The waiver by DCH of any breach of any provision contained in this Contract shall not be deemed to be a waiver of such provision on any subsequent breach of the same or any other provision contained in this Contract and shall not establish a course of performance between the parties contradictory to the terms hereof.

31.7 FORCE MAJEURE

Neither party to this Contract shall be responsible for delays or failures in performance resulting from acts beyond the control of such party. Such acts shall include, but not be limited to, acts of God, strikes, riots, lockouts, and acts of war, epidemics, fire, earthquakes, or other disasters.

31.8 BINDING

This Contract and all of its terms, conditions, requirements, and amendments shall be binding on DCH, the Contractor, and their respective successors and permitted assigns.

31.9 TIME IS OF THE ESSENCE

Time is of the essence in this Contract. Any reference to "Days" shall be deemed Calendar Days unless otherwise specifically stated.

31.10 AUTHORITY

DCH has full power and authority to enter into this Contract, and the person acting on behalf of and signing for the Contractor has full authority to enter into this Contract, and the person signing on behalf of the Contractor has been properly authorized and empowered to enter into this Contract on behalf of the Contractor and to bind the Contractor to the terms of this Contract. Each party further acknowledges that it has had the opportunity to consult with and/or retain legal counsel of its choice, read this Contract, understands this Contract, and agrees to be bound by it.

31.11 ETHICS IN PUBLIC CONTRACTING

The Contractor understands, states, and certifies that it made its proposal to the RFP without collusion or fraud and that it did not offer or receive any kickbacks or other inducements from any other Contractor, supplier, manufacturer, or Subcontractor in connection with its proposal to the RFP.

31.12 CONTRACT LANGUAGE INTERPRETATION

The Contractor and DCH agree that in the event of a disagreement regarding, arising out of, or related to, Contract language interpretation, DCH's interpretation of the Contract language in dispute shall control and govern. DCH's interpretation of the Contract language in dispute shall not be subject to Appeal under any circumstance.

31.13 ASSESSMENT OF FEES

The Contractor and DCH agree that DCH may elect to deduct any assessed fees from payments due or owing to the Contractor or direct the Contractor to make payment directly to DCH for any and all assessed fees. The choice is solely and strictly DCH's choice.

31.14 COOPERATION WITH OTHER CONTRACTORS

31.14.1 In the event that DCH has entered into, or enters into, agreements with other contractors for additional work related to the services rendered hereunder, the Contractor agrees to cooperate fully with such other contractors. The Contractor shall not commit any act that will interfere with the performance of work by any other contractor.

31.14.2 Additionally, if DCH eventually awards this Contract to another contractor, the Contractor agrees that it will not engage in any behavior or inaction that prevents or hinders the work related to the services contracted for in this Contract. In fact, the Contractor agrees to submit a written turnover plan and/or transition plan to DCH within thirty (30) Days of receiving the Department's intent to terminate letter. The Parties agree that the Contractor has not successfully met this obligation until the Department accepts its turnover plan and/or transition plan.

31.14.3 The Contractor's failure to cooperate and comply with this provision, shall be sufficient grounds for DCH to halt all payments due or owing to the Contractor until it becomes compliant with this or any other contract provision. DCH's determination on the matter shall be conclusive and not subject to Appeal.

31.15 SECTION TITLES NOT CONTROLLING

The Section titles used in this Contract are for reference purposes only and shall not be deemed a part of this Contract.

31.16 LIMITATION OF LIABILITY/EXCEPTIONS

Nothing in this Contract shall limit the Contractor's indemnification liability or civil liability arising from, based on, or related to claims brought by DCH or any third party or any claims brought against DCH or the State by a third party or the Contractor.

31.17 COOPERATION WITH AUDITS

31.17.1 The Contractor agrees to assist and cooperate with the Department in any and all matters and activities related to or arising out of any audit or review, whether federal, private, or internal in nature, at no cost to the Department.

31.17.2 The parties also agree that the Contractor shall be solely responsible for any costs it incurs for any audit related inquiries or matters. Moreover, the Contractor may not charge or collect any fees or compensation from DCH for any matter, activity, or inquiry related to, arising out of, or based on an audit or review.

31.18 HOMELAND SECURITY CONSIDERATIONS

31.18.1 The Contractor shall perform the services to be provided under this Contract entirely within the boundaries of the United States. In addition, the Contractor will not hire any individual to perform any services under this Contract if that individual is required to have a work visa approved by the U.S. Department of Homeland Security and such individual has not met this requirement.

31.18.2 If the Contractor performs services, or uses services, in violation of the foregoing paragraph, the Contractor shall be in material breach of this Contract and shall be liable to the Department for any costs, fees, damages, claims, or expenses it may incur. Additionally, the Contractor shall be required to hold harmless and indemnify DCH pursuant to the indemnification provisions of this Contract.

31.18.3 The prohibitions in this Section shall also apply to any and all agents and Subcontractors used by the Contractor to perform any services under this Contract.

31.19 PROHIBITED AFFILIATIONS WITH INDIVIDUALS DEBARRED AND SUSPENDED

31.19.1 The Contractor shall not knowingly have a relationship with an individual, or an affiliate of an individual, who is debarred, suspended, or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing Executive Order No. 12549. For the purposes of this Section, a "relationship" is described as follows:

- A director, officer or partner of the Contractor;
- A person with beneficial ownership of five percent (5%) or more of the Contractor entity; and
- A person with an employment, consulting or other arrangement with the Contractor's obligations under its Contract with the State.

31.19.2 The Contractor shall submit a monthly Program Integrity Exception List report that identifies Providers, owners, agents, employees, subcontractors and contractors (as defined in Section 8.6.5.2) that have been reported on the HHS-OIG LEIE (List of Excluded Individuals/Entities) (***http://oig.hhs.gov/fraud/exclusions/exclusions_list.asp***) and/or the CMS MED (Medicare Exclusion Database).

31.19.3 All disclosures required under this Section shall be included in the Contractor's monthly Fraud and Abuse Report (See Sections 4.13.4 and 4.18.3.5.2).

31.20 OWNERSHIP AND FINANCIAL DISCLOSURE

31.20.1 The Contractor shall disclose each person or corporation with an ownership or control interest of five percent (5%) or more in the Contractor's entity for the prior twelve (12) month period as required in Section 8.6.5 of this Contract. For the purposes of this Section, a person or corporation with an ownership or control interest shall mean a person or corporation:

- That owns directly or indirectly five percent (5%) or more of the Contractor's capital or stock or received five percent (5%) or more of its profits;
- That has an interest in any mortgage, deed of trust, note, or other obligation secured in whole or in part by the Contractor or by its property or assets, and that interest is equal to or exceeds five percent (5%) of the total property and assets of the Contractor; and
- That is an officer or director of the Contractor (if it is organized as a corporation) or is a partner in the Contractor's organization (if it is organized as a partnership).

32.0 AMENDMENT IN WRITING

No amendment, waiver, termination or discharge of this Contract, or any of the terms or provisions hereof, shall be binding upon either party unless confirmed in writing. None of the Solicitation Documents may be modified or amended, except by writing executed by both parties. Additionally, CMS approval may be required before any such amendment is effective. DCH will determine, in its sole discretion, when such CMS approval is required. Any agreement of the parties to amend, modify, eliminate or otherwise change any part of this Contract shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be of full force and effect as set out herein.

33.0 CONTRACT ASSIGNMENT

Contractor shall not assign this Contract, in whole or in part, without the prior written consent of DCH, and any attempted assignment not in accordance herewith shall be null and void and of no force or effect.

34.0 SEVERABILITY

Any section, subsection, paragraph, term, condition, provision, or other part of this Contract that is judged, held, found or declared to be voidable, void, invalid, illegal or otherwise not fully enforceable shall not affect any other part of this Contract, and the remainder of this Contract shall continue to be of full force and effect as set out herein.

35.0 COMPLIANCE WITH AUDITING AND REPORTING REQUIREMENTS FOR NONPROFIT ORGANIZATIONS (O.C.G.A. § 50-20-1 ET SEQ.)

The Contractor agrees to comply at all times with the provisions of the Federal Single Audit Act (hereinafter called the Act) as amended from time to time, all applicable implementing regulations, including but not limited to any disclosure requirements imposed upon non-profit organizations by the Georgia Department of Audits as a result of the Act, and to make complete restitution to DCH of any payments found to be improper under the provisions of the Act by the Georgia Department of Audits, the Georgia Attorney General's Office or any of their respective employees, agents, or assigns.

36.0 ENTIRE AGREEMENT

This Contract constitutes the entire agreement between the parties with respect to the subject matter hereof and supersedes all prior negotiations, representations or contracts. No written or oral agreements, representatives, statements, negotiations, understandings, or discussions that are not set out, referenced, or specifically incorporated in this Contract shall in any way be binding or of effect between the parties.

(Signatures on following page)

SIGNATURE PAGE

IN WITNESS WHEREOF, the parties state and affirm that, they are duly authorized to bind the respected entities designated below as of the day and year indicated.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

/s/ David A. Cook 11/17/2011
David A. Cook, Commissioner Date

/s/ Jerry Dubberly 11/4/2011
Jerry Dubberly, Chief – Medicaid Division Date

PEACH STATE HEALTH PLAN

BY: /s/ Patrick M. Healy 10/24/2011
Signature Date

Patrick M. Healy
Print/Type Name

President / CEO
*TITLE

* Must be President, Vice President, CEO or Other Officer Authorized by Corporate Resolution to Execute on Behalf of and Bind the Corporation to a Contract

ATTACHMENT A

DRUG FREE WORKPLACE CERTIFICATE

This certification is required by regulations implementing the Drug-Free Workplace Act of 1988 and O.C.G.A. § 50-24-1 *et seq*. The certification set out below is a material representation of fact upon which DCH relied when entering into Contract #0653 with Peach State Health Plan (hereinafter referred to as the "Contractor"). False certification or violation of the certification shall be grounds for suspension of payments, termination of the contract, or government-wide suspension or debarment.

By signing this Drug-Free Workplace Certificate, Contractor certifies that it will provide a drug-free workplace by:

1. Publishing a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession or use of a controlled substance or marijuana is prohibited in Contractor's workplace and specifying the actions that will be taken against employees for violations of such policy;

2. Establishing a drug-free awareness program to inform employees about:

    a. The dangers of drug abuse in the workplace;
    b. Contractor's policy of maintaining a drug-free workplace;
    c. Any available drug counseling, rehabilitation, and employee assistance programs; and
    d. The penalties that may be imposed upon employees for drug abuse violations;

3. Providing each employee with a copy of the statement provided for in paragraph (1) of this certification;

4. Notifying each employee in the statement provided for in paragraph (1) that, as a condition of employment, the employee shall:

    a. Abide by the terms of the statement; and
    b. Notify Contractor of any criminal drug statute conviction for a violation occurring in the workplace no later than five calendar days after such conviction;

5. Notifying DCH within ten calendar days after receiving notice under subparagraph 4(b) from an employee or otherwise receiving actual notice of such conviction;

6. Taking one of the following actions, within 30 days of receiving notice under subparagraph 4(b), with respect to any employee who is so convicted;

    a. Taking appropriate personnel action against such an employee, up to and including termination; or
    b. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a federal, state, or local health, law enforcement, or other appropriate agency;

7. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs 1, 2, 3, 4, 5, and 6.

Further, Contractor certifies that it will include in any agreement or contract with a subcontractor a provision that such subcontractor will provide a drug-free workplace for his employees by complying with the provisions of paragraphs (1), (2), (3), (4), and (6) of this subsection and by notifying Contractor of any criminal drug statute conviction for a violation occurring in the workplace involving the subcontractor or its employees within five calendar days of receiving notice of the conviction. Contractor will notify the contracting principal representative pursuant to paragraph (5) of this subsection.

PEACH STATE HEALTH PLAN

BY: /s/ Patrick M. Healy 10/24/2011
SIGNATURE DATE

Patrick M. Healy

President / CEO
TITLE

* Must be President, Vice President, CEO or Other Officer Authorized by Corporate Resolution to Execute on Behalf of and Bind the Corporation to a Contract

ATTACHMENT B

**CERTIFICATION REGARDING DEBARMENT, SUSPENSION,
PROPOSED DEBARMENT, AND OTHER RESPONSIBILITY MATTERS**

Federal Acquisition Regulation 52.209-5, Certification Regarding Debarment, Suspension, Proposed Debarment, and Other Responsibility Matters (March 1996)

A. CERTIFICATION
    (1) The Contractor certifies, to the best of its knowledge and belief, that—
        (i) The Contractor and/or any of its Principals—
            (a) Are are not presently debarred, suspended, proposed for debarment, or declared ineligible for award of Contracts by any Federal agency;

            (b) Have have not within a three-year period preceding this offer, been convicted of or had a civil judgment rendered against them for: commission of Fraud or criminal offense in connection with obtaining, attempting to obtain, or performing a public (federal, State, or local) Contract or subcontract; violation of federal or State antitrust statutes relating to the submission of offers; or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, evasion, or receiving stolen property; and

            (c) Are are not presently indicted for, or otherwise criminally or civilly charged by a governmental entity with commission of any of the offenses enumerated in subdivision (a) (1) (i) (B) of this provision.

        (ii) The Contractor has has not within a three-year period preceding this offer, had one or more Contracts terminated for default by any federal agency.

    (2) "Principals," for purposes of this certification, means officers, directors, owners, partners, and, persons having primary management or supervisory responsibilities within a business entity (e.g., general manager, plant manager, head of a subsidiary, division, or business segment; and similar positions).

    This certification concerns a matter within the jurisdiction of an Agency of the United States and the making of a false, fictitious, or Fraudulent certification may render the maker subject to prosecution under 18 U.S.C. § 1001.

B. The Contractor shall provide immediate written notice to the Contracting Officer if, at any time prior to Contract Award, the Contractor learns that its certification was erroneous when submitted or has become erroneous by reason of changed circumstances.

C. A certification that if any of the items in paragraph (a) of this provision exist will not necessarily result in Withholding of an award under this solicitation. However, the certification will be considered in connection with a determination of the Contractor's responsibility. Failure of the Contractor to furnish a certification or provide such additional information as requested by the Contracting Officer may render the Contractor non-responsible.

D. Nothing contained in the foregoing shall be construed to require establishment of a system of records in order to render, in good faith, the certification required by paragraph (a) of this provision. The knowledge and information of a Contractor is not required to exceed that which is normally possessed by a prudent person in the ordinary course of business dealings.

E. The certification in paragraph (a) of this provision is a material representation of fact upon which reliance was placed when making award. If it is later determined that the Contractor knowingly rendered an erroneous certification, in addition to other remedies available to the Government, the Contracting Officer may terminate the Contract resulting from this solicitation for default.

PEACH STATE HEALTH PLAN

By: /s/ Patrick M. Healy

Patrick M. Healy 10/24/2011
Signature Date

Pres / CEO
Name and Title

ATTACHMENT C

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
NONPROFIT ORGANIZATION DISCLOSURE FORM

Notice to all DCH Contractors: Pursuant to Georgia law, nonprofit organizations that receive funds from a State organization must comply with audit requirements as specified in O.C.G.A. § 50-20-1 et seq. (hereinafter "the Act") to ensure appropriate use of public funds. "Nonprofit Organization" means any corporation, trust, association, cooperative, or other organization that is operated primarily for scientific, educational, service, charitable, or similar purposes in the public interest; is not organized primarily for profit; and uses its net proceeds to maintain, improve or expand its operations. The term nonprofit organization includes nonprofit institutions of higher education and hospitals. For financial reporting purposes, guidelines issued by the American Institute of Certified Public Accountants should be followed in determining nonprofit status.

DCH must report Contracts with nonprofit organizations to the Department of Audits and must ensure compliance with the other requirements of the Act. Prior to execution of any Contract, the potential Contractor shall complete this form disclosing its corporate status to DCH. This form must be returned, along with proof of corporate status, to: Name, Director, Contract and Procurement Administration, Georgia Department of Community Health, 35th Floor, 2 Peachtree Street, N.W., Atlanta, Georgia 30303-3159.

Acceptable proof of corporate status includes, but is not limited to, the following documentation:

- Financial statements for the previous year;
- Employee list;
- Employee salaries;
- Employees' reimbursable expenses; and
- CAPA/PC

Entities that meet the definition of nonprofit organization provided above and are subject the requirements of the Act will be contacted by DCH for further information.

PEACH STATE HEALTH PLAN

ADDRESS: 3200 Highlands Parkway SE, Suite 300
Smyrna, GA 30082

PHONE: (678)556-2300 FAX: (678) 56-2309

CORPORATE STATUS: (check one) For Profit X Non-Profit

I, the undersigned duly Authorized Representative of Peach State Health Plan do hereby attest that the above information is true and correct to the best of my knowledge.

/s/ Patrick M. Healy 10/24/2011
Signature Date

ATTACHMENT D

STATE OF GEORGIA
THE GEORGIA DEPARTMENT OF COMMUNITY HEALTH
2 PEACHTREE STREET, N.W.
ATLANTA, GEORGIA 30303-3159

CONFIDENTIALITY STATEMENT
FOR SAFEGUARDING INFORMATION

I, the undersigned, understand, and by my signature agree to comply with Federal and State requirements **(References: 42 CFR 431.300 – 431.306. Chapter 350-5 of Rules of Georgia Department of Community Health)** regarding the safeguarding of Medicaid information in my possession, including but not limited to information which is electronically obtained from the Medicaid Management Information System (MMIS) while performing Contractual services with the Department of Community Health, its Agents or Contractors.

Individual's Name: (typed or printed): Patrick M. Healy

Signature: /s/ Patrick M. Healy Date:

Telephone No.: (678) 556-2419

Company or Agency Name and Address: **PEACH STATE HEALTH PLAN**
3200 Highlands Parkway SE
Suite 300
Smyrna, GA 30082

ATTACHMENT E

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (hereinafter referred to as "Agreement"), effective this 18th day of October, 2011 is made and entered into by and between the Georgia Department of Community Health (hereinafter referred to as "DCH") and Peach State Health Plan (hereinafter referred to as "Contractor") as Attachment E to Contract No. 0653 between DCH and Contractor dated July 18, 2005 ("Contract").

WHEREAS, DCH is required by the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), to enter into a Business Associate Agreement with certain entities that provide functions, activities, or services involving the use of Protected Health Information ("PHI");

WHEREAS, Contractor, under Contract No. 0653 (hereinafter referred to as "Contract"), may provide functions, activities, or services involving the use of PHI;

NOW, THEREFORE, for and in consideration of the mutual promises, covenants and agreements contained herein, and other good and valuable consideration, the receipt and sufficiency of which are hereby acknowledged, DCH and Contractor (each individually a "Party" and collectively the "Parties") hereby agree as follows:

1. Terms used but not otherwise defined in this Agreement shall have the same meaning as those terms in the Privacy Rule and the Security Rule, published as the Standards for Privacy and Security of Individually Identifiable Health

Information in 45 C.F.R. Parts 160 and 164 ("Privacy Rule" and "Security Rule").

2. Except as limited in this Agreement, Contractor may use or disclose PHI only to extent necessary to meet its responsibilities as set forth in the Contract provided that such use or disclosure would not violate the Privacy Rule or the Security Rule, if done by DCH.

3. Unless otherwise Provided by Law, Contractor agrees that it will:

A. Not request, create, receive, use or disclose PHI other than as permitted or required by this Agreement, the Contract, or as required by law.

B. Establish, maintain and use appropriate safeguards to prevent use or disclosure of the PHI other than as provided for by this Agreement or the Contract.

C. Implement and use administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of DCH.

D. Mitigate, to the extent practicable, any harmful effect that may be known to Contractor from a use or disclosure of PHI by Contractor in violation of the requirements of this Agreement, the Contract or applicable regulations.

E. Ensure that its agents or subcontractors are subject to at least the same obligations that apply to Contractor under this Agreement and ensure that its agents or subcontractors comply with the conditions, restrictions, prohibitions and other limitations regarding the request for, creation, receipt, use or disclosure of PHI, that are applicable to Contractor under this Agreement and the Contract.

F. Ensure that its agents and subcontractors, to whom it provides protected health information, agree to implement reasonable and appropriate safeguards to protect the information.

G. Report to DCH any use or disclosure of PHI that is not provided for by this Agreement or the Contract and to report to DCH any security incident of which it becomes aware. Contractor agrees to make such report to DCH in writing in such form as DCH may require within three (3) business days after Contractor becomes aware of the unauthorized use or disclosure or of the security incident.

H. Make any amendment(s) to PHI in a Designated Record Set that DCH directs or agrees to pursuant to 45 CFR 164.526 at the request of DCH or an Individual, within five (5) business days after request of DCH or of the Individual. Contractor also agrees to provide DCH with written confirmation of the amendment in such format and within such time as DCH may require.

I. Provide access to PHI in a Designated Record Set, to DCH upon request, within five (5) business days after such request, or, as directed by DCH, to an Individual. Contractor also agrees to provide DCH with written confirmation that access has been granted in such format and within such time as DCH may require.

J. Give the Secretary of the U.S. Department of Health and Human Services (the "Secretary") or the Secretary's designees access to Contractor's books and records and policies, practices or procedures relating to the use and disclosure of PHI for or on behalf of DCH within five (5) business days after the Secretary or the Secretary's designees request such access or otherwise as the Secretary or the Secretary's designees may require. Contractor also agrees to make such information available for review, inspection and copying by the Secretary or the Secretary's designees during normal business hours at the location or locations where such information is maintained or to otherwise provide such information to the Secretary or the Secretary's designees in such form, format or manner as the Secretary or the Secretary's designees may require.

K. Document all disclosures of PHI and information related to such disclosures as would be required for DCH to respond to a request by an Individual or by the Secretary for an accounting of disclosures of PHI in accordance with 45 C.F.R. § 164.528.

L. Provide to DCH or to an Individual, information collected in accordance with Section 3. I. of this Agreement, above, to permit DCH to respond to a request by an Individual for an accounting of disclosures of PHI as provided in the Privacy Rule.

4. Unless otherwise Provided by Law, DCH agrees that it will:

A. Notify Contractor of any new limitation in DCH's Notice of Privacy Practices in accordance with the provisions of the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such limitation will affect Contractor's use or disclosure of PHI.

B. Notify Contractor of any change in, or revocation of, permission by an Individual for DCH to use or disclose PHI to the extent that DCH determines in the exercise of its sole discretion that such change or revocation will affect Contractor's use or disclosure of PHI.

C. Notify Contractor of any restriction regarding its use or disclosure of PHI that DCH has agreed to in accordance with the Privacy Rule if, and to the extent that, DCH determines in the exercise of its sole discretion that such restriction will affect Contractor's use or disclosure of PHI.

D. Prior to agreeing to any changes in or revocation of permission by an Individual, or any restriction, to use or disclose PHI as referenced in subsections b. and c. above, DCH agrees to contact Contractor to determine feasibility of compliance. DCH agrees to assume all costs incurred by Contractor in compliance with such special requests.

5. The **Term of this Agreement** shall be effective as of October 18, 2011, and shall terminate when all of the PHI provided by DCH to Contractor, or created or received by Contractor on behalf of DCH, is destroyed or returned to DCH, or, if it is infeasible to return or destroy PHI, protections are extended to such information, in accordance with the termination provisions in this Section.

A. Termination for Cause. Upon DCH's knowledge of a material breach by Contractor, DCH shall either:

1) Provide an opportunity for Contractor to cure the breach within a reasonable period of time, which shall be within 30 days after receiving written notification of the breach by DCH;

2) If Contractor fails to cure the breach, terminate the contract upon 30 days' notice; or

3) If neither termination nor cure is feasible, DCH shall report the violation to the Secretary of the Department of Health and Human Services.

B. Effect of Termination

1) Upon termination of this Agreement, for any reason, DCH and Contractor shall determine whether return of PHI is feasible. If return of the PHI is not feasible, Contractor agrees to continue to extend the protections of Sections 3 (A) through (J) of this Agreement and applicable law to such PHI and limit further use of such PHI, except as otherwise permitted or required by this Agreement, for as long as Contractor maintains such PHI. If Contractor elects to destroy the PHI, Contractor shall notify DCH in writing that such PHI has been destroyed and provide proof, if any exists, of said destruction. This provision shall apply also to PHI that is in the possession of subcontractors or agents of Contractor. Neither Contractor nor its agents nor subcontractors shall retain copies of the PHI.

2) Contractor agrees that it will limit its further use or disclosure of PHI only to those purposes DCH may, in the exercise of its sole discretion, deem to be in the public interest or necessary for the protection of such PHI, and will take such additional actions as DCH may require for the protection of patient privacy and the safeguarding, security and protection of such PHI.

3) If neither termination nor cure is feasible, DCH shall report the violation to the Secretary. Particularly in the event of a pattern of activity or practice of Contractor that constitutes a material breach of Contractor's obligations under the Contract and this agreement; DCH shall invoke termination procedures or report to the Secretary.

4) Section 5. B. of this Agreement, regarding the effect of termination or expiration, shall survive the termination of this Agreement.

6. Interpretation

Any ambiguity in this Agreement shall be resolved to permit DCH to comply with applicable laws, rules and regulations, the HIPAA Privacy Rule, the HIPAA Security Rule and any rules, regulations, requirements, rulings, interpretations, procedures or other actions related thereto that are promulgated, issued or taken by or on behalf of the Secretary; provided that applicable laws, rules and regulations and the laws of the State of Georgia shall supersede the Privacy Rule if, and to the extent that, they impose additional requirements, have requirements that are more stringent than or have been interpreted to provide greater protection of patient privacy or the security or safeguarding of PHI than those of the HIPAA Privacy Rule.

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

IN WITNESS WHEREOF, Contractor, through its authorized officer and agent, has caused this Agreement to be executed on its behalf as of the date indicated.

PEACH STATE HEALTH PLAN

BY: /s/ Patrick M. Healy 10/24/2011
SIGNATURE DATE

Patrick M. Healy
Pres / CEO
TITLE

ATTACHMENT F

VENDOR LOBBYIST DISCLOSURE AND

REGISTRATION CERTIFICATION FORM

Pursuant to Executive Order Number 10.01.03.01 (the "Order"), which was signed by Governor Sonny Perdue on October 1, 2003, Contractors with the State are required to complete this form. The Order requires "Vendor Lobbyists," defined as those who lobby State officials on behalf of businesses that seek a Contract to sell goods or services to the State or those who oppose such a Contract, to certify that they have registered with the State Ethics Commission and filed the disclosures required by Article 4 of Chapter 5 of Title 21 of the Official Code of Georgia Annotated. Consequently, every vendor desiring to enter into a Contract with the State must complete this certification form. False, incomplete, or untimely registration, disclosure, or certification shall be grounds for termination of the award and Contract and may cause recumbent or refund actions against Contractor.

In order to be in compliance with Executive Order Number 10.01.03.01, please complete this Certification Form by designating only one of the following:

□ Contractor does not have any lobbyist employed, retained, or affiliated with the Contractor who is seeking or opposing Contracts for it or its clients. Consequently, Contractor has not registered anyone with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.

□ Contractor does have lobbyist(s) employed, retained, or affiliated with the Contractor who are seeking or opposing Contracts for it or its clients. The lobbyists are: ___Ray Williams, Nick deJong, Jay Morgan and Wendi Clifton_____

Contractor states, represents, warrants, and certifies that it has registered the above named lobbyists with the State Ethics Commission as required by Executive Order Number 10.01.03.01 and any of its related rules, regulations, policies, or laws.

Signatures on the following page

SIGNATURE PAGE

IN WITNESS WHEREOF, Contractor, through its authorized officer and agent, has caused this Agreement to be executed on its behalf as of the date indicated.

PEACH STATE HEALTH PLAN

BY: /s/ Patrick M. Healy 10/24/2011
SIGNATURE DATE

Patrick M. Healy

Pres / CEO
TITLE

* Must be President, Vice President, CEO or Other Officer Authorized by Corporate Resolution to Execute on Behalf of and Bind the Corporation to a Contract

ATTACHMENT G

RESERVED

ATTACHMENT H

CAPITATION PAYMENT

CONFIDENTIAL – NOT FOR CIRCULATION

Attachment H
Peach State Health Plan
FY11

Region	Aid Category	Age/Gender Group	FY 11 Peach State Health Plan
Atlanta	Medicaid (LIM/Refugee/RSM)	0 - 2 Months, Male and Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	3 - 11 Months, Male and Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	1 - 5 Years, Male and Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	6 - 13 Years, Male and Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Male	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Male	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	45+ Years, Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	45+ Years, Male	$ ***
Atlanta	PeachCare	0 - 2 Months, Male and Female	$ ***
Atlanta	PeachCare	3 - 11 Months, Male and Female	$ ***
Atlanta	PeachCare	1 - 5 Years, Male and Female	$ ***
Atlanta	PeachCare	6 - 13 Years, Male and Female	$ ***
Atlanta	PeachCare	14 - 20 Years, Female	$ ***
Atlanta	PeachCare	14 - 20 Years, Male	$ ***
Atlanta	Breast and Cervical Cancer	Breast and Cervical Cancer	$ ***
Atlanta	Maternity Delivery/Kick Payment	Maternity Delivery/Kick Payment	$ ***
Atlanta	NICU Kick	NICU Kick	$ ***
Central	Medicaid (LIM/Refugee/RSM)	0 - 2 Months, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	3 - 11 Months, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	1 - 5 Years, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	6 - 13 Years, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Male	$ ***
Central	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Male	$ ***
Central	Medicaid (LIM/Refugee/RSM)	45+ Years, Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	45+ Years, Male	$ ***
Central	PeachCare	0 - 2 Months, Male and Female	$ ***
Central	PeachCare	3 - 11 Months, Male and Female	$ ***
Central	PeachCare	1 - 5 Years, Male and Female	$ ***
Central	PeachCare	6 - 13 Years, Male and Female	$ ***
Central	PeachCare	14 - 20 Years, Female	$ ***
Central	PeachCare	14 - 20 Years, Male	$ ***
Central	Breast and Cervical Cancer	Breast and Cervical Cancer	$ ***
Central	Maternity Delivery/Kick Payment	Maternity Delivery/Kick Payment	$ ***
Central	NICU Kick	NICU Kick	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	0 - 2 Months, Male and Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	3 - 11 Months, Male and Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	1 - 5 Years, Male and Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	6 - 13 Years, Male and Female	$ ***

Southwest	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Male	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Male	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	45+ Years, Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	45+ Years, Male	$ ***
Southwest	PeachCare	0 - 2 Months, Male and Female	$ ***
Southwest	PeachCare	3 - 11 Months, Male and Female	$ ***
Southwest	PeachCare	1 - 5 Years, Male and Female	$ ***
Southwest	PeachCare	6 - 13 Years, Male and Female	$ ***
Southwest	PeachCare	14 - 20 Years, Female	$ ***
Southwest	PeachCare	14 - 20 Years, Male	$ ***
Southwest	Breast and Cervical Cancer	Breast and Cervical Cancer	$ ***
Southwest	Maternity Delivery/Kick Payment	Maternity Delivery/Kick Payment	$ ***
Southwest	NICU Kick	NICU Kick	$ ***

ATTACHMENT I

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF YOUR RIGHT TO A HEARING

You have the right to a hearing regarding this decision. To have a hearing, you must ask for one **in writing.** Your request for a hearing, along with a copy of the adverse action letter, must be received within **thirty (30) days** of the date of the letter. Please mail your request for a hearing to the appropriate MANAGED CARE ORGANIZATION.

NAME: _____

ADDRESS: _____

FAX#_____

The Office of State Administrative Hearings will notify you of the time, place and date of your hearing. An Administrative Law Judge will hold the hearing. In the hearing, you may speak for yourself or let a friend or family member to speak for you. You also may ask a lawyer to represent you. You may be able to obtain legal help at no cost. If you desire an attorney to help you, you may call one of the following telephone numbers:

Georgia Legal Services Program	**Georgia Advocacy Office**	**Atlanta Legal Aid**
1-800-498-9469	1-800-537-2329	404-377-0701 - (DeKalb & Gwinnett Counties)
(Statewide legal services, EXCEPT For the counties served by Atlanta)	(Statewide advocacy for persons with disabilities or mental illness)	770-528-2565 - (Cobb County)
		404-524-5811 - (Fulton County)
		404-669-0233 - (South Fulton & Clayton County)
		678-376-4545 - (Gwinnett County)

You may also ask for free mediation services after you have filed a Request for Hearing by calling (404) 657-2800. Mediation is another way to solve problems before going to a hearing.

If the problem cannot be solved during mediation, you still have the right to a hearing.

ATTACHMENT J

MAP OF SERVICE REGIONS/LIST OF COUNTIES BY SERVICE REGIONS

Atlanta	Central	East	North	SE	SW
Barrow	Baldwin	Burke	Banks	Appling	Atkinson
Bartow	Bibb	Columbia	Catoosa	Bacon	Baker
Butts	Bleckley	Emanuel	Chattooga	Brantley	Ben Hill
Carroll	Chattahoochee	Glascock	Clarke	Bryan	Berrien
Cherokee	Crawford	Greene	Dade	Bulloch	Brooks
Clayton	Crisp	Hancock	Dawson	Camden	Calhoun
Cobb	Dodge	Jefferson	Elbert	Candler	Clay
Coweta	Dooly	Jenkins	Fannin	Charlton	Clinch
DeKalb	Harris	Lincoln	Floyd	Chatham	Coffee
Douglas	Heard	McDuffie	Franklin	Effingham	Colquitt
Fayette	Houston	Putnam	Gilmer	Evans	Cook
Forsyth	Jones	Richmond	Gordon	Glynn	Decatur
Fulton	Lamar	Screven	Habersham	Jeff Davis	Dougherty
Gwinnett	Laurens	Taliaferro	Hall	Liberty	Early
Haralson	Macon	Warren	Hart	Long	Echols
Henry	Marion	Washington	Jackson	McIntosh	Grady
Jasper	Meriwether	Wilkes	Lumpkin	Montgomery	Irwin
Newton	Monroe		Madison	Pierce	Lanier
Paulding	Muscogee		Morgan	Tattnall	Lee
Pickens	Peach		Murray	Toombs	Lowndes
Rockdale	Pike		Oconee	Ware	Miller
Spalding	Pulaski		Oglethorpe	Wayne	Mitchell
Walton	Talbot		Polk		Quitman
	Taylor		Rabun		Randolph
	Telfair		Stephens		Seminole
	Treutlen		Towns		Schley
	Troup		Union		Stewart
	Twiggs		Walker		Sumter
	Upson		White		Terrell
	Wheeler		Whitfield		Thomas
	Wilcox				Tift
	Wilkinson				Turner
	Johnson				Webster
					Worth

ATTACHMENT K

APPLICABLE CO-PAYMENTS

Children under age twenty-one (21), pregnant women, nursing facility residents, members enrolled in breast and cervical cancer programs, and Hospice care Members are exempted from co-payments.

There are no co-payments for family planning services or for emergency services except as defined below.

Services cannot be denied to anyone based on the inability to pay these co-payments.

Service	Additional Exceptions	Co-Pay Amount
Ambulatory Surgical Centers		A $3 co-payment to be deducted from the surgical procedure code billed. In the case of multiple surgical procedures, only one $3 amount will be deducted per date of service.
FQHC/RHCs		A $2 co-payment on all FQHC and RHC.

Outpatient		A $3 member co-payment is required on all non-emergency outpatient hospital visits
Inpatient	Members who are admitted from an emergency department or following the receipt of urgent care or are transferred from a different hospital, from a skilled nursing facility, or from another health facility are exempted from the inpatient co-payment.	A co-payment of $12.50 will be imposed on hospital inpatient services
Emergency Department		A $3 co-payment will be imposed if the Condition is not an Emergency Medical Condition
Oral Maxiofacial Surgery		Effective with dates of service July 1, 2005, the Division is implementing a tiered member co-payment scale as described in 42CFR447.54 on all evaluation and management procedure codes (99201 - 99499) including the ophthalmologic services procedure codes (92002 - 92014) used by physicians or physicians' assistants. The tiered co-payment amounts are as follows: State's payment for the service Maximum co-payment chargeable to recipient $10.00 or less - $0.50 $10.01 to $25.00 - $1.00 $25.01 to $50.00 - $2.00 $50.01 or more - $3.00
Prescription Drugs	Drug Cost: <$10.01 $10.01 - $25.00 $25.01 - $50.00 >$50.01	Co-pay Amount $.50 $1.00 $2.00 $3.00

ATTACHMENT L

INFORMATION MANAGEMENT AND SYSTEMS

Georgia Cares Program (GCS) Program
Care Management Organization (CMO) Contract
Attachment L.1: Data and Document Management Requirements by Major Information Type

In order to meet programmatic, reporting and management requirements, CMO systems will serve as either a) the authoritative host of key data and documents or b) the host of valid, replicated data and documents from other systems. The following table lays out the requirements for managing (capturing, storing and maintaining) data and documents for the major **information types and subtypes** associated with the aforementioned programmatic, reporting and management requirements:

L.1.1 Member Data and Related Documents

Subtype ID	Subtype Name / Description	Role of CMO System	Data Management Requirements
1.1	Unique member identifier (UMI)	Authoritative host; retain relationship to Fiscal Agent-assigned member identifier	The UMI should span member's lifetime and should serve as an index to obtain member-specific information across multiple sub systems/databases of a single CMO
1.2	Fiscal Agent-assigned member identifier	Receive original record and updates from Fiscal Agent	Retain relationship to UMI
1.3	Member enrollment and enrollment status changes in Contractor's CMO	Receive original record and updates from DCH and/or its agent	The CMO shall retain in its "live" systems the most recent 7-year history (or less if member dies within 7-year period) of enrollment status changes, including multiple re-enrollments and disenrollments of the same member, indexed by and linked to the member's UMI and Fiscal Agent-assigned member identifier.
1.4	Member demographic profile	Reconcile as needed to data kept by DCH and/or its agent	Includes family relationships, age, sex, pregnancy and incarceration flags, standardized address linked to GCS service region and standard location codes (zip code, municipality, county, etc.)
1.5	Member financial, insurance and employment profile	TPL: exchange data with DCH and/or its agent. Other: reconcile as needed to data kept by DCH and/or its agent	Includes TPL data that my need to be provided to multiple CMO's and may include capitation rate cell to which the Member is associated.
1.6	Member assignments to PCP and, if applicable, to CMO sub programs/"plan options"	Authoritative host	

Special Considerations:
1.1 CMO system(s) shall conform to HIPAA-driven standards for individual and employer identification that are currently under development within 120 days of the standard's effective date or, if earlier, the date stipulated by CMS.

L.1.2 Provider Data and Related Documents

Subtype ID	Subtype Name / Description	Role of CMO System	Data Management Requirements
2.1	Unique provider identifier (UPI)	Authoritative host; retain relationship to Fiscal Agent-assigned Provider ID	The UPI wil meet the requirements of the National Provider ID (NPI) standards of HIPAA and will retain relationships to existing GA IDs. NPI requirements include indentifying providers using the NPI and/or utlizing standards consistent with NPI and HIPAA requirements that identify a unique number for a provider. Also, maintaining an on-line cross-reference of all old provider #'s to new provider #'s and historical information linked to the NPI.
2.2	Provider CMO affiliation	Authoritative host	The CMO will retain a 7-year history (or less if member dies within the 7 year period) of enrollment status changes, including multiple re-enrollments and disenrollments of the same provider; indexed by and linked to the provider's UPI.
2.3	Contractor-Provider agreement document	Authoritative host	Signed; indexed by and linked to the provider's UPI.
2.4	Provider location(s)	Reconcile as needed to data kept by DCH and/or its agent	Includes location codes that enable map and GIS based rederings of network coverage and capacity by provider type and geographic area. Include standardized office/practice

			address (es).
2.5	Provider credentializing Information	Authoritative host for non-mandated Providers (year 1) - receive original record and updates from Fiscal Agent; Authoritative host for all Providers thereafter	At a minimum: licensure status, board eligibility/certification. Includes indexed images of applicable documents.
2.6	Provider specialties, affiliation and relation to other provider Information	Authoritative host; reconcile as needed to data kept by DCH and/or its agent	Specialties for which s/he is certified, professional affiliations, group/practice associations, hospital admitting privileges. Includes indexed images of applicable documents.
2.7	Provider descriptive	Authoritative host for non-mandated Providers (year 1) - receive original record and updates from Fiscal Agent; Authoritative host for all Providers thereafter	Race, sex, languages spoken by him/her and staff, education and training

L.1.2 Provider Data and Related Documents (cont.)

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
2.8	Provider medical and service profile	Authoritative host; reconcile as needed to data kept by DCH and/or its agent	Member assessments, reported incidents, malpractice cases, etc. Includes indexed images of applicable documents.
2.9	Provider financial	Authoritative host; reconcile as needed to data kept by DCH and/or its agent	At a minimum: FEINs/tax IDs, 1099s. Includes indexed images of applicable documents.

L.1.3 Service-Specific Utilization and Financial ("Encounter") Data and Related Documents

Data to be extracted from claims management systems and other sources as needed.

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
3.1	Claim data including subsequent claim adjustment	Authoritative host; provide to State and/or its agent following format and procedure in Attachment L5.	Capture data elements per applicable standard format/layout to be adopted by all CMOs (UB-92, CMS-1500, ADA, NCPDP). Capture EPSDT flags where applicable; all claim adjustments shall be logically linked to the original claim (parent/child data relationship). Contractor shall retain up to seven (7) years of Claims history per Member (less if Member dies within 7-year period).
3.2	Encounter data from sub-captitated provider	Authoritative host; provide to State and/or its agent following format and procedure in Attachment L5.	Encounter data from sub-capitated provider shall be equivalent (in terms of fields captured per record) to data obatained from claim submissions (ref. 3.1). Contractor shall retain up to seven (7) years of history of this type of Encounter data per Member (less if Member dies within 7-year period).

Special Considerations:

3.1 CMO systems will flag all services related to Federal EPSDT requirements, including diagnostic and treatment services resulting from an EPSDT requirements, including diagnostic and treatment services resulting from an EPSDT screening service, for the purposes of consolidated EPSDT activity reporting (e.g. CMS form 416) and other managment applications.

L.1.4 Utilization Management and Care Coordination Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
4.1	In-network specialist referrals	Authoritative host	7-year history (or less if member dies within 7-year period) of all medical management transactions by member. Capture and retain link/logical relationship to subsequent claim(s).
4.2	In-network authorizations	Authoritative host	7-year history (or less if member dies within 7-year period) of all medical management transactions by member. Capture and retain link/logical relationship to subsequent claim(s).
4.3	Out-of-network service referrals and authorizations	Authoritative host	7-year history (or less if member dies within 7-year period) of all medical management transactions by member. Capture and retain link/logical relationship to subsequent claim(s).
4.4	"Transition" service authorizations	Receive original record DCH and/or its agent	Service authorizations issued by DCH and/or its agent during period prior to enrollment in CMO. Retain history of all of these authorizations. Capture and retain link/logical relationship to subsequent claim(s).

L.1.5 Health Status, Clinical and Outcomes Data and Related Documents

Subtype ID	Subtype Name/Description	Role of CMO System	Data Management Requirements
5.1	Focused studies	Authoritative host	Unique ID per study; codify results for summarization and analysis based on scheme TBD.
5.2	Member (clinical) safety - reported incidents/occurrences	Authoritative host	Unique ID per reported incident/occurrence; codify for summarization and analysis based on scheme TBD.

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

AMENDMENT #12 TO CONTRACT NO. 0653 BETWEEN
GEORGIA DEPARTMENT OF COMMUNITY HEALTH AND
PEACH STATE HEALTH PLAN

This Amendment is between the Georgia Department of Community Health (hereinafter referred to as "DCH" or the "Department") and Peach State Health Plan (hereinafter referred to as "Contractor") and is made effective upon the date signed by the DCH Commissioner (hereinafter referred to as the "Effective Date"). Other than the changes, modifications and additions specifically articulated in this Amendment #12 to Contract #0653, RFP#41900-001-0000000027, the original Contract shall remain in effect and binding on and against DCH and Contractor. Unless expressly modified or added in the Amendment #12, the terms and conditions of the original Contract are expressly incorporated into this Amendment #12 as if completely restated herein.

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

WHEREAS, DCH pays Contractor a per member per month capitation rate for each Georgia Families member enrolled in the Contractor's plan;

WHEREAS, DCH and Contractor have agreed to revise the capitation rates payable to Contractor for State Fiscal Year (SFY) 2012 subject to the approval of the Centers for Medicare and Medicaid Services (hereinafter referred to as "CMS"); and

WHEREAS, pursuant to **Section 32.0 *Amendments in Writing***, DCH and Contractor desire to amend the above-referenced Contract by adding additional funding as set forth below.

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

I. Upon DCH's receipt of written notice from CMS indicating that agency's approval of the revised capitation rates, to be effective for SFY 2012 (July 1, 2011 to June 30, 2012), the parties shall delete the current **Attachment H, *Capitation Payment,*** in its entirety and replace it with the new **Attachment H, *Capitation Payment***, contained at Exhibit 1 to this Amendment. In the event CMS disapproves revision of the capitation rates as described herein, this amendment shall have no effect. DCH shall notify Contractor in writing upon receipt of the CMS decision regarding the revision of the capitation rates.

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

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

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

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

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

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

SIGNATURE PAGE

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

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

/s/ David A. Cook **11/22/11**
David A. Cook, Commissioner Date

/s/ Jerry Dubberly **11/17/11**
Jerry Dubberly, Chief -
Medicaid Division Date

PEACH STATE HEALTH PLAN

BY: **/s/ Patrick M. Healy** **11/16/11**
SIGNATURE Date

Patrick M. Healy
Print/Type Name

President/Chief Exec Officer
*TITLE

*Must be President, Vice President, CEO or Other Officer Authorized by Corporate Resolution to Execute on Behalf of and Bind the Corporation to a Contract

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EXHIBIT 1

CONFIDENTIAL –NOT FOR CIRCULATION
ATTACHMENT H

Attachment H is a table displaying the contracted rates by rate cell for each contracted region. These rates will be the basis for calculating capitation payments in each contracted Region for SFY 2012.

(The table is displayed on the following page.)

Attachment H
Peach State Health Plan
FY12

Region	Aid Category	Age/Gender Group	FY 12 Peach State Health Plan
Atlanta	Medicaid (LIM/Refugee/RSM)	0 - 2 Months, Male and Female	$ ***

Atlanta	Medicaid (LIM/Refugee/RSM)	3 - 11 Months, Male and Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	1 - 5 Years, Male and Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	6 - 13 Years, Male and Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Male	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Male	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	45+ Years, Female	$ ***
Atlanta	Medicaid (LIM/Refugee/RSM)	45+ Years, Male	$ ***
Atlanta	PeachCare	0 - 2 Months, Male and Female	$ ***
Atlanta	PeachCare	3 - 11 Months, Male and Female	$ ***
Atlanta	PeachCare	1 - 5 Years, Male and Female	$ ***
Atlanta	PeachCare	6 - 13 Years, Male and Female	$ ***
Atlanta	PeachCare	14 - 20 Years, Female	$ ***
Atlanta	PeachCare	14 - 20 Years, Male	$ ***
Atlanta	Breast and Cervical Cancer	Breast and Cervical Cancer	$ ***
Atlanta	Maternity Delivery/Kick Payment	Maternity Delivery/Kick Payment	$ ***
Atlanta	NICU Kick	NICU Kick	$ ***
Central	Medicaid (LIM/Refugee/RSM)	0 - 2 Months, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	3 - 11 Months, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	1 - 5 Years, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	6 - 13 Years, Male and Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Male	$ ***
Central	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Male	$ ***
Central	Medicaid (LIM/Refugee/RSM)	45+ Years, Female	$ ***
Central	Medicaid (LIM/Refugee/RSM)	45+ Years, Male	$ ***
Central	PeachCare	0 - 2 Months, Male and Female	$ ***
Central	PeachCare	3 - 11 Months, Male and Female	$ ***
Central	PeachCare	1 - 5 Years, Male and Female	$ ***
Central	PeachCare	6 - 13 Years, Male and Female	$ ***
Central	PeachCare	14 - 20 Years, Female	$ ***
Central	PeachCare	14 - 20 Years, Male	$ ***
Central	Breast and Cervical Cancer	Breast and Cervical Cancer	$ ***
Central	Maternity Delivery/Kick Payment	Maternity Delivery/Kick Payment	$ ***
Central	NICU Kick	NICU Kick	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	0 - 2 Months, Male and Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	3 - 11 Months, Male and Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	1 - 5 Years, Male and Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	6 - 13 Years, Male and Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	14 - 20 Years, Male	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	21 - 44 Years, Male	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	45+ Years, Female	$ ***
Southwest	Medicaid (LIM/Refugee/RSM)	45+ Years, Male	$ ***
Southwest	PeachCare	0 - 2 Months, Male and Female	$ ***
Southwest	PeachCare	3 - 11 Months, Male and Female	$ ***
Southwest	PeachCare	1 - 5 Years, Male and Female	$ ***
Southwest	PeachCare	6 - 13 Years, Male and Female	$ ***
Southwest	PeachCare	14 - 20 Years, Female	$ ***
Southwest	PeachCare	14 - 20 Years, Male	$ ***
Southwest	Breast and Cervical Cancer	Breast and Cervical Cancer	$ ***
Southwest	Maternity Delivery/Kick Payment	Maternity Delivery/Kick Payment	$ ***
Southwest	NICU Kick	NICU Kick	$ ***

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

HHSC Contract No. 529-06-0280-00014-U
Version 1.20

Part 1: Parties to the Contract:

This Contract Amendment (the "Amendment") is between the Texas Health and Human Services Commission (HHSC), an administrative agency within the executive department of the State of Texas, having its principal office at 4900 North Lamar Boulevard, Austin, Texas 78751, and Superior HealthPlan, Inc. (HMO) a corporation organized under the laws of the State of Texas, having its principal place of business at: 2100 South IH-35, Suite 202, Austin, Texas 78704. HHSC and HMO may be referred to in this Amendment individually as a "Party" and collectively as the "Parties."

The Parties hereby agree to amend their original contract, HHSC contract number 529-06-0280-00014 (the "Contract") as set forth herein. The Parties agree that the terms of the Contract will remain in effect and continue to govern except to the extent modified in this Amendment.

This Amendment is executed by the Parties in accordance with the authority granted in Attachment A to the HHSC Managed Care Contract document, "HHSC Uniform Managed Care Contract Terms & Conditions," Article 8, "Amendments and Modifications."

Part 2: Effective Date of Amendment:	**Part 3: Contract Expiration Date**	**Part 4: Operational Start Date:**
January 1, 2012	August 31, 2013	STAR and CHIP HMOs: September 1, 2006 STAR+PLUS HMOs: February 1, 2007 CHIP Perinatal HMOs: January 1, 2007

Part 5: Project Managers:

HHSC:
Scott Schalchlin
Director, Health Plan Operations
11209 Metric Boulevard, Building H
Austin, Texas 78758
Phone: 512-491-1866
Fax: 512-491-1969

HMO:
Susan Erickson
Director of Contract Management
2100 South IH-35, Suite 202
Austin, Texas 78704
Phone: 512-692-1465
Fax: 512-692-1474
E-mail: serickson@centene.com

Part 6: Deliver Legal Notices to:

HHSC:
General Counsel
4900 North Lamar Boulevard, 4th Floor
Austin, Texas 78751
Fax: 512-424-6586

HMO:
Superior HealthPlan
2100 South IH-35, Suite 202
Austin, Texas 78704
Fax: 512-692-1435

Part 7: HMO Programs and Service Areas:

This Contract applies to the following HHSC HMO Programs and Service Areas (*check all that apply*). All references in the Contract Attachments to HMO Programs or Service Areas that are not checked are superfluous and do not apply to the HMO.

☑ **Medicaid STAR HMO Program**

Service Areas:

☑ Bexar
o Dallas
☑ El Paso
o Harris
o Jefferson
☑ Lubbock
☑ Nueces
o Tarrant
☑ Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the STAR Service Areas.

☑ **Medicaid STAR+PLUS HMO Program**

Service Areas:

☑ Bexar
o Harris
o Jefferson
☑ Nueces
o Travis

See Attachment B-6.1, "Map of Counties with STAR+PLUS HMO Program Service Areas," for listing of counties included within the STAR+PLUS Service Areas.

☑ **CHIP HMO Program**

Core Service Areas:

☑ Bexar
o Dallas
☑ El Paso
o Harris
☑ Lubbock
☑ Nueces
o Tarrant
☑ Travis

Optional Service Areas:

☑ Bexar
☑ El Paso
o Harris
☑ Lubbock
☑ Nueces
☑ Travis

See Attachment B-6, "Map of Counties with HMO Program Service Areas," for listing of counties included within the CHIP Core Service Areas and CHIP Optional Service Areas.

☑ **CHIP Perinatal Program**

Core Service Areas:

☑ Bexar
o Dallas
☑ El Paso
o Harris
☑ Lubbock
☑ Nueces
o Tarrant
☑ Travis

Optional Service Areas:

☑ Bexar
☑ El Paso
o Harris
☑ Lubbock
☑ Nueces
☑ Travis

See Attachment B-6.2, "Map of Counties with CHIP Perinatal HMO Program Service Areas," for a list of counties included within the CHIP Perinatal Service Areas.

Part 8: Payment

Part 8 of the HHSC Managed Care Contract document, "Payment," is modified to add the capitation rates for Rate Period 6.
☑ **Medicaid STAR HMO Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR Program. The following Rate Cells and Capitation Rates will apply to Rate Period 6:

Service Area: BEXAR	Rate Cell	Rate Period 6 Capitation Rates (9/1/11 - 12/31/11)	Rate Period 6 Capitation Rates (1/1/12 - 2/29/11)
1	TANF Child > 12 months	$ ***	$ ***
2	TANF child ≤ 12 months	$ ***	$ ***
3	TANF Adult	$ ***	$ ***
4	Pregnant Woman	$ ***	$ ***
5	Newborn ≤ 12 months	$ ***	$ ***
6	Expansion Child > 12 months	$ ***	$ ***
7	Expansion child ≤ 12 months	$ ***	$ ***
8	Federal Mandate child	$ ***	$ ***
9	Delivery Supplemental Payment	$ ***	$ ***

Service Area: EL PASO	Rate Cell	Rate Period 6 Capitation Rates (9/1/11 - 12/31/11)	Rate Period 6 Capitation Rates (1/1/12 - 2/29/11)
1	TANF Child > 12 months	$ ***	$ ***
2	TANF child ≤ 12 months	$ ***	$ ***
3	TANF Adult	$ ***	$ ***
4	Pregnant Woman	$ ***	$ ***
5	Newborn ≤ 12 months	$ ***	$ ***
6	Expansion Child > 12 months	$ ***	$ ***
7	Expansion child ≤ 12 months	$ ***	$ ***
8	Federal Mandate child	$ ***	$ ***
9	Delivery Supplemental Payment	$ ***	$ ***

Service Area: LUBBOCK	Rate Cell	Rate Period 6 Capitation Rates (9/1/11 - 12/31/11)	Rate Period 6 Capitation Rates (1/1/12 - 2/29/11)
1	TANF Child > 12 months	$ ***	$ ***
2	TANF child ≤ 12 months	$ ***	$ ***
3	TANF Adult	$ ***	$ ***
4	Pregnant Woman	$ ***	$ ***
5	Newborn ≤ 12 months	$ ***	$ ***
6	Expansion Child > 12 months	$ ***	$ ***
7	Expansion child ≤ 12 months	$ ***	$ ***
8	Federal Mandate child	$ ***	$ ***
9	Delivery Supplemental Payment	$ ***	$ ***

Service Area: NUECES	Rate Cell	Rate Period 6 Capitation Rates (9/1/11 - 12/31/11)	Rate Period 6 Capitation Rates (1/1/12 - 2/29/11)
1	TANF Child > 12 months	$ ***	$ ***
2	TANF child ≤ 12 months	$ ***	$ ***
3	TANF Adult	$ ***	$ ***
4	Pregnant Woman	$ ***	$ ***
5	Newborn ≤ 12 months	$ ***	$ ***
6	Expansion Child > 12 months	$ ***	$ ***
7	Expansion child ≤ 12 months	$ ***	$ ***
8	Federal Mandate child	$ ***	$ ***
9	Delivery Supplemental Payment	$ ***	$ ***

Service Area: TRAVIS	Rate Cell	Rate Period 6 Capitation Rates (9/1/11 - 12/31/11)	Rate Period 6 Capitation Rates (1/1/12 - 2/29/11)
1	TANF Child > 12 months	$ ***	$ ***
2	TANF child ≤ 12 months	$ ***	$ ***
3	TANF Adult	$ ***	$ ***
4	Pregnant Woman	$ ***	$ ***
5	Newborn ≤ 12 months	$ ***	$ ***
6	Expansion Child > 12 months	$ ***	$ ***
7	Expansion child ≤ 12 months	$ ***	$ ***
8	Federal Mandate child	$ ***	$ ***
9	Delivery Supplemental Payment	$ ***	$ ***

Star SSI Administrative Fee: HHSC will pay a STAR HMO a monthly Administrative Fee of $*** per SSI Beneficiary who voluntarily enrolls in the HMS in acordance with Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10.

Delivery Supplemental Payment: See Attachment A, “HHSC Uniform Managed Care Contract Terms and Conditions,” Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the STAR Program.

☑ **Medicaid STAR+PLUS HMO Program**

Capitation: See Attachment A, “HHSC Uniform Managed Care Contract Terms and Conditions,” Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the STAR+PLUS Program. The following Rate Cells and Capitation Rates will apply to Rate Period 6:

STAR+PLUS Service Area: BEXAR	Rate Cell	Rate Period 6 Capitation Rates (9/1/11 - 12/31/11)	Rate Period 6 Capitation Rates (1/1/12 - 2/29/11)
1.	Medicaid Only Standard Rate	$ ***	$ ***
2.	Medicaid Only 1915(C) Nursing Facility Waiver Rate	$ ***	$ ***
3.	Dual Eligible Standard Rate	$ ***	$ ***
4.	Dual Eligible 1915(C) Nursing Facility Waiver Rate	$ ***	$ ***
5.	Nursing Facility – Medicaid Only	$ ***	$ ***
6.	Nursing Facility – Dual Eligible	$ ***	$ ***

STAR+PLUS Service Area: NUECES	Rate Period 6 Capitation Rates	Rate Period 6 Capitation Rates

	Rate Cell	(9/1/11 - 12/31/11)	(1/1/12 - 2/29/11)
1.	Medicaid Only Standard Rate	$ ***	$ ***
2.	Medicaid Only 1915(C) Nursing Facility Waiver Rate	$ ***	$ ***
3.	Dual Eligible Standard Rate	$ ***	$ ***
4.	Dual Eligible 1915(C) Nursing Facility Waiver Rate	$ ***	$ ***
5.	Nursing Facility – Medicaid Only	$ ***	$ ***
6.	Nursing Facility – Dual Eligible	$ ***	$ ***

☑ **CHIP HMO PROGRAM**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Program. The following Rate Cells and Capitation Rates will apply to Rate Period 6:

Service Area: BEXAR

	Rate Cell	Rate Period 6 Capitation Rates
1.	< Age 1	$ ***
2.	Ages 1 through 5	$ ***
3.	Ages 6 through 14	$ ***
4.	Ages 15 through 18	$ ***

Service Area: EL PASO

	Rate Cell	Rate Period 6 Capitation Rates
1.	< Age 1	$ ***
2.	Ages 1 through 5	$ ***
3.	Ages 6 through 14	$ ***
4.	Ages 15 through 18	$ ***

Service Area: LUBBOCK

	Rate Cell	Rate Period 6 Capitation Rates
1.	< Age 1	$ ***
2.	Ages 1 through 5	$ ***
3.	Ages 6 through 14	$ ***
4.	Ages 15 through 18	$ ***

Service Area: NUECES

	Rate Cell	Rate Period 6 Capitation Rates
1.	< Age 1	$ ***
2.	Ages 1 through 5	$ ***
3.	Ages 6 through 14	$ ***
4.	Ages 15 through 18	$ ***

Service Area: TRAVIS

	Rate Cell	Rate Period 6 Capitation Rates
1.	< Age 1	$ ***
2.	Ages 1 through 5	$ ***
3.	Ages 6 through 14	$ ***
4.	Ages 15 through 18	$ ***

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the CHIP Program. The CHIP Delivery Supplemental Payment is $*** for all Service Areas.

☑ **CHIP Perinatal Program**

Capitation: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the Capitation Rate-setting methodology and the Capitation Payment requirements for the CHIP Perinatal Program.

Service Area: BEXAR

	Rate Cell	Rate Period 6 Capitation Rates
1.	Perinate Newborn 0% to 185%	$ ***
2.	Perinate Newborn Above 185% to 200%	$ ***
3.	Perinate 0% to 185%	$ ***
4.	Perinate Above 185% to 200%	$ ***

Service Area: EL PASO

	Rate Cell	Rate Period 6 Capitation Rates
1.	Perinate Newborn 0% to 185%	$ ***
2.	Perinate Newborn Above 185% to 200%	$ ***
3.	Perinate 0% to 185%	$ ***
4.	Perinate Above 185% to 200%	$ ***

Service Area: LUBBOCK

	Rate Cell	Rate Period 6 Capitation Rates
1.	Perinate Newborn 0% to 185%	$ ***
2.	Perinate Newborn Above 185% to 200%	$ ***
3.	Perinate 0% to 185%	$ ***
4.	Perinate Above 185% to 200%	$ ***

Service Area: NUECES

	Rate Cell	Rate Period 6 Capitation Rates
1.	Perinate Newborn 0% to 185%	$ ***
2.	Perinate Newborn Above 185% to 200%	$ ***
3.	Perinate 0% to 185%	$ ***
4.	Perinate Above 185% to 200%	$ ***

Service Area: TRAVIS

	Rate Cell	Rate Period 6 Capitation Rates
1.	Perinate Newborn 0% to 185%	$ ***
2.	Perinate Newborn Above 185% to 200%	$ ***
3.	Perinate 0% to 185%	$ ***
4.	Perinate Above 185% to 200%	$ ***

Delivery Supplemental Payment: See Attachment A, "HHSC Uniform Managed Care Contract Terms and Conditions," Article 10, for a description of the methodology for establishing the Delivery Supplemental Payment for the CHIP Perinatal Program. The CHIP Perinatal Delivery Supplemental Payment is $*** for Perinates between 186% and 200% of the Federal Poverty Level for all Service Areas.

Part 9: Contract Attachments:

Modifications to Part 9 of the HHSC Managed Care Contract document, "Contract Attachments," are italicized below:

A: HHSC Uniform Managed Care Contract Terms & Conditions - *Version 1.19 is replaced with Version 1.20*

B: Scope of Work/Performance Measures – *Version 1.19 is replaced with Version 1.20 for all attachments, except if noted.*

B-1: HHSC RFP 529-04-272, Sections 6-9
B-2: Covered Services
B-2.1 STAR+PLUS Covered Services
B-2.2 CHIP Perinatal Program Covered Services
B-3: Value-added Services

B-3.1 STAR+PLUS Value-added Services
B-3.2 CHIP Perinatal Program Value-added Services
B-4: Performance Improvement Goals
B-4.1 SFY 2008 Performance Improvement Goals
B-5: Deliverables/Liquidated Damages Matrix
B-6: Map of Counties with STAR and CHIP HMO Program Service Areas
B-6.1 STAR+PLUS Service Areas
B-6.2 CHIP Perinatal Program Service Areas
B-7: STAR+PLUS Attendant Care Enhanced Payment Methodology

C: HMO's Proposal and Related Documents

C-1: HMO's Proposal
C-2: HMO Supplemental Responses
C-3: Agreed Modifications to HMO's Proposal

Part 10: Special Provision for Nueces Service Area

Attachment A, Section 10.04 is amended to include sub-part (b) as follows:

(b) In addition to the reasons set forth in Section 10.04(a), the Parties expressly understand and agree that HHSC may, at any time, unilaterally adjust the Rate Period 2 STAR Program Capitation Rates for the Nueces Service Area. HHSC is entitled to unilaterally adjust such rates, prospectively and/or retrospectively, if it determines that: (1) the cumulative Rate Period 2 Encounter Data for all HMOs in the Nueces Service Area does not support the Capitation Rates; or (2) economic factors in the Nueces Service Area significantly and measurably impact providers or the delivery of Covered Services to Members. For adjustments made pursuant to this Section 10.04(b), HHSC will provide written notice at least ten (10) Business Days before: (1) the effective date of a prospective adjustment; (2) offsetting Capitation Payments to recover retrospective adjustments. Any adjustments to the Rate Period 2 Capitation Rates must meet the actuarial soundness requirements of Attachment A, Section 10.03, "Certification of Capitation Rates."

Part 11: Signatures:

The Parties have executed this Contract Amendment in their capacities as stated below with authority to bind their organizations on the dates set forth by their signatures. By signing this Amendment, the Parties expressly understand and agree that this Amendment is hereby made part of the Contract as though it were set out word for word in the Contract.

Texas Health and Human Services Commission
/s/ Billy Millwee
Billy Milwee, Deputy Executive Commissioner for Health Services
Date: 12/9/11

Superior HealthPlan, Inc.
/s/ Thomas Wise
By: Thomas Wise
Title: President and CEO
Date: 11/28/11

Responsible Office: HHSC Office of General Counsel (OGC)
Subject: Attachment A -- HHSC Uniform Managed Care Contract Terms & Conditions Version 1.20

Texas Health & Human Services Commission

Uniform Managed Care Contract Terms & Conditions
Version 1.20

DOCUMENT HISTORY LOG

STATUS1	DOCUMENT REVISION2	EFFECTIVE DATE	DESCRIPTION3
Baseline	n/a		Initial version of the Uniform Managed Care Contract Terms & Conditions
Revision	1.1	June 30, 2006	Revised version of the Uniform Managed Care Contract Terms & Conditions that includes provisions applicable to MCOs participating in the STAR+PLUS Program. Article 2, "Definitions," is amended to add or modify the following definitions: 1915(c) Nursing Facility Waiver; Community-based Long Term Care Services; Court-ordered Commitment; Default Enrollment; Dual Eligibles; Eligibles; Functionally Necessary Covered Services; HHSC Administrative Services Contractor; HHSC HMO Programs or HMO Programs; Medicaid HMOs; Medical Assistance Only; Member; Minimum Data Set For Home Care (MSD-HC); Nursing Facility Cost Ceiling; Nursing Facility Level of Care; Outpatient Hospital Service; Qualified and Disabled Working Individual (QDWI); Qualified Medicare Beneficiary; Service Coordination; Service Coordinator; Specified Low-income Medicare Beneficiary (SMBL); STAR+PLUS or STAR+PLUS Program; STAR+PLUS HMO; Supplemental Security Income (SSI). Article 4, "Contract Administration and Management," is amended to add Sections 4.02(a)(12) and 4.04.1, relating to the STAR+PLUS Service Coordinator. Article 8, "Amendments and Modifications," Section 8.06 is amended to clarify that CMS must approve all amendments to STAR and STAR+PLUS HMO contracts. Article 10, "Terms and Conditions of Payment," Section 10.05.1 is added to include the Capitation Rate structure provisions relating to STAR+PLUS. Section 10.11 is modified to apply only to STAR and CHIP. Section 10.11.1 is added to include the Experience Rebate provisions relating to STAR+PLUS.
Revision	1.2	September 1, 2006	Revised version of the Uniform Managed Care Contract Terms & Conditions that includes provisions applicable to MCOs participating in the STAR and CHIP Programs. Section 4.04(a) is amended to change the reference from "Texas Board of Medical Examiners" to "Texas Medical Board". Article 5 is amended to clarify the following sections: 5.02(e)(5), regarding disenrollment of Members; 5.02(i), regarding disenrollment of foster care children; and 5.04(b), regarding CHIP eligibility and enrollment for babies of CHIP Members

STATUS1	DOCUMENT REVISION2	EFFECTIVE DATE	DESCRIPTION3
Revision	1.3	September 1, 2006	Article 10 is amended to clarify the following sections: 10.01(d), regarding the fixed monthly Capitation Rate components; 10.10(c), regarding updating the state system for Members who become eligible for SSI. Section 10.17 is added regarding recoupment for federal disallowance. Article 17 is amended to clarify the following section: 17.01, naming HHSC as an additional insured. Article 2 is amended to modify and add the following definitions to include the CHIP Perinatal Program- Appeal, CHIP Perinatal Program, CHIP Perinatal HMO, CHIP Perinate, CHIP Perinate Newborn, Covered Services, Complaint, Delivery Supplemental Payment, Eligibles, Experience Rebate, HHSC Administrative Services Contractor, Major Population Group, Member, Optional Service Area, and Service Management. Article 5 is amended to add the following sections: 5.04.1 CHIP Perinatal eligibility and enrollment; 5.05(c) CHIP Perinatal HMOs. Article 10 is amended to apply to the CHIP Perinatal Program. Section 10.06(a) is amended to add the Capitation Rates Structure for CHIP Perinates and CHIP Perinate Newborns. Section 10.06(e) is added to include a description of the rate-setting methodology for the CHIP Perinatal Program. 10.09(b) is modified to include CHIP Perinatal Program; Section 10.11 is amended to add the CHIP Perinatal Program to the STAR and CHIP Experience Rebate. Section 10.12(c) amended to clarify cost sharing for the CHIP Perinatal Program.
Revision	1.4	September, 1 2006	Contract amendment did not revise Attachment A HHSC Uniform Managed Care Terms and Conditions
Revision	1.5	January 1, 2007	Revised version of the Uniform Managed Care Contract Terms & Conditions that includes provisions applicable to MCOs participating in the STAR, STAR+PLUS, CHIP, and CHIP Perinatal Programs. Section 5.04(a) is amended to clarify the period of CHIP continuous coverage.

			Section 5.04.1 is amended to clarify the process for a CHIP Perinatal Newborn to move into CHIP at the end of the 12month CHIP Perinatal Program eligibility. Section 5.08 is added to include STAR+PLUS special default language. Section 10.06.1 is amended to correct the FPL percentages for CHIP Perinates and CHIP Perinate Newborns. Section 17.01 is amended to clarify the insurance requirements for the HMOs and Network Providers and to remove the insurance requirements for Subcontractors.

STATUS1	DOCUMENT REVISION2	EFFECTIVE DATE	DESCRIPTION3
			Section 17.02(b) is added to clarify that a separate Performance Bond is not needed for the CHIP Perinatal Program.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment A HHSC Uniform Managed Care Terms and Conditions
Revision	1.7	July 1, 2007	Article 2 is modified to correct and align definition for “Clean Claim” with the UMCM. Section 4.08(c) is modified to add a cross-reference to new Attachment B-1, Section 8.1.1.2. Section 5.05(a), Medicaid HMOs, is amended to clarify provisions regarding enrollment into Medicaid Managed Care from Medicaid Fee-for-Service while in the hospital, changing HMOs while in the hospital, and addressing which HMO is responsible for professional and hospital charges during the hospital stay. New Section 10.05.1 (c) is added to clarify capitation payments (delays in payment and levels of capitation) for Members certified to receive STAR+PLUS Waiver Services. Section 10.06.1 is modified to include the CHIP Perinatal pass through for delivery physician services for women under 185% FPL. Section 10.11 is modified to include treatment of the new Incentives and Disincentives (within the Experience Rebate determination); additionally, several clarifications are added with respect to the continuing accrual of any unpaid interest, etc. Section 10.11.1 is modified to include treatment of the new Incentives and Disincentives (within the Experience Rebate determination); additionally, several clarifications are added with respect to the continuing accrual of any unpaid interest, etc.
Revision	1.8	September 1, 2007	Article 2 is modified to add definitions for Migrant Farmworker and FWC as a result of the Frew litigation corrective action plans. Article 2 is modified to reflect legislative changes required by SB 10 to the definition for Value-added Services. New Section 5.03.1 is added to clarify the enrollment process for infants born to pregnant women in STAR+PLUS. Section 5.04 is modified to reflect legislative changes required by HB 109. Section 10.18 is added to clarify the required pass through of physician rate increases for all programs to comply with HHSC directives.

STATUS1	DOCUMENT REVISION2	EFFECTIVE DATE	DESCRIPTION3
Revision	1.9	December 1, 2007	Section 10.11(d) is modified to increase the Experience rebate loss carry forward from 1 year to 2 years. Section 10.11(e) is modified to eliminate the plan's responsibility to submit the actuarial certification on the 90 day FSR. Section 10.11.1 (d) is modified to increase the Experience rebate loss carry forward from 1 year to 2 years. Section 10.11.1 (e) is modified to eliminate the plan's responsibility to submit the actuarial certification on the 90 day FSR.
Revision	1.10	March 1, 2008	Article 2 is modified to remove the word “administrative” from the definition for Allowable Expenses”. Article 2 is modified to update the definition for Affiliate. Section 4.08 is modified to provide consistency of language in sections 4.08(b)(3), and to obligate the HMOs to provide HHSC with copies of amended Subcontracts. Section 7.05 is modified to update the requirements regarding with state and federal anti-discrimination laws. Section 10.06.1 is modified to clarify the CHIP Perinatal pass through for delivery physician services for women under 185% FPL. Section 10.11 (b) is modified to change the heading in the table from Experience Rebate as a % of Revenues to Pre-tax Income as a % of Revenues Section 10.11 (c) (1) is modified to remove the word “administrative” from the title of UMCM chapter reference. Section 10.11 (e) (4) is modified to remove the word “administrative” from the title of UMCM chapter reference. Section 10.11.1 (b) is modified to establish new STAR+PLUS rebate brackets for Rate Period 2 and after. Section 10.11.1 (c) (1) is modified to remove the word “administrative” from the title of UMCM chapter reference.
Revision	1.11	September 1, 2008	Article 2 is modified to add definitions for Discharge and Transfer. Article 2 is modified to remove the “Pediatric and Family” qualifier from Advanced Practice Nurses in the definition for PCP. Section 5.02 is modified to clarify that only Medicaid HMOs have a limited right to request that a Member be disenrolled. Section 5.03 is modified to clarify that newborns must remain in their mother’s Medicaid HMO for at least 90 days following the date of birth, unless the mother request s a plan change. Section 5.05(a), is modified to clarify provisions regarding enrollment into Medicaid Managed Care from Medicaid Fee-for-Service while in the hospital and changing HMOs while in the hospital. Section 5.05(c) is modified to clarify the span of coverage for CHIP Perinate Newborns who are in the hospital on the effective date of disenrollment. Section 05.07.1 is added to establish a special temporary STAR default process for service areas with HMOs that did not contract with HHSC prior to September 1, 2006. Section 05.08.1 is added to establish a special temporary STAR+PLUS default process for service areas with HMOs that did not contract with HHSC prior to September 1, 2006. Section 09.06 is added to require the HMOs to notify HHSC of legal and other proceedings, and related events. Section 10.11 (e) is modified to clarify the settlement process. Section 10.11 (f) is modified to require the payment of interest on any Experience Rebate unpaid 35 days after the due date for the 90-day FSR Report. Section 10.11.1 (e) is modified to reference the process defined in Sections 10.11 (e) and (f). Section 10.11.1 (f) is deleted as part of the Section 10.11.1 (e) alignment with the process defined in Sections 10.11 (e) and (f). Section 10.11.2 is added to institute the STAR, CHIP, CHIP Perinatal, and STAR+PLUS Administrative Expense Cap. Section 10.12 (b) is modified to address federal CHIP regulations. Section 11.07 is modified to remove extraneous word.
Revision	1.12	March 1, 2009	Article 2 is modified to add the definitions for Bariatric Supplemental Payment and TP 13; and to clarify the definitions for Migrant Farmworker, TP 40, and TP 45.

			Section 5.05 is modified to add item (a)(6) to clarify movement from STAR+PLUS to STAR Health; add item (a)(7) regarding movement from STAR, STAR+PLUS, or FFS due to SSI status; clarify item (c); and add item (d) regarding effective date of SSI status. These ratifications of existing policies and processes are effective 9/1/08. Any future change to such policies or processes will require adjustments to the capitation payments. Section 5.07.1 is modified to include the Harris Expansion Service Area. Section 10.06.1(a) is modified to accurately reflect the percentage breakdown. Section 10.09(b) is modified to accurately reflect the percentage breakdown. Section 10.10(c) is modified to conform to clarifications in Section 5.05(d). Section 10.11.2 is modified to add Bariatric Supplemental Payments. Section 10.11.2(d) is modified to correct a contract reference. Section 10.19, Bariatric Supplemental Payment for STAR and STAR+PLUS HMOs is added.
Revision	1.13	September 1, 2009	All references to “THSteps” are changed to “Texas Health Steps” Article 2 is amended to add the definitions for Rate Period 3, and Rate Period 4. Section 5.05 is amended to clarify that Hospital facility charges for inpatient mental health Covered Services will be paid by the STAR+PLUS HMO. Section 5.09 Default Methodology for Frew Incentives and Disincentives is added. Section 7.02 is modified to add references to 1 T.A.C. Part 15, Chapter 371 and the Frew Consent Decree and Alberto N. Partial Settlement Agreements Section 10.11(a) is amended to change “Rate Year” to “Rate Period” Section 10.11(b) is amended to reflect the change in the SFY 2010 sharing tier structure for the Experience Rebate. Section 10.11(d) is amended to clarify the two year loss carry forward. Section 10.11(e) is amended to clarify the required documentation for non-scheduled payments. Section 10.11.1(a) is amended to change “Rate Year” to “Rate Period” and to clarify when the HMO must pay an Experience Rebate. Section 10.11.1(b) is amended to reflect the change in the SFY 2010 sharing tier structure for the Experience Rebate. Section 10.11.1(d) is amended to clarify the two year loss carry forward. Section 10.12 is modified to include CHIP enrollees in prohibition against liability for payment (Balance Billing). Section 12.15 is added to establish a pre-termination process. Section 17.01(a) is modified to provide clarification of required insurance coverage, including deletion of Standard Worker’s Section 17.01(b) is modified to correctly identify the type of professional liability coverage required. Section 17.01(c)(4) is modified to require that HHSC is named as loss payee of insurance coverage. Section 17.01(c)(5) is modified to require continuous coverage during Term of Contract. Section 17.01(c)(6) is modified to require notification prior to reduction in coverage and to add provision to insurance policy requiring 30-day notice prior to reduction in, cancellation, or non-renewal of, the policy. Section 17.02(a) is modified to align the performance bond requirements with insurance practices by requiring one bond per MCO with a defined term and amount and to require annual renewal of the bond. Section 17.02(c) is added to establish a process for release of previous performance bonds received by HHSC.
Revision	1.14	December 1, 2009	Section 17.02 (a) is modified to require the single bond per MCO with a defined term and amount beginning in SFY2010.
Revision	1.15	March 1, 2010	Article 2 is amended to revise the definition for "Material Subcontractor or Major Subcontractor" All references to “Frew vs. Hawkins” are changed to “Frew vs. Suehs”. Definition of CHIP Perinate Newborn is modified. Definition for Medicaid HMOs is modified to include the STAR Health Program. Definition for Primary care Physician or Primary Care Provider (PCP) is modified to clarify that APNs and PAs must practice under the supervision of a PCP. Definitions for Rate Periods 5 and 6 are added.
Revision	1.16	September 1, 2010	Section 4.02 is amended to clarify that STAR+PLUS HMOs must notify HHSC when the management/leadership for the STAR+PLUS Service Coordinators changes. Section 4.08(b)(3) and (4) are modified to clarify the timeframes for notification. Section 5.04.1 is modified to reflect changes to CHIP Perinatal Program eligibility, effective 9/1/10. The section is also modified to clarify that CHIP Perinatal members have 90 days to select an HMO if defaulted upon enrollment. Section 5.05 is modified to reflect changes to CHIP Perinatal Program eligibility, effective 9/1/10, and to remove (d)(4) reference to ICM Program. Section 7.07 is amended to add subsection (b). Section 9.02(c) is modified to add “the Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee”. Section 10.06.1 has been modified to clarify the CHIP Perinate Newborn 0% to 185% rate cell
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment A HHSC Uniform Managed Care Terms and Conditions
Revision	1.18	March 1, 2011	Definition of "Major Population Group" is modified The definition of "Medically Necessary" is revised to address the review criteria applicable to children in Medicaid, consistent with 42 USC § 1396(r)(5) and Alberto N requirements. The HMOs are already contractually obligated to comply with these requirments, so the change is for clarification only. Definition of "Outpatient Hospital Services" is modifed to remove language that is included in UMCM. Definition of "Post-stabilization Care Services" is modified. Definition of "Texas Health Network" is deleted. Definition of "Uniform Managed Care Manual" is modified. Section 4.08 is modified to prohibit Medicaid payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 4.10 is modifed to prohibit medicaid payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 5.04 is modified to clarify that infants born to CHIP members are not automatically enrolled in CHIP. Section 5.05(a)(3) is modified to correct contract cross-reference. Section 7.02(a) is modified to remove case identification information from the Frew and Alberto N items. Section 8.06 is revised to apply generally to all HMO contracts.

			Section 9.01 is revised to clarify the requirments for record retention in accordance with Federal requirments. Section 10.11.1 is modified to let the HMOs consoldiate their DFW STAR+PLUS experience with their other STAR+PLUS products.
			Definition for Expansion Counties is added. Definition for Fair Hearing is modified. Definition for PPACA is added. Definition for Transition Phase is modified. Section 4.08 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC). Section 4.10 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC).
Revision	1.19	September 1, 2011	Section 7.08, “Historically Underutilized Business Participation Requirements” is added. Section 9.01 is modified to clarify compliance with 45 CFR 74.53. Section 10.01(d) is modified to remove pass through funds for high volume providers from the list of Capitation Rate components. Section 10.08(a) is modified to include a new item addressing the State’s right to recoup if the CMS has imposed a payment denial as a sanction (42 CFR §438.726(b)), and to modify (a)(1-2). Section 10.19 is modified to remove the Bariatric Supplemental Payment for dates of service on or after September 1, 2011, when all funding will be included in the capitation rates. Section 11.08, “Information Security” is added. Section 12.02(d) is modified to refer to the circumstances prompting temporary management in 42 C.F.R. §438.706.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment A HHSC Uniform Managed Care Terms and Conditions

1 Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
2 Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
3 Brief description of the changes to the document made in the revision.

Responsible Office: HHSC Office of General Counsel (OGC)

Subject: Attachment A -- HHSC Uniform Managed Care Contract Terms & Conditions Version 1.20

TABLE OF CONTENTS

Article 1. Introduction

Section 1.01 ***Purpose.***

The purpose of this Contract is to set forth the terms and conditions for the HMO's participation as a managed care organization in one or more of the HMO Programs administered by HHSC. Under the terms of this Contract, HMO will provide comprehensive health care services to qualified Program recipients through a managed care delivery system.

Section 1.02 ***Risk-based contract.***

This is a Risk-based contract.

Section 1.03 ***Inducements.***

In making the award of this Contract, HHSC relied on HMO's assurances of the following:

(1) HMO is an established health maintenance organization that arranges for the delivery of health care services, is currently licensed as such in the State of Texas and is fully authorized to conduct business in the Service Areas;

(2) HMO and the HMO Administrative Service Subcontractors have the skills, qualifications, expertise, financial resources and experience necessary to provide the Services and Deliverables described in the RFP, HMO's Proposal, and this Contract in an efficient, cost-effective manner, with a high degree of quality and responsiveness, and has performed similar services for other public or private entities;

(3) HMO has thoroughly reviewed, analyzed, and understood the RFP, has timely raised all questions or objections to the RFP, and has had the opportunity to review and fully understand HHSC's current program and operating environment for the activities that are the subject of the Contract and the needs and requirements of the State during the Contract term;

(4) HMO has had the opportunity to review and understand the State's stated objectives in entering into this Contract and, based on such review and understanding, HMO currently has the capability to perform in accordance with the terms and conditions of this Contract;

(5) HMO also has reviewed and understands the risks associated with the HMO Programs as described in the RFP, including the risk of non-appropriation of funds.

Accordingly, on the basis of the terms and conditions of this Contract, HHSC desires to engage HMO to perform the Services and provide the Deliverables described in this Contract under the terms and conditions set forth in this Contract.

Section 1.04 ***Construction of the Contract.***

(a) Scope of Introductory Article.

The provisions of any introductory article to the Contract are intended to be a general introduction and are not intended to expand the scope of the Parties' obligations under the Contract or to alter the plain meaning of the terms and conditions of the Contract.

(b) References to the "State." References in the Contract to the "State" shall mean the State of Texas unless otherwise specifically indicated and shall be interpreted, as appropriate, to mean or include HHSC and other agencies of the State of Texas that may participate in the administration of the HMO Programs, provided, however, that no provision will be interpreted to include any entity other than HHSC as the contracting agency.

(c) Severability. If any provision of this Contract is construed to be illegal or invalid, such interpretation will not affect the legality or validity of any of its other provisions. The illegal or invalid provision will be deemed stricken and deleted to the same extent and effect as if never incorporated in this Contract, but all other provisions will remain in full force and effect.

(d) Survival of terms. Termination or expiration of this Contract for any reason will not release either Party from any liabilities or obligations set forth in this Contract that:

(1) The Parties have expressly agreed shall survive any such termination or expiration; or

(2) Arose prior to the effective date of termination and remain to be performed or by their nature would be intended to be applicable following any such termination or expiration.

(e) Headings. The article, section and paragraph headings in this Contract are for reference and convenience only and may not be considered in the interpretation of this Contract.

(f) Global drafting conventions.

(1) The terms "include," "includes," and "including" are terms of inclusion, and where used in this Contract, are deemed to be followed by the words "without limitation."

(2) Any references to "sections," "appendices," "exhibits" or "attachments" are deemed to be references to sections, appendices, exhibits or attachments to this Contract.

(3) Any references to laws, rules, regulations, and manuals in this Contract are deemed references to these documents as amended, modified, or supplemented from time to time during the term of this Contract.

Section 1.05 ***No implied authority.***
The authority delegated to HMO by HHSC is limited to the terms of this Contract. HHSC is the state agency designated by the Texas Legislature to administer the HMO Programs, and no other agency of the State grants HMO any authority related to this program unless directed through HHSC. HMO may not rely upon implied authority, and specifically is not delegated authority under this Contract to:
(1) make public policy;

(2) promulgate, amend or disregard administrative regulations or program policy decisions made by State and federal agencies responsible for administration of HHSC Programs; or

(3) unilaterally communicate or negotiate with any federal or state agency or the Texas Legislature on behalf of HHSC regarding the HHSC Programs.

HMO is required to cooperate to the fullest extent possible to assist HHSC in communications and negotiations with state and federal governments and agencies concerning matters relating to the scope of the Contract and the HMO Program(s), as directed by HHSC.

Section 1.06 ***Legal Authority.***

(a) HHSC is authorized to enter into this Contract under Chapters 531 and 533, Texas Government Code; Section 2155.144, Texas Government Code; and/or Chapter 62, Texas Health & Safety Code. HMO is authorized to enter into this Contract pursuant to the authorization of its governing board or controlling owner or officer.

(b) The person or persons signing and executing this Contract on behalf of the Parties, or representing themselves as signing and executing this Contract on behalf of the Parties, warrant and guarantee that he, she, or they have been duly authorized to execute this Contract and to validly and legally bind the Parties to all of its terms, performances, and provisions.

Article 2. Definitions
As used in this Contract, the following terms and conditions shall have the meanings assigned below:

1915(c) Nursing Facility Waiver means the HHSC waiver program that provides home and community based services to aged and disabled adults as cost-effective alternatives to institutional care in nursing homes.

Abuse means provider practices that are inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid or CHIP Program, or in reimbursement for services that are not Medically Necessary or that fail to meet professionally recognized standards for health care. It also includes Member practices that result in unnecessary cost to the Medicaid or CHIP Program.

Account Name means the name of the individual who lives with the child(ren) and who applies for the Children's Health Insurance Program coverage on behalf of the child(ren).

Action (Medicaid only) means:

(1) the denial or limited authorization of a requested Medicaid service, including the type or level of service;

(2) the reduction, suspension, or termination of a previously authorized service;

(3) the denial in whole or in part of payment for service;

(4) the failure to provide services in a timely manner;

(5) the failure of an HMO to act within the timeframes set forth in the Contract and 42 C.F.R. §438.408(b); or

(6) for a resident of a rural area with only one HMO, the denial of a Medicaid Members' request to obtain services outside of the Network.

An Adverse Determination is one type of Action.

Acute Care means preventive care, primary care, and other medical care provided under the direction of a physician for a condition having a relatively short duration.

Acute Care Hospital means a hospital that provides acute care services

Adjudicate means to deny or pay a clean claim.

Administrative Services see HMOAdministrative Services.

Administrative Services Contractor see HHSC Administrative Services Contractor.

Adverse Determination means a determination by an HMO or Utilization Review agent that the Health Care Services furnished, or proposed to be furnished to a patient, are not Medically Necessary or not appropriate.

Affiliate means any individual or entity that meets *any* of the following criteria: 1) owns or holds more than a five percent (5%) interest in the HMO (either directly, or through one or more intermediaries); 2) in which the HMO owns or holds more than a five percent (5%) interest (either directly, or through one or more intermediaries); 3) any parent entity or subsidiary entity of the HMO, regardless of the organizational structure of the entity; 4) any entity that has a common parent with the HMO (either directly, or through one or more intermediaries); 5) any entity that directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with, the HMO; or, 6) any entity that would be considered to be an affiliate by any Securities and Exchange Commission (SEC) or Internal Revenue Service (IRS) regulation, Federal Acquisition Regulations (FAR), or by another applicable regulatory body.

Agreement or Contract means this formal, written, and legally enforceable contract and amendments thereto between the Parties.

Allowable Expenses means all expenses related to the Contract between HHSC and the HMO that are incurred during the Contract Period, are not reimbursable or recovered from another source, and that conform with the HHSC Uniform Managed Care Manual's "Cost Principles for Expenses."

AAP means the American Academy of Pediatrics.

Approved Non-Profit Health Corporation (ANHC) means an organization formed in compliance with Chapter 844 of the Texas Insurance Code and licensed by TDI. See also **HMO**.

Appeal (Medicaid only) means the formal process by which a Member or his or her representative request a review of the HMO's Action, as defined above.

Appeal (CHIP and CHIP Perinatal Program only) means the formal process by which a Utilization Review agent addresses Adverse Determinations.

Auxiliary Aids and Services includes:

(1) qualified interpreters or other effective methods of making aurally delivered materials understood by persons with hearing impairments;

(2) taped texts, large print, Braille, or other effective methods to ensure visually delivered materials are available to individuals with visual impairments; and

(3) other effective methods to ensure that materials (delivered both aurally and visually) are available to those with cognitive or other Disabilities affecting communication.

Bariatric Supplemental Payments means a one-time per bariatric surgery supplemental payment made by HHSC to STAR and STAR+PLUS HMOs.

Behavioral Health Services means Covered Services for the treatment of mental, emotional, or chemical dependency disorders.

Benchmark means a target or standard based on historical data or an objective/goal.

Business Continuity Plan or BCP means a plan that provides for a quick and smooth restoration of MIS operations after a disruptive event. BCP includes business impact analysis, BCP development, testing, awareness, training, and maintenance. This is a day-to-day plan.

Business Day means any day other than a Saturday, Sunday, or a state or federal holiday on which HHSC's offices are closed, unless the context clearly indicates otherwise.

CAHPS means the Consumer Assessment of Health Plans Survey. This survey is conducted annually by the EQRO.

Call Coverage means arrangements made by a facility or an attending physician with an appropriate level of health care provider who agrees to be available on an as-needed basis to provide medically appropriate services for routine, high risk, or Emergency Medical Conditions or Emergency Behavioral Health Conditions that present without being scheduled at the facility or when the attending physician is unavailable.

Capitation Rate means a fixed predetermined fee paid by HHSC to the HMO each month in accordance with the Contract, for each enrolled Member in a defined Rate Cell, in exchange for the HMO arranging for or providing a defined set of Covered Services to such a Member, regardless of the amount of Covered Services used by the enrolled Member.

Capitation Payment means the aggregate amount paid by HHSC to the HMO on a monthly basis for the provision of Covered Services to enrolled Members in accordance with the Capitation Rates in the Contract.

Case Head means the head of the household that is applying for Medicaid.

C.F.R. means the Code of Federal Regulations.

Chemical Dependency Treatment means treatment provided for a chemical dependency condition by a Chemical Dependency Treatment facility, chemical dependency counselor or hospital.

Children's Health Insurance Program or **CHIP** means the health insurance program authorized and funded pursuant to Title XXI, Social Security Act (42 U.S.C. §§ 1397aa-1397jj) and administered by HHSC.

Child (or Children) with Special Health Care Needs (CSHCN) means a child (or children) who:

(1) ranges in age from birth up to age nineteen (19) years;

(2) has a serious ongoing illness, a complex chronic condition, or a disability that has lasted or is anticipated to last at least twelve (12) continuous months or more;

(3) has an illness, condition or disability that results (or without treatment would be expected to result) in limitation of function, activities, or social roles in comparison with accepted pediatric age-related milestones in the general areas of physical, cognitive, emotional, and/or social growth and/or development;

(4) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel; and

(5) has a need for health and/or health-related services at a level significantly above the usual for the child's age.

CHIP HMO Program, or CHIP Program, means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Members.

CHIP HMOs means HMOs participating in the CHIP HMO Program.

CHIP Perinatal HMOs means HMOs participating in the CHIP Perinatal Program.

CHIP Perinatal Program means the State of Texas program in which HHSC contracts with HMOs to provide, arrange for, and coordinate Covered Services for enrolled CHIP Perinate and CHIP Perinate Newborn Members. Although the CHIP Perinatal Program is part of the CHIP Program, for Contract administration purposes it is identified independently in this Contract. An HMO must specifically contract with HHSC as a CHIP Perinatal HMO in order to participate in this part of the CHIP Program.

CHIP Perinate means a CHIP Perinatal Program Member identified prior to birth.

CHIP Perinate Newborn means a CHIP Perinate who has been born alive and whose family income meets the criteria for continued participation in the CHIP Perinatal Program (refer to Section 5.04.1 for information concerning eligibility).

Chronic or Complex Condition means a physical, behavioral, or developmental condition which may have no known cure and/or is progressive and/or can be debilitating or fatal if left untreated or under-treated.

Clean Claim means a claim submitted by a physician or provider for medical care or health care services rendered to a Member, with the data necessary for the MCO or subcontracted claims processor to adjudicate and accurately report the claim. A Clean Claim must meet all requirements for accurate and complete data as defined in the appropriate 837-(claim type) encounter guides as follows:

(1) 837 Professional Combined Implementation Guide

(2) 837 Institutional Combined Implementation Guide

(3) 837 Professional Companion Guide

(4) 837 Institutional Companion Guide

The HMO may not require a physician or provider to submit documentation that conflicts with the requirements of Texas Administrative Code, Title 28, Part 1, Chapter 21, Subchapters C and T.

CMS means the Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HCFA), which is the federal agency responsible for administering Medicare and overseeing state administration of Medicaid and CHIP.

COLA means the Cost of Living Adjustment.

Community-based Long Term Care Services means services provided to STAR+PLUS Members in their home or other community based settings necessary to provide assistance with activities of daily living to allow the Member to remain in the most integrated setting possible. Community-based Long-term Care includes services available to all STAR+PLUS Members as well as those services available only to STAR+PLUS Members who qualify under the 1915(c) Nursing Facility Waiver services.

Community Resource Coordination Groups (CRCGs) means a statewide system of local interagency groups, including both public and private providers, which coordinate services for "multi-need" children and youth. CRCGs develop individual service plans for children and adolescents whose needs can be met only through interagency cooperation. CRCGs address Complex Needs in a model that promotes local decision-making and ensures that children receive the integrated combination of social, medical and other services needed to address their individual problems.

Complainant means a Member or a treating provider or other individual designated to act on behalf of the Member who filed the Complaint.

Complaint (CHIP and CHIP Perinatal Programs only) means any dissatisfaction, expressed by a Complainant, orally or in writing to the HMO, with any aspect of the HMO's operation, including, but not limited to, dissatisfaction with plan administration, procedures related to review or Appeal of an Adverse Determination, as defined in Texas Insurance Code, Chapter 843, Subchapter G; the denial, reduction, or termination of a service for reasons not related to medical necessity; the way a service is provided; or disenrollment decisions. The term does not include misinformation that is resolved promptly by supplying the appropriate information or clearing up the misunderstanding to the satisfaction of the CHIP Member.

Complaint (Medicaid only) means an expression of dissatisfaction expressed by a Complainant, orally or in writing to the HMO, about any matter related to the HMO other than an Action. As provided by 42 C.F.R. §438.400, possible subjects for Complaints include, but are not limited to, the quality of care of services provided, and aspects of interpersonal relationships such as rudeness of a provider or employee, or failure to respect the Medicaid Member's rights.

Complex Need means a condition or situation resulting in a need for coordination or access to services beyond what a PCP would normally provide, triggering the HMO's determination that Care Coordination is required.

Comprehensive Care Program: See definition for Texas Health Steps.

Confidential Information means any communication or record (whether oral, written, electronically stored or transmitted, or in any other form) consisting of:

(1) Confidential Client information, including HIPAA-defined protected health information;

(2) All non-public budget, expense, payment and other financial information;

(3) All Privileged Work Product;

(4) All information designated by HHSC or any other State agency as confidential, and all information designated as confidential under the Texas Public Information Act, Texas Government Code, Chapter 552;

(5) The pricing, payments, and terms and conditions of the Contract, unless disclosed publicly by HHSC or the State; and

(6) Information utilized, developed, received, or maintained by HHSC, the HMO, or participating State agencies for the purpose of fulfilling a duty or obligation under this Contract and that has not been disclosed publicly.

Consumer-Directed Services means the Member or his legal guardian is the employer of and retains control over the hiring, management, and termination of an individual providing personal assistance or respite.

Continuity of Care means care provided to a Member by the same PCP or specialty provider to ensure that the delivery of care to the Member remains stable, and services are consistent and unduplicated.

Contract or **Agreement** means this formal, written, and legally enforceable contract and amendments thereto between the Parties.

Contract Period or **Contract Term** means the Initial Contract Period plus any and all Contract extensions.

Contractor or **HMO** means the HMO that is a party to this Contract and is an insurer licensed by TDI as an HMO or as an ANHC formed in compliance with Chapter 844 of the Texas Insurance Code.

Core Service Area (CSA) means the core set Service Area counties defined by HHSC for the STAR and/or CHIP HMO Programs in which Eligibles will be required to enroll in an HMO. (See Attachment B-6 to the HHSC Managed Care Contract document for detailed information on the Service Area counties.)

Copayment (CHIP only) means the amount that a Member is required to pay when utilizing certain benefits within the health care plan. Once the copayment is made, further payment is not required by the Member.

Corrective Action Plan means the detailed written plan that may be required by HHSC to correct or resolve a deficiency or event causing the assessment of a remedy or damage against HMO.

Court-Ordered Commitment means a commitment of a STAR, STAR+PLUS or CHIP Member to a psychiatric facility for treatment ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII Subtitle C.

Covered Services means Health Care Services the HMO must arrange to provide to Members, including all services required by the Contract and state and federal law, and all Value-added Services negotiated by the Parties (see **Attachments B-2, B2.1, B-2.2 and B-3** of the **HHSC Managed Care Contract** relating to "Covered Services" and "Valueadded Services"). Covered Services include Behavioral Health Services.

Credentialing means the process of collecting, assessing, and validating qualifications and other relevant information pertaining to a health care provider to determine eligibility and to deliver Covered Services.

Cultural Competency means the ability of individuals and systems to provide services effectively to people of various cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves their dignity.

Date of Disenrollment means the last day of the last month for which HMO receives payment for a Member.

Day means a calendar day unless specified otherwise.

Default Enrollment means the process established by HHSC to assign a mandatory STAR, STAR+PLUS, or CHIP Perinate enrollee who has not selected an MCO to an MCO.

Deliverable means a written or recorded work product or data prepared, developed, or procured by HMO as part of the Services under the Contract for the use or benefit of HHSC or the State of Texas.

Delivery Supplemental Payment means a onetime per pregnancy supplemental payment for STAR, CHIP and CHIP Perinatal HMOs.

DADS means the Texas Department of Aging and Disability Services or its successor agency (formerly Department of Human Services).

DSHS means the Texas Department of State Health Services or its successor agency (formerly Texas Department of Health and Texas Department of Mental Health and Mental Retardation).

Discharge means a formal release of a Member from an Inpatient Hospital stay when the need for continued care at an inpatient level has concluded. Movement or Transfer from one Acute Care Hospital or Long Term Care Hospital /facility and readmission to another within 24 hours for continued treatment is not a discharge under this Contract.

Disease Management means a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

Disproportionate Share Hospital (DSH) means a hospital that serves a higher than average number of Medicaid and other low-income patients and receives additional reimbursement from the State.

Disabled Person or Person with Disability means a person under sixty-five (65) years of age, including a child, who qualifies for Medicaid services because of a disability.

Disability means a physical or mental impairment that substantially limits one or more of an individual's major life activities, such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and/or working.

Disability-related Access means that facilities are readily accessible to and usable by individuals with disabilities, and that auxiliary aids and services are provided to ensure effective communication, in compliance with Title III of the Americans with Disabilities Act.

Disaster Recovery Plan means the document developed by the HMO that outlines details for the restoration of the MIS in the event of an emergency or disaster.

DSM-IV means the *Diagnostic and Statistical Manual of Mental Disorders*, *Fourth Edition*, which is the American Psychiatric Association's official classification of behavioral health disorders.

Dual Eligibles means Medicaid recipients who are also eligible for Medicare.

ECI means Early Childhood Intervention, a federally mandated program for infants and children under the age of three with or at risk for developmental delays and/or disabilities. The federal ECI regulations are found at 34 §C.F.R. 303.1 *et seq*. The State ECI rules are found at 25 TAC §621.21 *et seq*.

EDI means electronic data interchange.

Effective Date means the effective date of this Contract, as specified in the HHSC Managed Care Contract document.

Effective Date of Coverage means the first day of the month for which the HMO has received payment for a Member.

Eligibles means individuals residing in one of the Service Areas and eligible to enroll in a STAR, STAR+PLUS, CHIP, or CHIP Perinatal HMO, as applicable.

Emergency Behavioral Health Condition means any condition, without regard to the nature or cause of the condition, which in the opinion of a prudent layperson possessing an average knowledge of health and medicine:

(1) requires immediate intervention and/or medical attention without which Members would present an immediate danger to themselves or others, or

(2) which renders Members incapable of controlling, knowing or understanding the consequences of their actions.

Emergency Services means covered inpatient and outpatient services furnished by a provider that is qualified to furnish such services under the Contract and that are needed to evaluate or stabilize an Emergency Medical Condition and/or an Emergency Behavioral Health Condition, including Post-stabilization Care Services.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of recent onset and sufficient severity (including severe pain), such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical care could result in:

(1) placing the patient's health in serious jeopardy;

(2) serious impairment to bodily functions;

(3) serious dysfunction of any bodily organ or part;

(4) serious disfigurement; or

(5) in the case of a pregnant women, serious jeopardy to the health of a woman or her unborn child.

Encounter means a Covered Service or group of Covered Services delivered by a Provider to a Member during a visit between the Member and Provider. This also includes Value-added Services.

Encounter Data means data elements from Fee-for-Service claims or capitated services proxy claims that are submitted to HHSC by the HMO in accordance with HHSC's required format for Medicaid and CHIP HMOs.

Enrollment Report/Enrollment File means the daily or monthly list of Eligibles that are enrolled with an HMO as Members on the day or for the month the report is issued.

EPSDT means the federally mandated Early and Periodic Screening, Diagnosis and Treatment program contained at 42 U.S.C. 1396d(r). The name has been changed to Texas Health Steps in the State of Texas.

Exclusive Provider Organization (EPO) means the vendor contracted with HHSC to operate the CHIP EPO in Texas.

Expansion Area means a county or Service Area that has not previously provided healthcare to HHSC's HMO Program Members utilizing a managed care model.

Expansion Children means children who are generally at least one, but under age 6, and live in a family whose income is at or below 133 percent of the federal poverty level (FPL). Children in this coverage group have either elected to bypass TANF or are not eligible for TANF in Texas.

Expansion Counties – means the following counties with a STAR and/or STAR+PLUS Operational Start Date of September 1, 2011: Bandera, Austin, Matagorda, Wharton, Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, , Polk, San Jacinto, Tyler, Walker, Brooks, Goliad, Karnes, Kenedy, Live Oak, Fayette, Hudspeth, Carson, Deaf Smith, Hutchinson, Potter, Randall, and Swisher.

Experience Rebate means the portion of the HMO's net income before taxes that is returned to the State in accordance with Section 10.11 for the STAR, CHIP and CHIP Perinatal Programs and 10.11.1 for the STAR+PLUS Program ("Experience Rebate").

Expedited Appeal means an appeal to the HMO in which the decision is required quickly based on the Member's health status, and the amount of time necessary to participate in a standard appeal could jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.

Expiration Date means the expiration date of this Contract, as specified in HHSC's Managed Care Contract document.

External Quality Review Organization (EQRO) means the entity that contracts with HHSC to provide external review of access to and quality of healthcare provided to Members of HHSC's HMO Programs.

Fair Hearing means the process adopted and implemented by HHSC in 1 T.A.C. Chapter 357, in compliance with federal regulations and state rules relating to Medicaid Fair Hearings.

Farmworker Child (FWC) means a child under age 21 of a Migrant Farmworker.

Fee-for-Service means the traditional Medicaid Health Care Services payment system under which providers receive a payment for each unit of service according to rules adopted pursuant to Chapter 32, Texas Human Resources Code.

Force Majeure Event means any failure or delay in performance of a duty by a Party under this Contract that is caused by fire, flood, hurricane, tornadoes, earthquake, an act of God, an act of war, riot, civil disorder, or any similar event beyond the reasonable control of such Party and without the fault or negligence of such Party.

FQHC means a Federally Qualified Health Center, certified by CMS to meet the requirements of §1861(aa)(3) of the Social Security Act as a federally qualified health center, that is enrolled as a provider in the Texas Medicaid program.

FPL means the Federal Poverty Level.

Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable federal or state law.

FSR means Financial Statistical Report.

Functionally Necessary Covered Services means Community-based Long Term Care services provided to assist STAR+PLUS Members with activities of daily living based on a functional assessment of the Member's activities of daily living and a determination of the amount of supplemental supports necessary for the STAR+PLUS Member to remain independent or in the most integrated setting possible.

Habilitative and Rehabilitative Services means Health Care Services described in **Attachment B-2** that may be required by children who fail to reach (habilitative) or have lost (rehabilitative) age appropriate developmental milestones.

Health Care Services means the Acute Care, Behavioral Health Care and health-related services that an enrolled population might reasonably require in order to be maintained in good health.

Health and Human Services Commission or **HHSC** means the administrative agency within the executive department of Texas state government established under Chapter 531, Texas Government Code, or its designee, including, but not limited to, the HHS Agencies.

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

HEDIS, the Health Plan Employer Data and Information Set, is a registered trademark of NCQA. HEDIS is a set of standardized performance measures designed to reliably compare the performance of managed health care plans. HEDIS is sponsored, supported and maintained by NCQA.

HHS Agency means the Texas health and human service agencies subject to HHSC's oversight under Chapter 531, Texas Government Code, and their successor agencies.

HHSC Administrative Services Contractor (ASC) means an entity performing HMO administrative services functions, including member enrollment functions, for STAR, STAR+PLUS, CHIP, or CHIP Perinatal HMO Programs under contract with HHSC.

HHSC HMO Programs or HMO Programs mean the STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMO Programs.

HHSC Uniform Managed Care Manual means the manual published by or on behalf of HHSC that contains policies and procedures required of all HMOs participating in the HHSC Programs.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (August 21, 1996), as amended or modified.

HMO or **Contractor** means the HMO that is a party to this Contract, and is either:

(1) an insurer licensed by TDI as a Health Maintenance Organization in accordance with Chapter 843 of the Texas Insurance Code, or

(2) a certified Approved Non-Profit Health Corporation (ANHC) formed in compliance with Chapter 844 of the Texas Insurance Code.

HMO Administrative Services means the performance of services or functions, other than the direct delivery of Covered Services, necessary for the management of the delivery of and payment for Covered Services, including but not limited to Network, utilization, clinical and/or quality management, service authorization, claims processing, management information systems operation and reporting.

HMO's Service Area means all the counties included in any HHSC-defined Core or Optional Service Area, as applicable to each HMO Program and within which the HMO has been selected to provide HMO services.

Home and Community Support Services Agency or HCSS means an entity licensed to provide home health, hospice, or personal assistance services provided to individuals in their own home or independent living environment as prescribed by a physician or individualized service plan. Each HCSS must provide clients with a plan of care that includes specific services the agency agrees to perform. The agencies are licensed and monitored by DADS or its successor.

Hospital means a licensed public or private institution as defined by Chapter 241, Texas Health and Safety Code, or in Subtitle C, Title 7, Texas Health and Safety Code.

ICF-MR means an intermediate care facility for the mentally retarded.

Individual Family Service Plan (IFSP) means the plan for services required by the Early Childhood Intervention (ECI) Program and developed by an interdisciplinary team.

Initial Contract Period means the Effective Date of the Contract through August 31, 2008.

Inpatient Stay means at least a 24-hour stay in a facility licensed to provide hospital care.

JCAHO means Joint Commission on Accreditation of Health Care Organizations.

Joint Interface Plan (JIP) means a document used to communicate basic system interface information. This information includes: file structure, data elements, frequency, media, type of file, receiver and sender of the file, and file I.D. The JIP must include each of the HMO's interfaces required to conduct business under this Contract. The JIP must address the coordination with each of the HMO's interface partners to ensure the development and maintenance of the interface; and the timely transfer of required data elements between contractors and partners.

Key HMO Personnel means the critical management and technical positions identified by the HMO in accordance with **Article 4**.

Linguistic Access means translation and interpreter services, for written and spoken language to ensure effective communication. Linguistic access includes sign language interpretation, and the provision of other auxiliary aids and services to persons with disabilities.

Local Health Department means a local health department established pursuant to Health and Safety Code, Title 2, Local Public Health Reorganization Act §121.031.

Local Mental Health Authority (LMHA) means an entity within a specified region responsible for planning, policy development, coordination, and resource development and allocation and for supervising and ensuring the provision of mental health care services to persons with mental illness in one or more local service areas.

Major Population Group means any population, which represents at least 10% of the Medicaid, CHIP, and/or CHIP Perinatal Program population in the Service Area served by the HMO.

Material Subcontractor or **Major Subcontractor** means any entity that contracts with the HMO, where the value of the subcontract $100,000, or is reasonably expected to exceed $100,000, per State Fiscal Year, including any amendments. For the purposes of this Agreement, Material Subcontractors do not include providers in the HMO's Provider Network and contracts with any non-Affiliates for utilities (e.g., water, electricity, telephone, Internet), mail/shipping, office space, or computer hardware. Material Subcontractors may include, without limitation, Affiliates, subsidiaries, and affiliated and unaffiliated third parties.

Mandated or Required Services means services that a state is required to offer to categorically needy clients under a state Medicaid plan.

Marketing means any communication from the HMO to a Medicaid or CHIP Eligible who is not enrolled with the HMO that can reasonably be interpreted as intended to influence the Eligible to:
(1) enroll with the HMO; or
(2) not enroll in, or to disenroll from, another MCO.

Marketing Materials means materials that are produced in any medium by or on behalf of the HMO and can reasonably be interpreted as intending to market to potential Members. Health-related Materials are not Marketing Materials.

MCO means managed care organization.

Medicaid means the medical assistance entitlement program authorized and funded pursuant to Title XIX, Social Security Act (42 U.S.C. §1396 *et seq*.) and administered by HHSC.

Medicaid HMOs means contracted HMOs participating in STAR, STAR+PLUS, and/or STAR Health.

Medical Assistance Only (MAO) means a person that does not receive SSI benefits but qualifies financially and functionally for limited Medicaid assistance.

Medical Home means a PCP or specialty care Provider who has accepted the responsibility for providing accessible, continuous, comprehensive and coordinated care to Members participating in a HHSC HMO Program.

Medically Necessary means:

(1) For Medicaid Members birth through age 20, the following Texas Health Steps services:

(a) screening, vision, and hearing services; and
(b) other Health Care Services, including Behavioral Health Services, that are necessary to correct or ameliorate a defect or physical or mental illness or condition. A determination of whether a service is necessary to correct or ameliorate a defect or physical or mental illness or condition:

(i) must comply with the requirments of the *Alberto N., et al v. Suehs, et al.* partial settlement agreements; and

(ii) may include consideration of other relevant factors, such as the criteria described in parts (2)(b-g) and (3) (b-g) of this definition.
(1) For Medicaid and CHIP Members, non-behavioral health related Health Care Services (that for Medicaid Members birth through age 20 are not available through Texas Health Steps) that are:

(a) reasonable and necessary to prevent illnesses or medical conditions, or provide early screening, interventions, and/or treatments for conditions that cause suffering or pain, cause physical deformity or limitations in function, threaten to cause or worsen a handicap, cause illness or infirmity of a Member, or endanger life;

(b) provided at appropriate facilities and at the appropriate levels of care for the treatment of a Member's health conditions;

(c) consistent with health care practice guidelines and standards that are endorsed by professionally recognized health care organizations or governmental agencies;

(d) consistent with the Member's diagnoses;

(e) no more intrusive or restrictive than necessary to provide a proper balance of safety, effectiveness, and efficiency;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or Provider; and

(2) For Medicaid and CHIP Members Behavioral Health Services (that for Medicaid Members birth through age 20 are not available through Texas Health Steps) that are:

(a) are reasonable and necessary for the diagnosis or treatment of a mental health or chemical dependency disorder, or to improve, maintain, or prevent deterioration of functioning resulting from such a disorder;

(b) are in accordance with professionally accepted clinical guidelines and standards of practice in behavioral health care;

(c) are furnished in the most appropriate and least restrictive setting in which services can be safely provided;

(d) are the most appropriate level or supply of service that can safely be provided;

(e) could not be omitted without adversely affecting the Member's mental and/or physical health or the quality of care rendered;

(f) are not experimental or investigative; and

(g) are not primarily for the convenience of the Member or Provider.

Member means a person who:
(1) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included in the STAR or STAR+PLUS Program, and is enrolled in the STAR or STAR+PLUS Program and the HMO's STAR or STAR+PLUS HMO;

(2) is entitled to benefits under Title XIX of the Social Security Act and Medicaid, is in a Medicaid eligibility category included as a voluntary participant in the STAR or STAR+PLUS Program, and is enrolled in the STAR or STAR+PLUS Program and the HMO's STAR or STAR+PLUS HMO;

(3) has met CHIP eligibility criteria and is enrolled in the HMO's CHIP HMO; or

(4) has met CHIP Perinatal Program eligibility criteria and is enrolled in the HMO's CHIP Perinatal Program.

Member Materials means all written materials produced or authorized by the HMO and distributed to Members or potential members containing information concerning the HMO Program(s). Member Materials include, but are not limited to, Member ID cards, Member handbooks, Provider directories, and Marketing Materials.

Member Month means one Member enrolled with the HMO during any given month. The total Member Months for each month of a year comprise the annual Member Months.

Member(s) with Special Health Care Needs (MSHCN) includes a Child or Children with a Special Health Care Need (CSHCN) and any adult Member who:

(1) has a serious ongoing illness, a Chronic or Complex Condition, or a Disability that has lasted or is anticipated to last for a significant period of time, and

(2) requires regular, ongoing therapeutic intervention and evaluation by appropriately trained health care personnel.

Migrant Farmworker means a migratory agricultural worker, generally defined as an individual:
(1) whose principal employment is in agriculture on a seasonal basis,
(2) who has been so employed within the last twenty-four months,
(3) who performs any activity directly related to teh production or processing of crops, dairy products, poultry, or livestock for initial commercial sale or as a principal menas of personal subsistence; and
(4) who establishes for the purposes of such employment a temporary abode.

Minimum Data Set for Home Care (MDS-HC) means the assessment instrument included in the **Uniform Managed Care Manual** that is used to collect data such as health, social support and service use information on persons receiving long term care services outside of an institutional setting.

MIS means Management Information System.

National Committee for Quality Assurance (NCQA) means the independent organization that accredits HMOs, managed behavioral health organizations, and accredits and certifies disease management programs. HEDIS and the Quality Compass are registered trademarks of NCQA.

Net Income before Taxes means an aggregate excess of Revenues over Allowable Expenses.

Network or Provider Network means all Providers that have a contract with the HMO, or any Subcontractor, for the delivery of Covered Services to the HMO's Members under the Contract.

Network Provider or Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Non-capitated Services means those Medicaid services identified in Attachment B-1, Section 8.2.2.8.

Non-provider Subcontracts means contracts between the HMO and a third party that performs a function, excluding delivery of health care services, that the HMO is required to perform under its Contract with HHSC.

Nursing Facility Cost Ceiling means the annualized cost of serving a client in a nursing facility. A per diem cost is established for each Medicaid nursing facility resident based on the level of care needed. This level of care is referred to as the Texas Index for Level of Effort or the TILE level. The per diem cost is annualized to achieve the nursing facility ceiling.

Nursing Facility Level of Care means the determination that the level of care required to adequately serve a STAR+PLUS Member is at or above the level of care provided by a nursing facility.

OB/GYN means obstetrician-gynecologist.

Open Panel means Providers who are accepting new patients for the HMO Program(s) served.

Operational Start Date means the first day on which an HMO is responsible for providing Covered Services to Members of an HMO Program in a Service Area in exchange for a Capitation Payment under the Contract. The Operational Start Date may vary per HMO Program and Service Area. The Operational Start Date(s) applicable to this Contract are set forth in the **HHSC Managed Care Contract** document.

Operations Phase means the period of time when HMO is responsible for providing the Covered Services and all related Contract functions for a Service Area. The Operations Phase begins on the Operational Start Date, and may vary by HMO Program and Service Area.

Optional Service Area (OSA) means an HHSC defined county or counties, contiguous to a CSA, in which CHIP or CHIP Perinatal HMOs provide health care coverage to CHIP Eligibles. The CHIP or CHIP Perinatal HMO must serve the associated Core Service Area in order to provide coverage in the OSA. The **HHSC Managed Care Contract** document includes OSAs, if applicable.

Out-of-Network (OON) means an appropriately licensed individual, facility, agency, institution, organization or other entity that has not entered into a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Outpatient Hospital Services means diagnostic, therapeutic, and rehabilitative services that are provided to Members in an organized medical facility, for less than a 24-hour period, by or under the direction of a physician.

Parties means HHSC and HMO, collectively.

Party means either HHSC or HMO, individually.

Pended Claim means a claim for payment, which requires additional information before the claim can be adjudicated as a clean claim.

Population Risk Group means a distinct group of members identified by age, age range, gender, type of program, or eligibility category.

Post-stabilization Care Services means Covered Services, related to an Emergency Medical Condition that are provided after a Member is stabilized in order to maintain the stabilized condition, or, for a Medicaid Member, under the circumstances described in 42 §§C.F.R. 438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii) to improve or resolve the Medicaid Member's condition.

PPACA – means the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA).

Primary Care Physician or Primary Care Provider (PCP)
means a physician or provider who has agreed with the HMO to provide a Medical Home to Members and who is responsible for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for care.

Provider types that can be PCPs are from any of the following practice areas: General Practice, Family Practice, Internal Medicine, Pediatrics, Obstetrics/Gynecology (OB/GYN), Advanced Practice Nurses (APNs) and Physician Assistants (when APNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract), , Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs) and similar community clinic s; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions.

Proposal means the proposal submitted by the HMO in response to the RFP.

Provider or Network Provider means an appropriately credentialed and licensed individual, facility, agency, institution, organization or other entity, and its employees and subcontractors, that has a contract with the HMO for the delivery of Covered Services to the HMO's Members.

Provider Contract means a contract entered into by a direct provider of health care services and the HMO or an intermediary entity.

Provider Network or Network means all Providers that have contracted with the HMO for the applicable HMO Program.

Proxy Claim Form means a form submitted by Providers to document services delivered to Members under a capitated arrangement. It is not a claim for payment.

Public Health Entity means a HHSC Public Health Region, a Local Health Department, or a hospital district.

Public Information means information that:

(1) Is collected, assembled, or maintained under a law or ordinance or in connection with the transaction of official business by a governmental body or for a governmental body; and

(2) The governmental body owns or has a right of access to.

Qualified and Disabled Working Individual (QDWI) means an individual whose only Medicaid benefit is payment of the Medicare Part A premium.

Qualified Medicare Beneficiary (QMB) means a Medicare beneficiary whose only Medicaid benefits are payment of Medicare premiums, deductibles, and coinsurance for individuals who are entitled to Medicare Part A, whose income does not exceed 100% of the federal poverty level, and whose resources do not exceed twice the resource limit of the SSI program.

Quality Improvement means a system to continuously examine, monitor and revise processes and systems that support and improve administrative and clinical functions.

Rate Cell means a Population Risk Group for which a Capitation Rate has been determined.

Rate Period 1 means the period of time beginning on the Operational Start Date and ending on August 31, 2007.

Rate Period 2 means the period of time beginning on September 1, 2007 and ending on August 31, 2008.

Rate Period 3 means the period of time beginning on September 1, 2008 and ending on August 31, 2009.

Rate Period 4 means the period of time beginning on September 1, 2009 and ending on August 31, 2010.

Rate Period 5 means the period of time beginning on September 1, 2010 and ending on August 31, 2011.

Rate Period 6 means the period of time beginning on September 1, 2011 and ending on August 31, 2012.

Real-Time Captioning (also known as CART, Communication Access Real-Time Translation) means a process by which a trained individual uses a shorthand machine, a computer, and real-time translation software to type and simultaneously translate spoken language into text on a computer screen. Real Time Captioning is provided for individuals who are deaf, have hearing impairments, or have unintelligible speech. It is usually used to interpret spoken English into text English but may be used to translate other spoken languages into text.

Readiness Review means the assurances made by a selected HMO and the examination conducted by HHSC, or its agents, of HMO's ability, preparedness, and availability to fulfill its obligations under the Contract.

Request for Proposals or **RFP** means the procurement solicitation instrument issued by HHSC under which this Contract was awarded and all RFP addenda, corrections or modifications, if any.

Revenue means all managed care revenue received by the HMO pursuant to this Contract during the Contract Period, including retroactive adjustments made by HHSC. This would include any funds earned on Medicaid or CHIP managed care funds such as investment income, earned interest, or third party administrator earnings from services to delegated Networks.

Risk means the potential for loss as a result of expenses and costs of the HMO exceeding payments made by HHSC under the Contract.

Routine Care means health care for covered preventive and medically necessary Health Care Services that are non-emergent or non-urgent.

Rural Health Clinic (RHC) means an entity that meets all of the requirements for designation as a rural health clinic under 1861(aa)(1) of the Social Security Act and approved for participation in the Texas Medicaid Program.

Service Coordination means a specialized care management service that is performed by a Service Coordinator and that includes but is not limited to:

(1) identification of needs, including physical health, mental health services and for STAR+PLUS Members, long term support services,

(2) development of a Service Plan to address those identified needs;

(3) assistance to ensure timely and a coordinated access to an array of providers and Covered Services;

(4) attention to addressing unique needs of Members; and

(5) coordination of Plan services with social and other services delivered outside the Plan, as necessary and appropriate.

Service Coordinator means the person with primary responsibility for providing service coordination and care management to STAR+PLUS Members.

Scope of Work means the description of Services and Deliverables specified in this Contract, the RFP, the HMO's Proposal, and any agreed modifications to these documents.

SDX means State Data Exchange.

SED means severe emotional disturbance as determined by a Local Mental Health Authority.

Service Area means the counties included in any HHSC-defined Core and Optional Service Area as applicable to each HMO Program.

Service Management is an administrative service in the STAR, CHIP and CHIP Perinatal Programs performed by the HMO to facilitate development of a Service Plan and coordination of services among a Member's PCP, specialty providers and non-medical providers to ensure Members with Special Health Care Needs and/or Members needing high-cost treatment have access to, and appropriately utilize, Medically Necessary Covered Services, Noncapitated Services, and other services and supports.

Service Plan (SP) means an individualized plan developed with and for Members with Special Health Care Needs, including persons with disabilities or chronic or complex conditions. The SP includes, but is not limited to, the following:
(1) the Member's history;

(2) summary of current medical and social needs and concerns;

(3) short and long term needs and goals;

(4) a list of services required, their frequency, and

(5) a description of who will provide such services.

The Service Plan should incorporate as a component of the plan the Individual Family Service Plan (IFSP) for members in the Early Childhood Intervention (ECI) Program
The Service Plan may include information for services outside the scope of covered benefits such as how to access affordable, integrated housing.

Services means the tasks, functions, and responsibilities assigned and delegated to the HMO under this Contract.

Significant Traditional Provider or STP (for Medicaid) means primary care providers and long-term care providers, identified by HHSC as having provided a significant level of care to Fee-for-Service clients. Disproportionate Share Hospitals (DSH) are also Medicaid STPs.

Significant Traditional Provider or STP (for CHIP) means primary care providers participating in the CHIP HMO Program prior to May 2004, and Disproportionate Share Hospitals (DSH).

Skilled Nursing Facility Services (CHIP only) Services provided in a facility that provides nursing or rehabilitation services and Medical supplies and use of appliances and equipment furnished by the facility.

Software means all operating system and applications software used by the HMO to provide the Services under this Contract.

SPMI means severe and persistent mental illness as determined by the Local Mental Health Authority.

Specialty Hospital means any inpatient hospital that is not a general Acute Care hospital.

Specialty Therapy means physical therapy, speech therapy or occupational therapy.

Specified Low-Income Medicare Beneficiary (SLMB) means a Medicare beneficiary whose only Medicaid benefit is payment of the Medicare Part B premium.

SSA means the Social Security Administration.

SSI Administrative Fee means the monthly per member per month fee paid to an HMO to provide administrative services to manage the healthcare of the HMO's voluntary SSI beneficiaries. These services are described in more detail under Section 10.10 of this document.

Stabilize means to provide such medical care as to assure within reasonable medical probability that no deterioration of the condition is likely to result from, or occur from, or occur during discharge, transfer, or admission of the Member.

STAR+PLUS or STAR+PLUS Program means the State of Texas Medicaid managed care program in which HHSC contracts with HMOs to provide, arrange, and coordinate preventive, primary, acute and long term care Covered Services to adult persons with disabilities and elderly persons age 65 and over who qualify for Medicaid through the SSI program and/or the MAO program. Children under age 21, who qualify for Medicaid through the SSI program, may voluntarily participate in the STAR+PLUS program.

STAR+PLUS HMOs means contracted HMOs participating in the STAR+PLUS Program.

State Fiscal Year (SFY) means a 12-month period beginning on September 1 and ending on August 31 the following year.

Subcontract means any agreement between the HMO and other party to fulfill the requirements of the Contract.

Subcontractor means any individual or entity, including an Affiliate, that has entered into a Subcontract with HMO.

Subsidiary means an Affiliate controlled by such person or entity directly or indirectly through one or more intermediaries.

Supplemental Security Income (SSI) means a Federal income supplement program funded by general tax revenues (not Social Security taxes) designed to help aged, blind and disabled people with little or no income by providing cash to meet basic needs for food, clothing and shelter.

T.A.C. means Texas Administrative Code.

TDD means telecommunication device for the deaf. It is interchangeable with the term Teletype machine or TTY.

TDI means the Texas Department of Insurance.

Temporary Assistance to Needy Families (TANF) means the federally funded program that provides assistance to single parent families with children who meet the categorical requirements for aid. This program was formerly known as the Aid to Families with Dependent Children (AFDC) program.

Texas Health Steps is the name adopted by the State of Texas for the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. It includes the State's Comprehensive Care Program extension to EPSDT, which adds benefits to the federal EPSDT requirements contained in 42 U.S.C. §1396d(r), and defined and codified at 42 C.F.R. §§440.40 and 441.56-62. HHSC's rules are contained in 25 T.A.C., Chapter 33 (relating to Early and Periodic Screening, Diagnosis and Treatment).

Texas Medicaid Bulletin means the bi-monthly update to the Texas Medicaid Provider Procedures Manual.

Texas Medicaid Provider Procedures Manual means the policy and procedures manual published by or on behalf of HHSC that contains policies and procedures required of all health care providers who participate in the Texas Medicaid program. The manual is published annually and is updated bimonthly by the Texas Medicaid Bulletin.

Texas Medicaid Service Delivery Guide means an attachment to the Texas Medicaid Provider Procedures Manual.

Third Party Liability (TPL) means the legal responsibility of another individual or entity to pay for all or part of the services provided to Members under the Contract (see 1 TAC §354.2301 *et seq*., relating to Third Party Resources).

Third Party Recovery (TPR) means the recovery of payments on behalf of a Member by HHSC or the HMO from an individual or entity with the legal responsibility to pay for the Covered Services.

TP 13 means Type Program 13, which is a Medicaid program eligibility type assigned to persons determined eligible for federal SSI assistance by the Social Security Administration (SSA). If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 13 include the subsequent identifier.

TP 40 means Type Program 40, which is a Medicaid program eligibility type assigned to pregnant women under 185% of the federal poverty level (FPL). If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 40 include the subsequent identifier.

TP 45 means Type Program 45, which is a Medicaid program eligibility code assigned to newborns (under 12 months of age) who are born to mothers who are Medicaid eligible at the time of the child's birth. If a subsequent eligibility system uses a different identifier for this eligibility type, references to TP 40 include the subsequent identifier.

Transfer means the movement of the Member from one Acute Care Hospital or Long Term Care Hospital/facility and readmission to another Acute Care Hospital or Long Term Care Hospital/facility within 24 hours for continued treatment.

Transition Phase includes all activities the HMO is required to perform between the Contract Effective Date and the Operational Start Date for all or part of a Service Area.

Turnover Phase includes all activities the HMO is required to perform in order to close out the Contract and/or transition Contract activities and operations for a Service Area to HHSC or a subsequent contractor.

Turnover Plan means the written plan developed by HMO, approved by HHSC, to be employed during the Turnover Phase. The Turnover Plan describes HMO's policies and procedures that will assure:

(1) The least disruption in the delivery of Health Care Services to those Members who are enrolled with the HMO during the transition to a subsequent health plan;

(2) Cooperation with HHSC and the subsequent health plan in notifying Members of the transition and of their option to select a new plan, as requested and in the form required or approved by HHSC; and

(3) Cooperation with HHSC and the subsequent health plan in transferring information to the subsequent health plan, as requested and in the form required or approved by HHSC.

Uniform Managed Care Manual(UMCM) means the manual published by or on behalf of HHSC that contains policies and procedures required of all HMOs participating in the HHSC Programs. The UMCM, as amended or modified, is incorporated by reference into the Contract.

URAC /American Accreditation Health Care Commission means the independent organization that accredits Utilization Review functions and offers a variety of other accreditation and certification programs for health care organizations.

Urgent Behavioral Health Situation means a behavioral health condition that requires attention and assessment within twenty-four (24) hours but which does not place the Member in immediate danger to himself or herself or others and the Member is able to cooperate with treatment.

Urgent Condition means a health condition including an Urgent Behavioral Health Situation that is not an emergency but is severe or painful enough to cause a prudent layperson, possessing the average knowledge of medicine, to believe that his or her condition requires medical treatment evaluation or treatment within twenty-four (24) hours by the Member's PCP or PCP designee to prevent serious deterioration of the Member's condition or health.

Utilization Review means the system for retrospective, concurrent, or prospective review of the medical necessity and appropriateness of Health Care Services provided, being provided, or proposed to be provided to a Member. The term does not include elective requests for clarification of coverage.

Value-added Services means additional services for coverage beyond those specified in Attachments B-2, B-2.1, and B-2.2. Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improve health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.

Waste means practices that are not cost-efficient.

Article 3. General Terms & Conditions

Section 3.01 ***Contract elements.***

(a) Contract documentation. The Contract between the Parties will consist of the HHSC Managed Care Contract document and all attachments and amendments.

(b) Order of documents. In the event of any conflict or contradiction between or among the contract documents, the documents shall control in the following order of precedence:

(1) The final executed **HHSC Managed Care Contract** document, and all amendments thereto;

(2) HHSC Managed Care Contract **Attachment A** – "HHSC's Uniform Managed Care Contract Terms and Conditions," and all amendments thereto;

(3) HHSC Managed Care Contract **Attachment B** – "Scope of Work/Performance Measures," and all attachments and amendments thereto;

(4) The **HHSC Uniform Managed Care Manual**, and all attachments and amendments thereto;

(5) HHSC Managed Care Contract **Attachment C-3** – "Agreed Modifications to HMO's Proposal;"

(6) HHSC Managed Care Contract **Attachment C-2**, "HMO Supplemental Responses," and

(7) HHSC Managed Care Contract

Attachment C-1 – "HMO's Proposal."

Section 3.02 ***Term of the Contract.***

The term of the Contract will begin on the Effective Date and will conclude on the Expiration Date. The Parties may renew the Contract for an additional period or periods, but the Contract Term may not exceed a total of eight (8) years. All reserved contract extensions beyond the Expiration Date will be subject to good faith negotiations between the Parties and mutual agreement to the extension(s).

Section 3.03 ***Funding.***

This Contract is expressly conditioned on the availability of state and federal appropriated funds. HMO will have no right of action against HHSC in the event that HHSC is unable to perform its obligations under this Contract as a result of the suspension, termination, withdrawal, or failure of funding to HHSC or lack of sufficient funding of HHSC for any activities or functions contained within the scope of this Contract. If funds become unavailable, the provisions of **Article 12** ("Remedies and Disputes") will apply. HHSC will use all reasonable efforts to ensure that such funds are available, and will negotiate in good faith with HMO to resolve any HMO claims for payment that represent accepted Services or Deliverables that are pending at the time funds become unavailable. HHSC shall make best efforts to provide reasonable written advance notice to HMO upon learning that funding for this Contract may be unavailable.

Section 3.04 ***Delegation of authority.***

Whenever, by any provision of this Contract, any right, power, or duty is imposed or conferred on HHSC, the right, power, or duty so imposed or conferred is possessed and exercised by the Commissioner unless any such right, power, or duty is specifically delegated to the duly appointed agents or employees of HHSC. The Commissioner will reduce any such delegation of authority to writing and provide a copy to HMO on request.

Section 3.05 ***No waiver of sovereign immunity.***

The Parties expressly agree that no provision of this Contract is in any way intended to constitute a waiver by HHSC or the State of Texas of any immunities from suit or from liability that HHSC or the State of Texas may have by operation of law.

Section 3.06 ***Force majeure.***

Neither Party will be liable for any failure or delay in performing its obligations under the Contract if such failure or delay is due to any cause beyond the reasonable control of such Party, including, but not limited to, unusually severe weather, strikes, natural disasters, fire, civil disturbance, epidemic, war, court order, or acts of God. The existence of such causes of delay or failure will extend the period of performance in the exercise of reasonable diligence until after the causes of delay or failure have been removed. Each Party must inform the other in writing with proof of receipt within five (5) Business Days of the existence of a force majeure event or otherwise waive this right as a defense.

Section 3.07 ***Publicity.***

(a) HMO may use the name of HHSC, the State of Texas, any HHS Agency, and the name of the HHSC HMO Program in any media release, public announcement, or public disclosure relating to the Contract or its subject matter only if, at least seven (7) calendar days prior to distributing the material, the HMO submits the information to HHSC for review and comment. If HHSC has not responded within seven

(7) calendar days, the HMO may use the submitted information. HHSC reserves the right to object to and require changes to the publication if, at HHSC's sole discretion, it determines that the publication does not accurately reflect the terms of the Contract or the HMO's performance under the Contract. .

(b) HMO will provide HHSC with one (1) electronic copy of any information described in Subsection 3.07(a) prior to public release. HMO will provide additional copies, including hard copies, at the request of HHSC.

(c) The requirements of Subsection 3.07(a) do not apply to:

(1) proposals or reports submitted to HHSC, an administrative agency of the State of Texas, or a governmental agency or unit of another state or the federal government;

(2) information concerning the Contract's terms, subject matter, and estimated value:

(a) in any report to a governmental body to which the HMO is required by law to report such information, or

(b) that the HMO is otherwise required by law to disclose; and

(3) Member Materials (the HMO must comply with **the Uniform Managed Care Manual's** provisions regarding the review and approval of Member Materials).

Section 3.08 ***Assignment.***
(a) Assignment by HMO. HMO shall not assign all or any portion of its rights under or interests in the Contract or delegate any of its duties without prior written consent of HHSC. Any written request for assignment or delegation must be accompanied by written acceptance of the assignment or delegation by the assignee or delegation by the delegate. Except where otherwise agreed in writing by HHSC, assignment or delegation will not release HMO from its obligations pursuant to the Contract. An HHSC-approved Material Subcontract will not be considered to be an assignment or delegation for purposes of this section.

(b) Assignment by HHSC. HMO understands and agrees HHSC may in one or more transactions assign, pledge, transfer, or hypothecate the Contract. This assignment will only be made to another State agency or a non-State agency that is contracted to perform agency support.

(c) Assumption. Each party to whom a transfer is made (an "Assignee") must assume all or any part of HMO'S or HHSC's interests in the Contract, the product, and any documents executed with respect to the Contract, including, without limitation, its obligation for all or any portion of the purchase payments, in whole or in part.

Section 3.09 ***Cooperation with other vendors and prospective vendors.***
HHSC may award supplemental contracts for work related to the Contract, or any portion thereof. HMO will reasonably cooperate with such other vendors, and will not commit or permit any act that may interfere with the performance of work by any other vendor.

Section 3.10 ***Renegotiation and reprocurement rights.***

(a) Renegotiation of Contract terms. Notwithstanding anything in the Contract to the contrary, HHSC may at any time during the term of the Contract exercise the option to notify HMO that HHSC has elected to renegotiate certain terms of the Contract. Upon HMO's receipt of any notice pursuant to this Section, HMO and HHSC will undertake good faith negotiations of the subject terms of the Contract, and may execute an amendment to the Contract in accordance with **Article 8**.

(b) Reprocurement of the services or procurement of additional services.

Notwithstanding anything in the Contract to the contrary, whether or not HHSC has accepted or rejected HMO's Services and/or Deliverables provided during any period of the Contract, HHSC may at any time issue requests for proposals or offers to other potential contractors for performance of any portion of the Scope of Work covered by the Contract or Scope of Work similar or comparable to the Scope of Work performed by HMO under the Contract.

(c) Termination rights upon reprocurement. If HHSC elects to procure the Services or Deliverables or any portion of the Services or Deliverables from another vendor in accordance with this Section, HHSC will have the termination rights set forth in **Article 12** ("Remedies and Disputes").

Section 3.11 ***RFP errors and omissions.***
HMO will not take advantage of any errors and/or omissions in the RFP or the resulting Contract. HMO must promptly notify HHSC of any such errors and/or omissions that are discovered.

Section 3.12 ***Attorneys' fees.***
In the event of any litigation, appeal, or other legal action to enforce any provision of the Contract, HMO agrees to pay all reasonable expenses of such action, including attorneys' fees and costs, if HHSC is the prevailing Party.

Section 3.13 ***Preferences under service contracts.***
HMO is required in performing the Contract to purchase products and materials produced in the State of Texas when they are available at a price and time comparable to products and materials produced outside the State.

Section 3.14 ***Time of the essence.***
In consideration of the need to ensure uninterrupted and continuous HHSC HMO Program performance, time is of the essence in the performance of the Scope of Work under the Contract.

Section 3.15 ***Notice***

(a) Any notice or other legal communication required or permitted to be made or given by either Party pursuant to the Contract will be in writing and in English, and will be deemed to have been given:

(1) Three (3) Business Days after the date of mailing if sent by registered or certified U.S. mail, postage prepaid, with return receipt requested;

(2) When transmitted if sent by facsimile, provided a confirmation of transmission is produced by the sending machine; or

(3) When delivered if delivered personally or sent by express courier service.

(b) The notices described in this Section may not be sent by electronic mail.

(c) All notices must be sent to the Project Manager identified in the **HHSC Managed Care Contract** document. In addition, legal notices must be sent to the Legal Contact identified in the **HHSC Managed Care Contract** document.

(d) Routine communications that are administrative in nature will be provided in a manner agreed to by the Parties.

Article 4. Contract Administration & Management
Section 4.01 ***Qualifications, retention and replacement of HMO employees.***
HMO agrees to maintain the organizational and administrative capacity and capabilities to carry out all duties and responsibilities under this Contract. The personnel HMO assigns to perform the duties and responsibilities under this Contract will be properly trained and qualified for the functions they are to perform. Notwithstanding transfer or turnover of personnel, HMO remains obligated to perform all duties and responsibilities under this Contract without degradation and in accordance with the terms of this Contract.

Section 4.02 ***HMO's Key Personnel.***
(a) Designation of Key Personnel. HMO must designate key management and technical personnel who will be assigned to the Contract. For the purposes of this requirement, Key Personnel are those with management responsibility or principal technical responsibility for the following functional areas for each HMO Program included within the scope of the Contract:

(1) Member Services;

(2) Management Information Systems;

(3) Claims Processing,

(4) Provider Network Development and Management;

(5) Benefit Administration and Utilization and Care Management;

(6) Quality Improvement;

(7) Behavioral Health Services;

(8) Financial Functions;

(9) Reporting;

(10) Executive Director(s) for applicable HHSC HMO Program(s) as defined in **Section 4.03** ("Executive Director");

(11) Medical Director(s) for applicable HHSC HMO Program(s) as defined in **Section 4.04** ("Medical Director"); and

(12) Management positions for STAR+PLUS Service Coordinators for STAR+PLUS HMOs as defined in **Section 4.04.1** ("STAR+PLUS Service Coordinator.")

(b) Support and Replacement of Key Personnel.
The HMO must maintain, throughout the Contract Term, the ability to supply its Key Personnel with the required resources necessary to meet Contract requirements and comply with applicable law. The HMO must ensure project continuity by timely replacement of Key Personnel, if necessary, with a sufficient number of persons having the requisite skills, experience and other qualifications. Regardless of specific personnel changes, the HMO must maintain the overall level of expertise, experience, and skill reflected in the Key HMO Personnel job descriptions and qualifications included in the HMO's proposal.

(c) Notification of replacement of Key Personnel.
HMO must notify HHSC within fifteen (15) Business Days of any change in Key Personnel. Hiring or replacement of Key Personnel must conform to all Contract requirements. If HHSC determines that a satisfactory working relationship cannot be established between certain Key Personnel and HHSC, it will notify the HMO in writing. Upon receipt of HHSC's notice, HHSC and HMO will attempt to resolve HHSC's concerns on a mutually agreeable basis.

Section 4.03 ***Executive Director.***

(a) The HMO must employ a qualified individual to serve as the Executive Director for its HHSC HMO Program(s). Such Executive Director must be employed full-time by the HMO, be primarily dedicated to HHSC HMO Program(s), and must hold a Senior Executive or Management position in the HMO's organization, except that the HMO may propose an alternate structure for the Executive Director position, subject to HHSC's prior review and written approval.

(b) The Executive Director must be authorized and empowered to represent the HMO regarding all matters pertaining to the Contract prior to such representation. The Executive Director must act as liaison between the HMO and the HHSC and must have responsibilities that include, but are not limited to, the following:

(1) ensuring the HMO's compliance with the terms of the Contract, including securing and coordinating resources necessary for such compliance;

(2) receiving and responding to all inquiries and requests made by HHSC related to the Contract, in the time frames and formats specified by HHSC. Where practicable, HHSC must consult with the HMO to establish time frames and formats reasonably acceptable to the Parties;

(3) attending and participating in regular HHSC HMO Executive Director meetings or conference calls;

(4) attending and participating in regular HHSC Regional Advisory Committees (RACs) for managed care (the Executive Director may designate key personnel to attend a RAC if the Executive Director is unable to attend);

(5) making best efforts to promptly resolve any issues identified either by the HMO or HHSC that may arise and are related to the Contract;

(6) meeting with HHSC representative(s) on a periodic or as needed basis to review the HMO's performance and resolve issues, and

(7) meeting with HHSC at the time and place requested by HHSC, if HHSC determines that the HMO is not in compliance with the requirements of the Contract.

Section 4.04 ***Medical Director.***

(a) The HMO must have a qualified individual to serve as the Medical Director for its HHSC HMO Program(s). The Medical Director must be currently licensed in Texas under the Texas Medical Board as an M.D. or D.O. with no restrictions or other licensure limitations. The Medical Director must comply with the requirements of 28 T.A.C. §11.1606 and all applicable federal and state statutes and regulations.

(b) The Medical Director, or his or her physician designee meeting the same Contract qualifications that apply to the Medical Director, must be available by telephone 24 hours a day, seven days a week, for Utilization Review decisions. The Medical Director, and his/her designee, must either possess expertise with Behavioral Health Services, or ready access to such expertise to ensure timely and appropriate medical decisions for Members, including after regular business hours.

(c) The Medical Director, or his or her physician designee meeting the same Contract qualifications that apply to the Medical Director, must be authorized and empowered to represent the HMO regarding clinical issues, Utilization Review and quality of care inquiries. The Medical Director, or his or her physician designee, must exercise independent medical judgment in all decisions relating to medical necessity. The HMO must ensure that its decisions relating to medical necessity are not adversely influenced by fiscal management decisions. HHSC may conduct reviews of decisions relating to medical necessity upon reasonable notice.

Section 4.04.1 ***STAR+PLUS Service Coordinator***

(a) STAR+PLUS HMOs must employ as Service Coordinators persons experienced in meeting the needs of people with disabilities, old and young, and vulnerable populations who have Chronic or Complex Conditions. A Service Coordinator must have an undergraduate and/or graduate degree in social work or a related field, or be a Registered Nurse, Licensed Vocational Nurse, Advanced Nurse Practitioner, or a Physician Assistant.

(b) The STAR+PLUS HMO must monitor the Service Coordinator's workload and performance to ensure that he or she is able to perform all necessary Service Coordination functions for the STAR+PLUS Members in a timely manner.

(c) The Service Coordinator must be responsible for working with the Member or his or her representative, the PCP and other Providers to develop a seamless package of care in which primary, Acute Care, and long-term care service needs are met through a single, understandable, rational plan. Each Member's Service Plan must also be well coordinated with the Member's family and community support systems, including Independent Living Centers, Area Agencies on Aging and Mental Retardation Authorities. The Service Plan should be agreed to and signed by the Member or the Member's representative to indicate agreement with the plan. The plan should promote consumer direction and self-determination and may include information for services outside the scope of Covered Services such as how to access affordable, integrated housing. For dual eligible Members, the STAR+PLUS HMO is responsible for meeting the Member's Community Long- term Care Service needs.

(d) The STAR+PLUS HMO must empower its Service Coordinators to authorize the provision and delivery of Covered Services, including Community Long-term Care Covered Services.

Section 4.05 ***Responsibility for HMO personnel and Subcontractors.***

(a) HMO's employees and Subcontractors will not in any sense be considered employees of HHSC or the State of Texas, but will be considered for all purposes as the HMO's employees or its Subcontractor's employees, as applicable.

(b) Except as expressly provided in this Contract, neither HMO nor any of HMO's employees or Subcontractors may act in any sense as agents or representatives of HHSC or the State of Texas.

(c) HMO agrees that anyone employed by HMO to fulfill the terms of the Contract is an employee of HMO and remains under HMO's sole direction and control. HMO assumes sole and full responsibility for its acts and the acts of its employees and Subcontractors.

(d) HMO agrees that any claim on behalf of any person arising out of employment or alleged employment by the HMO (including, but not limited to, claims of discrimination against HMO, its officers, or its agents) is the sole responsibility of HMO and not the responsibility of HHSC. HMO will indemnify and hold harmless the State from any and all claims asserted against the State arising out of such employment or alleged employment by the HMO. HMO understands that any person who alleges a claim arising out of employment or alleged employment by HMO will not be entitled to any compensation, rights, or benefits from HHSC (including, but not limited to, tenure rights, medical and hospital care, sick and annual/vacation leave, severance pay, or retirement benefits).

(e) HMO agrees to be responsible for the following in respect to its employees:

(1) Damages incurred by HMO's employees within the scope of their duties under the Contract; and

(2) Determination of the hours to be worked and the duties to be performed by HMO's employees.

(f) HMO agrees and will inform its employees and Subcontractor(s) that there is no right of subrogation, contribution, or indemnification against HHSC for any duty owed to them by HMO pursuant to this Contract or any judgment rendered against the HMO. HHSC's liability to the HMO's employees, agents and Subcontractors, if any, will be governed by the Texas Tort Claims Act, as amended or modified (TEX. CIV. PRACT. & REM. CODE §101.001et seq.).

(g) HMO understands that HHSC does not assume liability for the actions of, or judgments rendered against, the HMO, its employees, agents or Subcontractors. HMO agrees that it has no right to indemnification or contribution from HHSC for any such judgments rendered against HMO or its Subcontractors.

Section 4.06 ***Cooperation with HHSC and stateadministrative agencies.***

(a) Cooperation with Other MCOs. HMO agrees to reasonably cooperate with and work with the other MCOs in the HHSC HMO Programs, Subcontractors, and third-party representatives as requested by HHSC. To the extent permitted by HHSC's financial and personnel resources, HHSC agrees to reasonably cooperate with HMO and to use its best efforts to ensure that other HHSC contractors reasonably cooperate with the HMO.

(b) Cooperation with state and federal administrative agencies.

HMO must ensure that HMO personnel will cooperate with HHSC or other state or federal administrative agency personnel at no charge to HHSC for purposes relating to the administration of HHSC programs including, but not limited to the following purposes:

(1) The investigation and prosecution of fraud, abuse, and waste in the HHSC programs;

(2) Audit, inspection, or other investigative purposes; and

(3) Testimony in judicial or quasi-judicial proceedings relating to the Services and/or Deliverables under this Contract or other delivery of information to HHSC or other agencies' investigators or legal staff.

Section 4.07 ***Conduct of HMO personnel.***

(a) While performing the Scope of Work, HMO's personnel and Subcontractors must:

(1) Comply with applicable State rules and regulations and HHSC's requests regarding personal and professional conduct generally applicable to the service locations; and

(2) Otherwise conduct themselves in a businesslike and professional manner.

(b) If HHSC determines in good faith that a particular employee or Subcontractor is not conducting himself or herself in accordance with this Contract, HHSC may provide HMO with notice and documentation concerning such conduct. Upon receipt of such notice, HMO must promptly investigate the matter and take appropriate action that may include:

(1) Removing the employee from the project;

(2) Providing HHSC with written notice of such removal; and

(3) Replacing the employee with a similarly qualified individual acceptable to HHSC.

(c) Nothing in the Contract will prevent HMO, at the request of HHSC, from replacing any personnel who are not adequately performing their assigned responsibilities or who, in the reasonable opinion of HHSC's Project Manager, after consultation with HMO, are unable to work effectively with the members of the HHSC's staff. In such event, HMO will provide replacement personnel with equal or greater skills and qualifications as soon as reasonably practicable. Replacement of Key Personnel will be subject to HHSC review. The Parties will work together in the event of any such replacement so as not to disrupt the overall project schedule.

(d) HMO agrees that anyone employed by HMO to fulfill the terms of the Contract remains under HMO's sole direction and control.

(e) HMO shall have policies regarding disciplinary action for all employees who have failed to comply with federal and/or state laws and the HMO's standards of conduct, policies and procedures, and Contract requirements. HMO shall have policies regarding disciplinary action for all employees who have engaged in illegal or unethical conduct.

Section 4.08 ***Subcontractors.***

(a) HMO remains fully responsible for the obligations, services, and functions performed by its Subcontractors to the same extent as if such obligations, services, and functions were performed by HMO's employees, and for purposes of this Contract such work will be deemed work performed by HMO. HHSC reserves the right to require the replacement of any Subcontractor found by HHSC to be unacceptable and unable to meet the requirements of the Contract, and to object to the selection of a Subcontractor.

(b) HMO must:

(1) actively monitor the quality of care and services, as well as the quality of reporting data, provided under a Subcontract;

(2) provide HHSC with a copy of TDI filings of delegation agreements;

(3) unless otherwise provided in this Contract, provide HHSC with written notice no later than:

(i) three (3) Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract;

(ii) 180 calendar days prior to the termination date of a Material Subcontract for MIS systems operation or reporting;

(iii) 90 calendar days prior to the termination date of a Material Subcontract for non-MIS HMO Administrative Services; and

(iv) 30 calendar days prior to the termination date of any other Material Subcontract.

HHSC may grant a written exception to these notice requirements if, in HHSC's reasonable determination, the HMO has shown good cause for a shorter notice period.

(c) During the Contract Period, Readiness Reviews by HHSC or its designated agent may occur if:

(1) a new Material Subcontractor is employed by HMO;

(2) an existing Material Subcontractor provides services in a new Service Area;

(3) an existing Material Subcontractor provides services for a new HMO Program;

(4) an existing Material Subcontractor changes locations or changes its MIS and or operational functions;

(5) an existing Material Subcontractor changes one or more of its MIS subsystems, claims processing or operational functions; or

(6) a Readiness Review is requested by HHSC. The HMO must submit information required by HHSC for each proposed Material Subcontractor as indicated in **Attachment B-1, Section 7**. Refer to **Attachment B-1, Sections 8.1.1.2 and 8.1.18** for additional information regarding HMO Readiness Reviews during the Contract Period.

(d) HMO must not disclose Confidential Information of HHSC or the State of Texas to a Subcontractor unless and until such Subcontractor has agreed in writing to protect the confidentiality of such Confidential Information in the manner required of HMO under this Contract.

(e)HMO must identify any Subcontractor that is a subsidiary or entity formed after the Effective Date of the Contract, whether or not an Affiliate of HMO, substantiate the proposed Subcontractor's ability to perform the subcontracted Services, and certify to HHSC that no loss of service will occur as a result of the performance of such Subcontractor. The HMO will assume responsibility for all contractual responsibilities whether or not the HMO performs them. Further, HHSC considers the HMO to be the sole point of contact with regard to contractual matters, including payment of any and all charges resulting from the Contract.

(f) Except as provided herein, all Subcontracts must be in writing and must provide HHSC the right to examine the Subcontract and all Subcontractor records relating to the Contract and the Subcontract. This requirement does not apply to agreements with utility or mail service providers.

(g) A Subcontract whereby HMO receives rebates, recoupments, discounts, payments, or other consideration from a Subcontractor (including without limitation Affiliates) pursuant to or related to the execution of this Contract must be in writing and must provide HHSC the right to examine the Subcontract and all records relating to such consideration.

(h) All Subcontracts described in subsections (f) and (g) must show the dollar amount or the value of any consideration that HMO pays to or receives from the Subcontractor.

(i) HMO must submit a copy of each Material Subcontract executed prior to the Effective Date of the Contract to HHSC no later than thirty (30) days after the Effective Date of the Contract. For Material Subcontracts executed or amended after the Effective Date of the Contract, HMO must submit a copy to HHSC no later than five (5) Business Days after execution or amendment.
(j) Network Provider Contracts must include the mandatory provisions included in the **HHSC Uniform Managed Care Manual**.

(k) HHSC reserves the right to reject any Subcontract or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

(l) HMO must comply with the requirments of Section 6505 of the PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States."

(m) Provider payment must comply with the requirements of Section 2702 of PPACA, entitled "Payment Adjustment for Health Acquired Conditions."

Section 4.09 ***HHSC's ability to contract withSubcontractors.***

The HMO may not limit or restrict, through a covenant not to compete, employment contract or other contractual arrangement, HHSC's ability to contract with Subcontractors or former employees of the HMO.

Section 4.10 ***HMO Agreements with Third Parties***

(a) If the HMO intends to report compensation paid to a third party (including without limitation an Affiliate) as an Allowable Expense under this Contract, and the compensation paid to the third party exceeds $100,000, or is reasonably anticipated to exceed $100,000, in a State Fiscal Year, then the HMO's agreement with the third party must be in writing. The agreement must provide HHSC the right to examine the agreement and all records relating to the agreement.

(b) All agreements whereby HMO receives rebates, recoupments, discounts, payments, or other consideration from a third party (including without limitation Affiliates) pursuant to or related to the execution of this Contract, must be in writing and must provide HHSC the right to examine the agreement and all records relating to such consideration.

(c) All agreements described in subsections (a) and (b) must show the dollar amount, the percentage of money, or the value of any consideration that HMO pays to or receives from the third party.

(d) HMO must submit a copy of each third party agreement described in subsections (a) and (b) to HHSC. If the third party agreement is entered into prior to the Effective Date of the Contract, HMO must submit a copy no later than thirty (30) days after the Effective Date of the Contract. If the third party agreement is executed after the Effective Date of the Contract, HMO must submit a copy no later than five (5) Business Days after execution.

(e) For third party agreements valued under $100,000 per State Fiscal Year that are reported as Allowable Expenses, the HMO must maintain financial records and data sufficient to verify the accuracy of such expenses in accordance with the requirements of **Article 9**.

(f) HHSC reserves the right to reject any third party agreement or require changes to any provisions that do not comply with the requirements or duties and responsibilities of this Contract or create significant barriers for HHSC in monitoring compliance with this Contract.

(g) This section shall not apply to Provider Contracts, or agreements with utility or mail service providers.

(h) HMO must comply with the requirements of Section 6505 of the PPACA, entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United Sates."

(i) Provider payment must comply with the requirements of Section 2702 of PPACA, entitled "Payment Adjustment for Health Acquired Conditions."

Article 5. Member Eligibility & Enrollment

Section 5.01 ***Eligibility Determination***

The State or its designee will make eligibility determinations for each of the HHSC HMO Programs.

Section 5.02 ***Member Enrollment & Disenrollment.***

(a) The HHSC Administrative Services Contractor will enroll and disenroll eligible individuals in the HMO Program. To enroll in an HMO, the Member's permanent residence must be located within the HMO's Service Area. The HMO is not allowed to induce or accept disenrollment from a Member. The HMO must refer the Member to the HHSC Administrative Services Contractor.

(b) HHSC makes no guarantees or representations to the HMO regarding the number of eligible Members who will ultimately be enrolled into the HMO or the length of time any such enrolling Members remain enrolled with the HMO beyond the minimum mandatory enrollment periods established for each HHSC HMO Program.

(c) The HHSC Administrative Services Contractor will electronically transmit to the HMO new Member information and change information applicable to active Members.

(d) As described in the following Sections, depending on the HMO Program, special conditions may also apply to enrollment and span of coverage for the HMO.

(e) A Medicaid HMO has a limited right to request a Member be disenrolled from HMO without the Member's consent. HHSC must approve any HMO request for disenrollment of a Member for cause. HHSC may permit disenrollment of a Member under the following circumstances:

(1) Member misuses or loans Member's HMO membership card to another person to obtain services.

(2) Member is disruptive, unruly, threatening or uncooperative to the extent that Member's membership seriously impairs HMO's or Provider's ability to provide services to Member or to obtain new Members, and Member's behavior is not caused by a physical or behavioral health condition.

(3) Member steadfastly refuses to comply with managed care restrictions (e.g., repeatedly using emergency room in combination with refusing to allow HMO to treat the underlying medical condition).

(4) HMO must take reasonable measures to correct Member behavior prior to requesting disenrollment. Reasonable measures may include providing education and counseling regarding the offensive acts or behaviors.

(5) For STAR+PLUS HMOs, under limited conditions, the HMO may request disenrollment of members who are totally dependent on a ventilator or who have been diagnosed with End Stage Renal Disease.

(f) HHSC must notify the Member of HHSC's decision to disenroll the Member if all reasonable measures have failed to remedy the problem.

(g) If the Member disagrees with the decision to disenroll the Member from HMO, HHSC must notify the Member of the availability of the Complaint procedure and, for Medicaid Members, HHSC's Fair Hearing process.

(h) HMO cannot request a disenrollment based on adverse change in the member's health status or utilization of services that are Medically Necessary for treatment of a member's condition.

(i) Upon implementation of the Comprehensive Healthcare Program for Foster Care, STAR and CHIP Members taken into conservatorship by the Department of Family and Protective Services (DFPS) will be disenrolled effective the date of conservatorship.

Section 5.03 ***STAR enrollment for pregnant women and infants.***
(a) The HHSC Administrative Services Contractor will retroactively enroll some pregnant Members in a Medicaid HMO based on their date of eligibility.

(b) The HHSC Administrative Services Contractor will enroll newborns born to Medicaid eligible mothers who are enrolled in a STAR HMO in the same HMO for at least 90 days following the date of birth, unless the mother requests a plan change as a special exception. The Administrative Service Contractor will consider such requests on a case-bycase basis. The HHSC Administrative Services Contractor will retroactively, to date of birth, enroll newborns in the applicable STAR HMO.

Section 5.03.1 Enrollment for infants born to pregnant women in STAR+PLUS.
If a newborn is born to a Medicaid-eligible mother enrolled in a STAR+PLUS HMO, the HHSC Administrative Service Contractor will enroll the newborn into that HMO's STAR HMO product, if one exists. All rules related to STAR newborn enrollment will apply to the newborn. If the STAR+PLUS HMO does not have a STAR product but the newborn is eligible for STAR, the newborn will be enrolled in traditional Fee-for-Service Medicaid, and given the opportunity to select a STAR HMO.

Section 5.04 ***CHIP eligibility and enrollment.***
(a) Term of coverage. The Administrative Services Contractor determines CHIP eligibility on behalf of HHSC. The Administrative Services Contractor will enroll and disenroll eligible individuals into and out of CHIP. CHIP Members with an Effective Date of Coverage on or after September 1, 2007 will have twelve (12) months of coverage. CHIP Members with an Effective Date of Coverage prior to September 1, 2007 will be required to re-enroll in the CHIP Program at the end of their six month coverage period, at which point they will have a new Effective Date of Coverage and twelve (12) months of coverage.

(b) Pregnant Members and Infants.

(1) If notified of a CHIP Member's pregnancy prior to birth, the HHSC Administrative Contractor will refer pregnant CHIP Member to Medicaid for eligibility determination (with the exception of Legal Permanent Residents and other legally qualified aliens barred from Medicaid due to federal eligibility restrictions). Those CHIP Members who are determined to be Medicaid Eligible will be disenrolled from HMO's CHIP plan. Medicaid coverage will be coordinated to begin after CHIP eligibility ends to avoid gaps in health care coverage.

(2) A pregnant CHIP Member's facility and professional costs associated with the delivery will be covered by CHIP in accordance with Attachment B-2, "CHIP Covered Services." This includes the post-delivery costs for the newborn's care while in the facility , as described in Attachment B-2, "CHIP Covered Services." The HHSC Adminstrative Services Contractor will set the pregnant CHIP Member's eligibilty expiration date at the later of (1) the end of the second month following the month of the pregnancy termination or the baby's birth or (2) the Member's original eligibility expiration date. The Administrative Services Contractor will screen the newborn's eligibility for Medicaid, and then CHIP (if the newborn is not eligible for Medicaid). If the newborn is eligible for CHIP, the Adminstrative Services Contractor will enroll the newborn in the mother's CHIP plan prospectively, following standard cut-off rules. The newborn's CHIP eligibility ends when the mother's CHIP eligibility expires, as described above.

Section 5.04.1 ***CHIP Perinatal eligibility, enrollment, and disenrollment***

(a) The HHSC Administrative Contractor will electronically transmit to the HMO new CHIP Perinate Member information based on the appropriate CHIP Perinate or CHIP Perinate Newborn Rate Cell. There is no waiting period for CHIP Perinatal Program Members.

(b) A CHIP Perinate born on or after September 1, 2010, and who lives in a family with an income at or below 185% of the FPL will be deemed eligible for 12 months of continuous Medicaid coverage (beginning on the date of birth). A CHIP Perinate will continue to receive coverage through the CHIP Perinatal Program as a "CHIP Perinate Newborn" if: (1) born before September 1, 2010, and (2) if born on or after September 1, 2010, to a family with an income above 185% to 200% FPL. A CHIP Perinate Newborn is eligible for 12 months continuous enrollment, beginning with the month of enrollment as a CHIP Perinate (month of enrollment plus 11 months). A CHIP Perinate Newborn will maintain coverage in his or her CHIP Perinatal health plan.

(c) If only one CHIP Perinatal HMO operates in a Service Area, HHSC will automatically enroll a prospective member in that CHIP Perinatal HMO. If multiple CHIP Perinatal HMOs offer coverage in the Service Area, HHSC will send an enrollment packet to the prospective Member's household. If the household of a prospective member does not make a selection within 15 calendar days, the HHSC Administrative Services Contractor will notify the household that the prospective member has been assigned to a CHIP Perinatal HMO ("Default Enrollment"). When this occurs the household has 90 calendar days to select another CHIP Perinatal HMO for the Member.

(d) HHSC's Administrative Services Contractor will assign prospective members to CHIP Perinatal HMOs in a Service Area in a rotational basis. Should HHSC implement one or more administrative rules governing the Default Enrollment processes, such administrative rules will take precedence over the Default Enrollment process set forth herein.

(e) When a member of a household enrolls in the CHIP Perinatal Program, all traditional CHIP members in the household will be disenrolled from their current health plans and prospectively enrolled in the CHIP Perinatal Program Member's health plan. All members of the household must remain in the same health plan until the later of (1) the end of the CHIP Perinatal Program Member's enrollment period, or (2) the end of the traditional CHIP members' enrollment period.

(f) In the 10th month of the CHIP Perinate Newborn's coverage, the family will receive a CHIP renewal form. The family must complete and submit the renewal form, which will be pre-populated to include the CHIP Perinate Newborn's and the CHIP Program Members' information. Once the child's CHIP Perinatal Program coverage expires, the child will be added to his or her siblings' existing CHIP program case.

Section 5.05 ***Span of Coverage***

(a) Medicaid HMOs.

(1) Open Enrollment.

HHSC will conduct continuous open enrollment for Medicaid Eligibles and the HMO must accept all persons who choose to enroll as Members in the HMO or who are assigned as Members in the HMO by HHSC, without regard to the Member's health status or any other factor.

(2) Enrollment of New Medicaid Eligibles.

Persons who become eligible for Medicaid during an Inpatient Stay in a Hospital will not be enrolled in a Medicaid HMO until discharged from the Hospital, with the following exceptions: (1) Members retroactively enrolled in STAR in accordance with Section 5.03, "STAR Enrollment of Pregnant Women and Infants," and (2) Members prospectively enrolled in STAR or STAR+PLUS who are at or below 12 months of age. Except as provided in the following table, if a Member is enrolled in a Medicaid HMO during an Inpatient Stay, the Medicaid HMO will be responsible for all Covered Services beginning on the Effective Date of Coverage. If a Member is enrolled during an Inpatient Stay under either of the above-referenced exceptions, responsibility for the Inpatient Stay services is assigned as follows:

Responsibility for Inpatient Stay Services		
Exception	Hospital Facility Charges	Professional Services Charges
Member Retroactively Enrolled in STAR per Section 5.03	STAR HMO	STAR HMO
Member ≤ 12 Months of Age Who Is Prospectively Enrolled in STAR	Medicaid FFS*	STAR HMO
Member ≤ 12 Months of Age Who Is Prospectively Enrolled in STAR+PLUS	STAR+PLUS HMO for Inpatient Mental Health Covered Services Medicaid FFS for all Other Inpatient Facility Services*	STAR+PLUS HMO

*These services are Non-Capitated Services.

(3) Movement between STAR or STAR+PLUS HMOs.

Except as provided in Section 5.05(a)(8), a Member cannot change from a STAR or STAR+PLUS HMO to a different STAR or STAR+PLUS HMO during an Inpatient Stay in a Hospital.

(4) Movement from a Medicaid Fee-for-Service or PCCM Program to a STAR or STAR+PLUS HMO.

A Medicaid recipient can move from the Medicaid Fee-for-Service or PCCM program into a STAR or STAR+PLUS HMO during an Inpatient Stay in a Hospital. Except as provided in subpart (a)(2), responsibility for claims incurred during the Inpatient Stay will be divided as follows: (1) the Medicaid Fee-for-Service program will continue to pay allowable Hospital facility charges until the earlier of the date of Discharge or loss of Medicaid eligibility; and (2) beginning on the Effective Date of Coverage, the STAR or STAR+PLUS HMO will pay for all other Covered Services.

(5) Movement from a STAR HMO to the STAR Health MCO.

A Medicaid recipient can move from the STAR Program into the STAR Health Program during an Inpatient Stay. In such cases, responsibility for claims incurred during the Inpatient stay will be divided as follows: (1) the STAR HMO will continue to pay Hospital facility charges for Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (2) beginning on the Effective Date of Coverage, the STAR Health MCO will pay for all other Covered Services.

(6) Movement from a STAR+PLUS HMO to the STAR Health MCO.

A Medicaid recipient can move from the STAR+PLUS program into the STAR Health Program during an Inpatient Stay. In such cases, responsibility for claims incurred during the Inpatient stay will be divided as follows: (1) the STAR+PLUS HMO will continue to pay Hospital facility charges for Behavioral Health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, (2) and the Medicaid FFS program will continue to pay Hospital facility charges for non-Behavioral Health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (3) beginning on the Effective Date of Coverage, the STAR Health MCO will pay for all other Covered Services.

(7) Movement from STAR+PLUS to Medicaid Fee-for-Service.

A Medicaid recipient can move from the STAR+PLUS program to FFS (if a child) during an Inpatient Stay. In such cases, responsibility for claims incurred during the Inpatient Stay will be divided as follows: (1) the STAR+PLUS HMO will continue to pay Hospital facility charges for inpatient mental health Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (2) beginning on the effective date of FFS coverage, FFS will pay for all other covered services.

(8) Movement from STAR to STAR+PLUS or Medicaid Fee-for-Service due to SSI Status.

When a STAR member becomes qualified for SSI, HHSC will allow the STAR member to move to FFS (if a child) or STAR+PLUS (if a child or adult) as set forth in Section 5.05(d). If a move occurs during an Inpatient Stay, responsibility for claims incurred during the Inpatient Stay will be divided as follows: (1) the STAR HMO will continue to pay Hospital facility charges for Covered Services until the earlier of the date of Discharge or loss of Medicaid eligibility, and (2) beginning on the Effective Date of Coverage for STAR+PLUS or the effective date of FFS coverage, the new entity will pay for all other Covered Services.

(9) Responsibility for Costs Incurred After Loss of Medicaid Eligibility.

Medicaid HMOs are not responsible for services incurred on or after the effective date of loss of Medicaid eligibility.

(10) Reenrollment after Temporary Loss of Medicaid Eligibility.

Members who are disenrolled because they are temporarily ineligible for Medicaid will be automatically re-enrolled into the same health plan, if available. Temporary loss of eligibility is defined as a period of six months or less.

(b) **CHIP HMOs.**

If a CHIP Member's Effective Date of Coverage occurs while the CHIP Member is confined in a hospital, HMO is responsible for the CHIP Member's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Member is disenrolled while the CHIP Member is confined in a hospital, HMO's responsibility for the CHIP Member's costs of Covered Services terminates on the Date of Disenrollment.

(c) CHIP Perinatal HMOs.

If a CHIP Perinate's Effective Date of Coverage occurs while the CHIP Perinate is confined in a Hospital, HMO is responsible for the CHIP Perinate's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Perinate is disenrolled while confined in a Hospital, the HMO's responsibility for the CHIP Perinate's costs of Covered Services terminates on the Date of Disenrollment. If a CHIP Perinate Newborn is disenrolled while confined in a Hospital, the HMO's responsibility for the CHIP Perinate Newborn's costs of Covered Services terminates on the Date of Disenrollment.

(d) Effective Date of SSI Status.

In accordance with Section 10.10, SSI status is effective on the date the State's eligibility system identifies a STAR, CHIP, or CHIP Perinatal Program Member as Type Program 13 (TP 13). HHSC is responsible for updating the State's eligibility system within 45 days of official notice of the Member's Federal SSI status by the Social Security Administration (SSA). Once HHSC has updated the State's eligibility system to identify the STAR, CHIP, or CHIP Perinatal Program Member as TP13, following standard eligibility cut-off rules, HHSC will allow the Member to:

(1) prospectively move to Medicaid FFS (if the Member is a child in any part of the State, or an adult in a Service Area not covered by STAR+PLUS);

(2) prospectively move to STAR+PLUS (if the Member is a child or adult in a STAR+PLUS Service Area); or

(3) remain in STAR (if the Member is a child who is already enrolled in STAR in the El Paso or Lubbock Service Areas).

HHSC will not retroactively disenroll a Member from the STAR, CHIP, or CHIP Perinatal Programs.

Section 5.06 ***Verification of Member Eligibility.***
Medicaid MCOs are prohibited from entering into an agreement to share information regarding their Members with an external vendor that provides verification of Medicaid recipients' eligibility to Medicaid providers. All such external vendors must contract with the State and obtain eligibility information from the State.

Section 5.07 ***Special Temporary STAR Default Process***

(a) STAR HMOs that did not contract with HHSC prior to the Effective Date of the Contract to provide Medicaid Health Care Services will be assigned a limited number of Medicaid-eligibles, who have not actively made a STAR HMO choice, for a finite period. The number will vary by Service Area as set forth below. To the extent possible, the special default assignment will be based on each eligible's prior history with a PCP and geographic proximity to a PCP.

(b) For the Bexar, Dallas, El Paso, Harris, Tarrant, and Travis Service Areas, the special default process will begin with the Operational Start Date and conclude when the HMO has achieved an enrollment of 15,000 mandatory STAR members, or at the end of six months, whichever comes first.

(c) For the Lubbock Service Area, the special default process will begin with the Operational Start Date and conclude when the HMO has achieved an enrollment of 5,000 mandatory STAR members, or at the end of six months, whichever comes first.

(d) Special default periods may be extended for one or more Service Areas if consistent with HHSC administrative rules.

(e) This Section does not apply to the Nueces Service Area.

Section 5.07.1 ***Special Temporary STAR Default Process – Rate Period 3***

In the Bexar, Dallas, Harris, Harris Expansion, Lubbock, and Tarrant STAR Service Areas, HHSC will implement a temporary default assignment for enrollees who have not actively made an HMO choice. HHSC will assign these enrollees equally among all HMOs in a Program Service Area. This temporary default process will be effective for monthly enrollments from October 2008 to March 2009, after which time HHSC will reinstate the standard enrollment process based on HMO elective choice percentages.

Section 5.08 *Special Temporary STAR+PLUS Default Process*

(a) STAR+PLUS HMOs that did not contract with HHSC to provide STAR+PLUS services in Harris County prior to the Effective Date of the Contract will be assigned a limited number of STAR+PLUS Medicaid-eligibles in Harris County, who have not actively made a STAR+PLUS HMO choice, for a finite period. To the extent possible, the special default assignment will be based on each eligible's prior history with a PCP and geographic proximity to a PCP.

(b) For the Harris Service Area, the special default process will begin on the Operational Start Date. All defaults for Harris County will be awarded to the new HMO during the special default process. The special default process will conclude at the end of the first 6-month period following the Operational Start Date, or when the HMO has achieved a total enrollment of 8,000 STAR+PLUS Members for the entire Harris Service Area (includes Harris and Harris Contiguous counties), whichever comes first.

(c) The special default process will apply to Harris County only. The Harris Contiguous counties will follow the standard default process.

(d) This Section does not apply to the Bexar, Nueces or Travis Service Areas for STAR+PLUS.

Section 5.08.1 ***Special Temporary STAR+PLUS Default Process – Rate Period 3***

In the Harris STAR+PLUS Service Area, HHSC will implement a temporary default assignment for enrollees who have not actively made an HMO choice. HHSC will assign these enrollees equally among all HMOs in a Program Service Area. This temporary default process will be effective for monthly enrollments from October 2008 to March 2009, after which time HHSC will reinstate the standard enrollment process based on HMO elective choice percentages.

Section 5.09 ***Default Methodology for Frew Incentives***
As required by the "Frew vs. Suehs Corrective Action Order: Managed Care," this Contract includes a system of incentives and disincentives associated with the Medicaid Managed Care Texas Health Steps Medical Checkups Reports. The default assignment methodology associated with these reports, and corresponding incentives and disincentives for Medicaid HMOs will be included in the **Uniform Managed Care Manual**.

Article 6. Service Levels & Performance Measurement

Section 6.01 ***Performance measurement.***
Satisfactory performance of this Contract will be measured by:

(a) Adherence to this Contract, including all representations and warranties;

(b) Delivery of the Services and Deliverables described in Attachment B;

(c) Results of audits performed by HHSC or its representatives in accordance with **Article 9** ("Audit and Financial Compliance");

(d) Timeliness, completeness, and accuracy of required reports; and

(e) Achievement of performance measures developed by HMO and HHSC and as modified from time to time by written agreement during the term of this Contract.

Article 7. Governing Law & Regulations

Section 7.01 ***Governing law and venue.***
This Contract is governed by the laws of the State of Texas and interpreted in accordance with Texas law. Provided HMO first complies with the procedures set forth in **Section 12.13 (**"Dispute Resolution,") proper venue for claims arising from this Contract will be in the State District Court of Travis County, Texas.

Section 7.02 ***HMO responsibility for compliance with laws and regulations.***

(a) HMO must comply, to the satisfaction of HHSC, with all provisions set forth in this Contract, all applicable provisions of state and federal laws, rules, regulations, federal waivers, policies and guidelines, and any court-ordered consent decrees, settlement agreements, or other court orders that govern the performance of the Scope of Work including, but not limited to:

(1) Titles XIX and XXI of the Social Security Act;
(2) Chapters 62 and 63, Texas Health and Safety Code;
(3) Chapters 531 and 533, Texas Government Code;
(4) 42 C.F.R. Parts 417 and 457, as applicable;
(5) 45 C.F.R. Parts 74 and 92;
(6) 48 C.F.R. Part 31, or OMB Circular A-122, based on whether the entity is for-profit or nonprofit;
(7) 1 T.A.C. Part 15, Chapters 361, 370, 371, 391, and 392;
(8) Consent Decree, *Frew, et al. v. Suehs, et al.*;
(9) partial settlement agreements, *Alberto N., et al. v. Suehs, et al.*(Medicaid HMOs only); and
(10) all State and Federal tax laws, State and Federal employment laws, State and Federal regulatory requirements, and licensing provisions.

(b) The Parties acknowledge that the federal and/or state laws, rules, regulations, policies, or guidelines, and court-ordered consent decrees, settlement agreements, or other court orders that affect the performance of the Scope of Work may change from time to time or be added, judicially interpreted, or amended by competent authority. HMO acknowledges that the HMO Programs will be subject to continuous change during the term of the Contract and, except as provided in Section 8.02, HMO has provided for or will provide for adequate resources, at no additional charge to HHSC, to reasonably accommodate such changes. The Parties further acknowledge that HMO was selected, in part, because of its expertise, experience, and knowledge concerning applicable Federal and/or state laws, regulations, policies, or guidelines that affect the performance of the Scope of Work. In keeping with HHSC's reliance on this knowledge and expertise, HMO is responsible for identifying the impact of changes in applicable Federal or state legislative enactments and regulations that affect the performance of the Scope of Work or the State's use of the Services and Deliverables. HMO must timely notify HHSC of such changes and must work with HHSC to identify the impact of such changes on how the State uses the Services and Deliverables.

(c) HHSC will notify HMO of any changes in applicable law, regulation, policy, or guidelines that HHSC becomes aware of in the ordinary course of its business.

(d) HMO is responsible for any fines, penalties, or disallowances imposed on the State or HMO arising from any noncompliance with the laws and regulations relating to the delivery of the Services or Deliverables by the HMO, its Subcontractors or agents.

(e) HMO is responsible for ensuring each of its employees, agents or Subcontractors who provide Services under the Contract are properly licensed, certified, and/or have proper permits to perform any activity related to the Services.

(f) HMO warrants that the Services and Deliverables will comply with all applicable Federal, State, and County laws, regulations, codes, ordinances, guidelines, and policies. HMO will indemnify HHSC from and against any losses, liability, claims, damages, penalties, costs, fees, or expenses arising from or in connection with HMO's failure to comply with or violation of any such law, regulation, code, ordinance, or policy.

Section 7.03 ***TDI licensure/ANHC certification and solvency.***

(a) Licensure HMO must be either licensed by the TDI as an HMO or a certified ANHC in all counties for the Service Areas included within the scope of the Contract.

(b) Solvency HMO must maintain compliance with the Texas Insurance Code and rules promulgated and administered by the TDI requiring a fiscally sound operation. HMO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI.

Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of benefits, until the time of discharge, to Members who are confined on the date of insolvency in a Hospital or other inpatient facility;

(2) payment to unaffiliated health care providers and affiliated health care providers whose agreements do not contain member "hold harmless" clauses acceptable to TDI, and

(3) continuation of benefits for the duration of the Contract period for which HHSC has paid a Capitation Payment.

Provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI.

Section 7.04 ***Immigration Reform and Control Act of 1986.***
HMO shall comply with the requirements of the Immigration Reform and Control Act of 1986 and the Immigration Act of 1990 (8 U.S.C. §1101, *et seq*.) regarding employment verification and retention of verification forms for any individual(s) hired on or after November 6, 1986, who will perform any labor or services under this Contract.

Section 7.05 ***Compliance with state and federal anti-discrimination laws.***

(a) HMO agrees to comply with state and federal anti-discrimination laws, including without limitation:

(1) Title VI of the Civil Rights Act of 1964 (42 U.S.C. §2000d *et seq.*);

(2) Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. §794);

(3) Americans with Disabilities Act of 1990 (42 U.S.C. §12101 *et seq.*);

(4) Age Discrimination Act of 1975 (42 U.S.C. §§6101-6107);

(5) Title IX of the Education Amendments of 1972 (20 U.S.C. §§1681-1688);

(6) Food Stamp Act of 1977 (7 U.S.C. §200 *et seq.*); and

(7) The HHS agency's administrative rules, as set forth in the Texas Administrative Code, to the extent applicable to this Agreement.

HMO agrees to comply with all amendments to the above-referenced laws, and all requirements imposed by the regulations issued pursuant to these laws. These laws provide in part that no persons in the United States may, on the grounds of race, color, national origin, sex, age, disability, political beliefs, or religion, be excluded from participation in or denied any aid, care, service or other benefits provided by Federal or State funding, or otherwise be subjected to discrimination.

(b) HMO agrees to comply with Title VI of the Civil Rights Act of 1964, and its implementing regulations at 45 C.F.R. Part 80 or 7 C.F.R. Part 15, prohibiting a contractor from adopting and implementing policies and procedures that exclude or have the effect of excluding or limiting the participation of clients in its programs, benefits, or activities on the basis of national origin. Applicable state and federal civil rights laws require contractors to provide alternative methods for ensuring access to services for applicants and recipients who cannot express themselves fluently in English. HMO agrees to ensure that its policies do not have the effect of excluding or limiting the participation of persons in its programs, benefits, and activities on the basis of national origin. HMO also agrees to take reasonable steps to provide services and information, both orally and in writing, in appropriate languages other than English, in order to ensure that persons with limited English proficiency are effectively informed and can have meaningful access to programs, benefits, and activities.

(c) HMO agrees to comply with Executive Order 13279, and its implementing regulations at 45 C.F.R. Part 87 or 7 C.F.R. Part 16. These provide in part that any organization that participates in programs funded by direct financial assistance from the United States Department of Agriculture or the United States Department of Health and Human Services shall not, in providing services, discriminate against a program beneficiary or prospective program beneficiary on the basis of religion or religious belief.

(d) Upon request, HMO will provide HHSC Civil Rights Office with copies of all of the HMO's civil rights policies and procedures.

(e) HMO must notify HHSC's Civil Rights Office of any civil rights complaints received relating to its performance under this Agreement. This notice must be delivered no more than ten (10) calendar days after receipt of a complaint. Notice provided pursuant to this section must be directed to:

HHSC Civil Rights Office
701 W. 51 Street, Mail Code W206
Austin, Texas 78751
Phone Toll Free: (888) 388-6332
Phone: (512) 438-4313
TTY Toll Free: (877) 432-7232
Fax: (512) 438-5885.

Section 7.06 ***Environmental protection laws.***
HMO shall comply with the applicable provisions of federal environmental protection laws as described in this Section:

(a) Pro-Children Act of 1994. HMO shall comply with the Pro-Children Act of 1994 (20 U.S.C. §6081 *et seq.*), as applicable, regarding the provision of a smoke-free workplace and promoting the non-use of all tobacco products.

(b) National Environmental Policy Act of 1969. HMO shall comply with any applicable provisions relating to the institution of environmental quality control measures contained in the National Environmental Policy Act of 1969 (42 U.S.C. §4321 *et seq.*) and Executive Order 11514 ("Protection and Enhancement of Environmental Quality").

(c) Clean Air Act and Water Pollution Control Act regulations.

HMO shall comply with any applicable provisions relating to required notification of facilities violating the requirements of Executive Order 11738 ("Providing for Administration of the Clean Air Act and the Federal Water Pollution Control Act with Respect to Federal Contracts, Grants, or Loans").

(d) State Clean Air Implementation Plan. HMO shall comply with any applicable provisions requiring conformity of federal actions to State (Clean Air) Implementation Plans under §176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §740 *et seq.*).

(e) Safe Drinking Water Act of 1974. HMO shall comply with applicable provisions relating to the protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (21 U.S.C. § 349; 42 U.S.C. §§ 300f to 300j-9).

Section 7.07 ***HIPAA.***

(a) HMO shall comply with applicable provisions of HIPAA. This includes, but is not limited to, the requirement that the HMO's MIS system comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to HIPAA. HMO must comply with HIPAA EDI requirements.

(b) Additionally, HMO must comply with HIPAA notification requirements, including those set forth in the Health Information Technology for Economic and Clinical Health Act (HITECH Act) at 42 U.S.C. 17931 *et.seq*. HMO must notify HHSC of all breaches or potential breaches of unsecured protected health information, as defined by the HITECH Act, without unreasonable delay and in no event later than 60 calendar days after discovery of the breach or potential breach. If, in HHSC's determination, HMO has not provided notice in the manner or format prescribed by the HITECH Act, then HHSC may require the HMO to provide such notice.

Section 7.08 ***Historically Underutilized Business Participation Requirements*** (a) Definitions.

For purposes of this Section:

(1) **"Historically Underutilized Business"** or **"HUB"** means a minority or women-owned business as defined by Texas Government Code, Chapter 2161.

(2) **"HSP"** means a HUB Subcontracting Plan.

(b) HUB Requirements.

(1) In accordance with Attachment B-1, Section 8.1.17.2, the HMO must submit an HSP for HHSC's approval during the Transition Phase, and maintain the HSP thereafter.

(2) HMO must report to HHSC's contract manager and HUB Office monthly, in the format required by Chapter 5.4.4.3 of the Uniform Managed Care Manual, its use of HUB subcontractors to fulfill the subcontracting opportunities identified in the HSP.

(3) HMO must obtain prior written approval from the HHSC HUB Office before making any changes to the HSP. The proposed changes must comply with HHSC's good faith effort requirements relating to the development and submission of HSPs.

(i) The HMO must submit a revised HSP to the HHSC HUB Office when it: changes the dollar amount of, terminates, or modifies an existing Subcontract for MCO Administrative Services; or enters into a new Subcontract for MCO Administrative Services. All proposed changes to the HSP must comply with the requirements of this Agreement**.**

(4) HHSC will determine if the value of Subcontracts to HUBs meet or exceed the HUB subcontracting provisions specified in the HMO's HSP. If HHSC determines that the HMO's subcontracting activity does not demonstrate a good faith effort, the HMO may be subject to provisions in the Vendor Performance and Debarment Program (Title 34, Part 1, Chapter 20, Subchapter C, Rule §20.105), and subject to remedies for Breach.

Article 8. Amendments & Modifications

Section 8.01 ***Mutual agreement.***
This Contract may be amended at any time by mutual agreement of the Parties. The amendment must be in writing and signed by individuals with authority to bind the Parties.

Section 8.02 ***Changes in law or contract.***
If Federal or State laws, rules, regulations, policies or guidelines are adopted, promulgated, judicially interpreted or changed, or if contracts are entered or changed, the effect of which is to alter the ability of either Party to fulfill its obligations under this Contract, the Parties will promptly negotiate in good faith appropriate modifications or alterations to the Contract and any schedule(s) or attachment(s) made a part of this Contract. Such modifications or alterations must be in writing and signed by individuals with authority to bind the parties, equitably adjust the terms and conditions of this Contract, and must be limited to those provisions of this Contract affected by the change.

Section 8.03 ***Modifications as a remedy.***
This Contract may be modified under the terms of **Article 12** ("Remedies and Disputes").

Section 8.04 ***Modifications upon renewal or extension of Contract.***

(a) If HHSC seeks modifications to the Contract as a condition of any Contract extension, HHSC's notice to HMO will specify those modifications to the Scope of Work, the Contract pricing terms, or other Contract terms and conditions.

(b) HMO must respond to HHSC's proposed modification within the timeframe specified by HHSC, generally within thirty (30) days of receipt. Upon receipt of HMO's response to the proposed modifications, HHSC may enter into negotiations with HMO to arrive at mutually agreeable Contract amendments. In the event that HHSC determines that the Parties will be unable to reach agreement on mutually satisfactory contract modifications, then HHSC will provide written notice to HMO of its intent not to extend the Contract beyond the Contract Term then in effect.

Section 8.05 ***Modification of HHSC Uniform Managed Care Manual.***

(a) HHSC will provide HMO with at least thirty (30) days advance written notice before implementing a substantive and material change in the HHSC Uniform Managed Care Manual (a change that materially and substantively alters the HMO's ability to fulfill its obligations under the Contract). The Uniform Managed Care Manual, and all modifications thereto made during the Contract Term, are incorporated by reference into this Contract. HHSC will provide HMO with a reasonable amount of time to comment on such changes, generally at least ten (10) Business Days. HHSC is not required to provide advance written notice of changes that are not material and substantive in nature, such as corrections of clerical errors or policy clarifications.

(b) The Parties agree to work in good faith to resolve disagreements concerning material and substantive changes to the HHSC Uniform Managed Care Manual. If the Parties are unable to resolve issues relating to material and substantive changes, then either Party may terminate the agreement in accordance with **Article 12** ("Remedies and Disputes").

(c) Changes will be effective on the date specified in HHSC's written notice, which will not be earlier than the HMO's response deadline, and such changes will be incorporated into the HHSC Uniform Managed Care Manual. If the HMO has raised an objection to a material and substantive change to the HHSC Uniform Managed Care Manual and submitted a notice of termination in accordance with **Section 12.04(d),** HHSC will not enforce the policy change during the period of time between the receipt of the notice and the date of Contract termination.

Section 8.06 ***CMS approval of Medicaid amendments***
The implementation of amendments, modifications, and changes to HMO contracts is subject to the approval of the Centers for Medicare and Medicaid Services ("CMS.")

Section 8.07 ***Required compliance with amendment and modification procedures.***

No different or additional services, work, or products will be authorized or performed except as authorized by this Article. No waiver of any term, covenant, or condition of this Contract will be valid unless executed in compliance with this Article. HMO will not be entitled to payment for any services, work or products that are not authorized by a properly executed Contract amendment or modification.

Article 9. Audit & Financial Compliance

Section 9.01 ***Financial record retention and audit.***

HMO agrees to maintain, and require its Subcontractors to maintain, records, books, documents, and information (collectively "records") that are adequate to ensure that services are provided and payments are made in accordance with the requirements of this Contract, including applicable Federal and State requirements (e.g., 45 CFR §74.53). Such records must be retained by HMO or its Subcontractors for a period of five (5) years after the Contract Expiration Date or until the resolution of all litigation, claim, financial management review or audit pertaining to this Contract, whichever is longer.

Section 9.02 ***Access to records, books, and documents.***

(a) Upon reasonable notice, HMO must provide, and cause its Subcontractors to provide, the officials and entities identified in this Section with prompt, reasonable, and adequate access to any records, books, documents, and papers that are related to the performance of the Scope of Work.

(b) HMO and its Subcontractors must provide the access described in this Section upon HHSC's request. This request may be for, but is not limited to, the following purposes:

(1) Examination;

(2) Audit;

(3) Investigation;

(4) Contract administration; or

(5) The making of copies, excerpts, or transcripts.

(c) The access required must be provided to the following officials and/or entities:

(1) The United States Department of Health and Human Services or its designee;

(2) The Comptroller General of the United States or its designee;

(3) HMO Program personnel from HHSC or its designee;

(4) The Office of Inspector General;

(5) The Medicaid Fraud Control Unit of the Texas Attorney General's Office or its designee;

(6) Any independent verification and validation contractor or quality assurance contractor acting on behalf of HHSC;

(7) The Office of the State Auditor of Texas or its designee;

(8) A State or Federal law enforcement agency;

(9) A special or general investigating committee of the Texas Legislature or its designee; and

(10) Any other state or federal entity identified by HHSC, or any other entity engaged by HHSC.

(d) HMO agrees to provide the access described wherever HMO maintains such books, records, and supporting documentation. HMO further agrees to provide such access in reasonable comfort and to provide any furnishings, equipment, and other conveniences deemed reasonably necessary to fulfill the purposes described in this Section. HMO will require its Subcontractors to provide comparable access and accommodations.

Section 9.03 ***Audits of Services, Deliverables and inspections.***

(a) Upon reasonable notice from HHSC, HMO will provide, and will cause its Subcontractors to provide, such auditors and inspectors as HHSC may from time to time designate, with access to:

(1) HMO service locations, facilities, or installations; and

(2) HMO Software and Equipment.

(b) The access described in this Section will be for the purpose of examining, auditing, or investigating:

(1) HMO's capacity to bear the risk of potential financial losses;

(2) the Services and Deliverables provided;

(3) a determination of the amounts payable under this Contract;

(4) detection of fraud, waste and/or abuse; or

(5) other purposes HHSC deems necessary to perform its regulatory function and/or enforce the provisions of this Contract.

(c) HMO must provide, as part of the Scope of Work, any assistance that such auditors and inspectors reasonably may require to complete such audits or inspections.

(d) If, as a result of an audit or review of payments made to the HMO, HHSC discovers a payment error or overcharge, HHSC will notify the HMO of such error or overcharge. HHSC will be entitled to recover such funds as an offset to future payments to the HMO, or to collect such funds directly from the HMO. HMO must return funds owed to HHSC within thirty (30) days after receiving notice of the error or overcharge, or interest will accrue on the amount due. HHSC will calculate interest at the Department of Treasury's Median Rate (resulting from the Treasury's auction of 13-week bills) for the week in which liability is assessed. In the event that an audit reveals that errors in reporting by the HMO have resulted in errors in payments to the HMO or errors in the calculation of the Experience Rebate, the HMO will indemnify HHSC for any losses resulting from such errors, including the cost of audit.

Section 9.04 ***SAO Audit***

The HMO understands that acceptance of funds under this Contract acts as acceptance of the authority of the State Auditor's Office ("SAO"), or any successor agency, to conduct an investigation in connection with those funds. The HMO further agrees to cooperate fully with the SAO or its successor in the conduct of the audit or investigation, including providing all records requested. The HMO will ensure that this clause concerning the authority to audit funds received indirectly by Subcontractors through HMO and the requirement to cooperate is included in any Subcontract it awards, and in any third party agreements described in **Section 4.10 (a-b)**.

Section 9.05 ***Response/compliance with audit or inspection findings.***

(a) HMO must take action to ensure its or a Subcontractor's compliance with or correction of any finding of noncompliance with any law, regulation, audit requirement, or generally accepted accounting principle relating to the Services and Deliverables or any other deficiency contained in any audit, review, or inspection conducted under this Article. This action will include HMO'S delivery to HHSC, for HHSC'S approval, a Corrective Action Plan that addresses deficiencies identified in any audit(s), review(s), or inspection(s) within thirty (30) calendar days of the close of the audit(s), review(s), or inspection(s).

(b) HMO must bear the expense of compliance with any finding of noncompliance under this Section that is:

(1) Required by Texas or Federal law, regulation, rule or other audit requirement relating to HMO's business;

(2) Performed by HMO as part of the Services or Deliverables; or

(3) Necessary due to HMO's noncompliance with any law, regulation, rule or audit requirement imposed on HMO.

(c) As part of the Scope of Work, HMO must provide to HHSC upon request a copy of those portions of HMO's and its Subcontractors' internal audit reports relating to the Services and Deliverables provided to HHSC under the Contract.

Section 9.06 ***Notification of Legal and Other Proceedings, and Related Events.***

The HMO must notify HHSC of all proceedings, actions, and events as specified in the Uniform Managed Care Manual, Chapter 5.8, "Report of Legal and Other Proceedings, and Related Events."

Article 10. Terms & Conditions of Payment

Section 10.01 ***Calculation of monthly Capitation Payment.***

(a) This is a Risk-based contract. For each applicable HMO Program, HHSC will pay the HMO fixed monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Members by each applicable Member Rate Cell. In consideration of the Monthly Capitation Payment(s), the HMO agrees to provide the Services and Deliverables described in this Contract.

(b) HMO will be required to provide timely financial and statistical information necessary in the Capitation Rate determination process. Encounter Data provided by HMO must conform to all HHSC requirements. Encounter Data containing noncompliant information, including, but not limited to, inaccurate client or member identification numbers, inaccurate provider identification numbers, or diagnosis or procedures codes insufficient to adequately describe the diagnosis or medical procedure performed, will not be considered in the HMO's experience for rate-setting purposes.

(c) Information or data, including complete and accurate Encounter Data, as requested by HHSC for rate-setting purposes, must be provided to HHSC: (1) within thirty (30) days of receipt of the letter from HHSC requesting the information or data; and (2) no later than March 31st of each year.

(d) The fixed monthly Capitation Rate consists of the following components:

(1) an amount for Health Care Services

(2) an amount for administering the program,

(3) an amount for the HMO's Risk margin, and

(e) HMO understands and expressly assumes the risks associated with the performance of the duties and responsibilities under this Contract, including the failure, termination or suspension of funding to HHSC, delays or denials of required approvals, and cost overruns not reasonably attributable to HHSC.

Section 10.02 ***Time and Manner of Payment.***

(a) During the Contract Term and beginning after the Operational Start Date, HHSC will pay the monthly Capitation Payments by the 10th Business Day of each month.

(b) The HMO must accept Capitation Payments by direct deposit into the HMO's account.

(c) HHSC may adjust the monthly Capitation Payment to the HMO in the case of an overpayment to the HMO, for Experience Rebate amounts due and unpaid, and if money damages are assessed in accordance with **Article 12** ("Remedies and Disputes").

(d) HHSC's payment of monthly Capitation Payments is subject to availability of federal and state appropriations. If appropriations are not available to pay the full monthly Capitation Payment, HHSC may:

(1) equitably adjust Capitation Payments for all participating Contractors, and reduce scope of service requirements as appropriate in accordance with **Article 8**, or

(2) terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.03 ***Certification of Capitation Rates.***
HHSC will employ or retain a qualified actuary to certify the actuarial soundness of the Capitation Rates contained in this Contract. HHSC will also employ or retain a qualified actuary to certify all revisions or modifications to the Capitation Rates.

Section 10.04 ***Modification of Capitation Rates.***
The Parties expressly understand and agree that the agreed Capitation Rates are subject to modification in accordance with **Article 8** ("Amendments and Modifications,") if changes in state or federal laws, rules, regulations or policies affect the rates or the actuarial soundness of the rates. HHSC will provide the HMO notice of a modification to the Capitation Rates 60 days prior to the effective date of the change, unless HHSC determines that circumstances warrant a shorter notice period. If the HMO does not accept the rate change, either Party may terminate the Contract in accordance with **Article 12** ("Remedies and Disputes").

Section 10.05 ***STAR Capitation Structure.***

(a) STAR Rate Cells. STAR Capitation Rates are defined on a per Member per month basis by Rate Cells and Service Areas. STAR Rate Cells are:

(1) TANF adults;

(2) TANF children over 12 months of age;

(3) Expansion children over 12 months of age;

(4) Newborns less than or equal to 12 months of age;

(5) TANF children less than or equal to 12 months of age;

(6) Expansion children less than or equal to 12 months of age;

(7) Federal mandate children; and

(8) Pregnant women.

(b) STAR Capitation Rate development:

(1) Capitation Rates for Rate Periods 1 and 2 for Service Areas with historical STAR Program participation.

For Service Areas where HHSC operated the STAR Program prior to the Effective Date of this Contract, HHSC will develop base Capitation Rates by analyzing historical STAR Encounter Data and financial data for the Service Area. This analysis will apply to all MCOs in the Service Area, including MCOs that have no historical STAR Program participation in the Service Area. The analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. If the HMO participated in the STAR Program in the Service Area prior to the Effective Date of this Contract, HHSC may modify the Service Area base Capitation Rates using diagnosis-based risk adjusters to yield the final Capitation Rates.

(2) Capitation Rates for Rate Periods 1 and 2 for Service Areas with no historical STAR Program participation.

For Service Areas where HHSC has not operated the STAR Program prior to the Effective Date of this Contract, HHSC will establish base Capitation Rates for Rate Periods 1 and 2 by analyzing Fee-for-Service claims data for the Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(3) Capitation Rates for subsequent Rate Periods for Service Areas with no historical STAR Program participation.
For Service Areas where HHSC has not operated the STAR Program prior to the Effective Date of this Contract, HHSC will establish base Capitation Rates for the Rate Periods following Rate Period 2 by analyzing historical STAR Encounter Data and financial data for the Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information.

(c) Acuity adjustment. HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the HMO for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all HMOs in a Service Area, and is determined by combining all the experience for all HMOs in a Service Area to get an average rate for the Service Area. Value-added Services will not be included in the rate-setting process.

Section 10.05.1*STAR+PLUS Capitation Structure.*
(a) STAR+PLUS Rate Cells. STAR+PLUS Capitation Rates are defined on a per Member per month basis by Rate Cells.

STAR+PLUS Rate Cells are based on client category as follows:

(1) Medicaid Only Standard Rate

(2) Medicaid Only 1915 (c) Nursing Facility Waiver Rate

(3) Dual Eligible Standard Rate

(4) Dual Eligible 1915(c) Nursing Facility Waiver Rate

(5) Nursing Facility – Medicaid only

(6) Nursing Facility - Dual Eligible

These Rate Cells are subject to change after Rate Period 2.

(b) STAR+PLUS Capitation Rates For All Service Areas, HHSC will establish base Capitation Rates by Service Area based on fee-forservice experience in the counties included in the Service Area. For the base Capitation Rate in the Harris Service Area, the encounter data from existing STAR+PLUS plans in Harris County will be blended with the fee-for-service experience from the balance of counties in the Harris Service Area. HHSC may adjust the base Capitation Rate by the HMO's Case Mix Index to yield the final Capitation Rates. HHSC reserves the right to trend forward these rates until sufficient Encounter Data is available to base Capitation Rates on Encounter Data.

(c) Delay in Increased Capitation Level for Certain Members Receiving Waiver Services

Once a current HMO Member has been certified to receive STAR+PLUS Waiver (SPW) services, there is a two-month delay before the HMO will begin receiving the higher capitation payment.

Non-Waiver Members who qualify for STAR+PLUS based on eligibility for SPW services and Waiver recipients who transfer from another region will not be subject to this two-month delay in the increased capitation payment. All SPW recipients will be registered into Service Authorization System Online (SASO). The Premium Payment System (PPS) will process data from the SASO system in establishing a Member's correct capitation payment.

Section 10.06 ***CHIP Capitation Rates Structure.***

(a) CHIP Rate Cells. CHIP Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to a Service Area. CHIP Rate Cells are based on the Member's age group as follows:

(1) under age one (1);

(2) ages one (1) through five (5);

(3) ages six (6) through fourteen (14); and

(4) ages fifteen (15) through eighteen (18).

(b) CHIP Capitation Rate development: HHSC will establish base Capitation Rates by analyzing Encounter Data and financial data for each Service Area. This analysis will include a review of historical enrollment and claims experience information; any changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the Service Area base Capitation Rate using diagnosis based risk adjusters to yield the final Capitation Rates.

(c) Acuity adjustment. HHSC may evaluate and implement an acuity adjustment methodology, or alternative reasonable methodology, that appropriately reimburses the HMO for acuity and cost differences that deviate from that of the community average, if HHSC in its sole discretion determines that such a methodology is reasonable and appropriate. The community average is a uniform rate for all HMOs in a Service Area, and is determined by combining all the experience for all HMOs in a Service Area to get an average rate for the Service Area.

(d) Value-added Services will not be included in the rate-setting process.

Section 10.06.1 ***CHIP Perinatal Program Capitation Structure.***

(a) CHIP Perinatal Program Rate Cells.

CHIP Perinatal Capitation Rates are defined on a per Member per month basis by the Rate Cells applicable to a Service Area. CHIP Perinatal Rate Cells are based on the Member's birth status and household income as follows:

(1) CHIP Perinate 0% to 185% of FPL;

(2) CHIP Perinate Above 185% to 200% of FPL;

(3) CHIP Perinate Newborn 0% to 185% of FPL (born before September 1, 2010); and

(4) CHIP Perinate Newborn Above 185% to 200% of FPL.

(b) CHIP Perinatal Program Capitation Rate Development

(1) Until such time as adequate encounter data is available to set rates, CHIP Perinatal Program capitation rates will be established based on experience from comparable populations in the Medicaid Fee-for-Service and STAR programs. This analysis will include: a review of historical enrollment and claims experience information; changes to Covered Services and covered populations; rate changes specified by the Texas Legislature; and any other relevant information. HHSC may modify the Service Area based Capitation Rate using diagnosis-based risk adjusters to yield the final Capitation Rates.

(2) Effective 4/1/07, on a prospective basis, the monthly Capitation Rate for CHIP Perinate Members at or below 185% of the Federal Poverty Level (FPL)has been increased. All physicians involved in a labor with delivery for CHIP Perinate Members at or below 185% FPL will share in the increase. For services provided on or after April 1, 2007 to CHIP Perinate Members, the HMO must increase its fee schedule in effect on March 31, 2007 by at least 26.1% for the procedure codes related to labor with delivery. The HMO's Chief Executive Officer will attest that the HMO has appropriately increased physician fees as required above. HHSC will perform sample audits to verify payments to physicians are in accordance with this Contract requirement.

(c) Value-added Services will not be included in the rate-setting process.

Section 10.07 ***HMO input during rate setting process.***

(1) In Service Areas with historical STAR or CHIP Program participation, HMO must provide certified Encounter Data and financial data as prescribed in **HHSC's Uniform Managed Care Manual**. Such information may include, without limitation: claims lag information by Rate Cell, capitation expenses, and stop loss reinsurance expenses. HHSC may request clarification or for additional financial information from the HMO. HHSC will notify the HMO of the deadline for submitting a response, which will include a reasonable amount of time for response.

(2) HHSC will allow the HMO to review and comment on data used by HHSC to determine base Capitation Rates. In Service Areas with no historical STAR Program participation, this will include Fee-for-Service data for Rate Periods 1 and 2. HHSC will notify the HMO of deadline for submitting comments, which will include a reasonable amount of time for response. HHSC will not consider comments received after the deadline in its rate analysis.

(3) During the rate setting process, HHSC will conduct at least two (2) meetings with the HMO. HHSC may conduct the meetings in person, via teleconference, or by another method deemed appropriate by HHSC. Prior to the first meeting, HHSC will provide the HMO with proposed Capitation Rates. During the first meeting, HHSC will describe the process used to generate the proposed Capitation Rates, discuss major changes in the rate setting process, and receive input from the HMO. HHSC will notify the HMO of the deadline for submitting comments, which will include a reasonable amount of time to review and comment on the proposed Capitation Rates and rate setting process. After reviewing such comments, HHSC will conduct a second meeting to discuss the final Capitation Rates and changes resulting from HMO comments, if any.

Section 10.08 ***Adjustments to Capitation Payments.***

(a) Recoupment.

HHSC may recoup a payment made to the HMO for a Member if:

(1) the Member is enrolled into the HMO in error;

(2) the Member moves outside the United States;

(3) the Member dies before the first day of the month for which the payment was made

(4) a Medicaid Member's eligibility status or program type is changed, corrected as a result of error, or is retroactively adjusted; or

(5) payment is denied by the CMS in accordance with the requirements in 42 C.F.R. §438.730.

(b) Appeal of recoupment.

The HMO may appeal the recoupment or adjustment of capitations in the above circumstances using the HHSC dispute resolution process set forth in **Section 12.13**, ("Dispute Resolution").

Section 10.09 ***Delivery Supplemental Payment for CHIP, CHIP Perinatal and STAR HMOs.***

(a) The Delivery Supplemental Payment (DSP) is a function of the average delivery cost in each Service Area. Delivery costs include facility and professional charges.

(b) CHIP and STAR HMOs will receive a Delivery Supplemental Payment (DSP) from HHSC for each live or stillbirth by a Member. CHIP Perinatal HMOs will receive a DSP from HHSC for each live or stillbirth by a mother of a CHIP Perinatal Program Member in the above 185% to 200% FPL (measured at the time of enrollment in the CHIP Perinatal Program). CHIP Perinatal HMOs will not receive a DSP from HHSC for a live or stillbirth by the mother of a CHIP Perinatal Program Member in the 0% to185% FPL. For STAR, CHIP and CHIP Perinatal Program HMOs, the one-time DSP payment is made in the amount identified in the **HHSC Managed Care Contract** document regardless of whether there is a single birth or there are multiple births at time of delivery. A delivery is the birth of a live born infant, regardless of the duration of the pregnancy, or a stillborn (fetal death) infant of twenty (20) weeks or more of gestation. A delivery does not include a spontaneous or induced abortion, regardless of the duration of the pregnancy.

(c) HMO must submit a monthly DSP Report as described in **Attachment B-1, Section 8** to the **HHSC Managed Care Contract** document, in the format prescribed in **HHSC's Uniform Managed Care Manual**.

(d) HHSC will pay the Delivery Supplemental Payment within twenty (20) Business Days after receipt of a complete and accurate report from the HMO.

(e) The HMO will not be entitled to Delivery Supplemental Payments for deliveries that are not reported to HHSC within 210 days after the date of delivery, or within thirty (30) days from the date of discharge from the hospital for the stay related to the delivery, whichever is later.

(f) HMO must maintain complete claims and adjudication disposition documentation, including paid and denied amounts for each delivery. The HMO must submit the documentation to HHSC within five (5) Business Days after receiving a request for such information from HHSC.

Section 10.10 ***Administrative Fee for SSI Members***

(a) Administrative Fee. STAR HMOs will receive a monthly fee for administering benefits to each SSI Beneficiary who voluntarily enrolls in the HMO (a "Voluntary SSI Member"), in the amount identified in the **HHSC Managed Care Contract** document. The HHSC will pay for Health Care Services for such Voluntary SSI Members under the Medicaid Fee-for-Services program. SSI Beneficiaries in all Service Areas except Nueces may voluntarily participate in the

STAR Program; however, HHSC reserves the right to discontinue such voluntary participation.

(b) Administrative services and functions.

(1) HMO must perform the same administrative services and functions for Voluntary SSI Members as are performed for other Members under this contract. These administrative services and functions include, but are not limited to:

(i) prior authorization of services;

(ii) all Member services functions, including linguistic services and Member materials in alternative formats for the blind and disabled;

(iii) health education;

(iv) utilization management using HHSC Administrative Services Contractor encounter data to provide service management and appropriate interventions;

(v) quality assessment and performance improvement activities;

(vi) coordination to link Voluntary SSI Members with applicable community resources and Noncapitated services.

(2) HMO must require Network Providers to submit claims for health and health-related services to the HHSC Administrative Services Contractor for claims adjudication and payment.

(3) HMO must provide services to Voluntary SSI Members within the HMO's Network unless necessary services are unavailable within Network. HMO must also allow referrals to Out-of-Network providers if necessary services are not available within the HMO's Network. Records must be forwarded to Member's PCP following a referral visit.

(c) Members who become eligible for SSI
A Member's SSI status is effective the date the State's eligibility system identifies the Member as Type Program 13 (TP13). The State is responsible for updating the State's eligibility system within 45 days of official notice of the Member's Federal SSI eligibility by the Social Security Administration (SSA).

Section 10.11 *STAR, CHIP, and CHIP Perinatal Experience Rebate*

(a) HMO's duty to pay.

At the end of each Rate Period beginning with Rate Period 1, the HMO must pay an Experience Rebate for the STAR, CHIP, and CHIP Perinatal Programs to HHSC if the HMO's Net Income before Taxes is greater than the percentage set forth below of the total Revenue for the period. The Experience Rebate is calculated in accordance with the tiered rebate method set forth below based on the consolidated Net Income before Taxes for all of the HMO's STAR, CHIP, and CHIP Perinatal Service Areas included within the scope of the Contract, as measured by any positive amount on the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC.

(b) Graduated Experience Rebate Sharing Method.
(1) Rate Periods 1 through 3:

Pre-Tax Income as a % of Revenues	HMO Share	HHSC Share
< 3%	100%	0%
> 3% and < 7%	75%	25%
> 7% and < 10%	50%	50%
> 10% and < 15%	25%	75%
> 15%	0%	100%

For Rate Periods 1 through 3, HHSC and the HMO will share the Net Income before Taxes for the STAR, CHIP, and CHIP Perinatal Programs as follows, unless HHSC provides the HMO an Experience Rebate Reward in accordance with Section 6 of **Attachment B-1** to the **HHSC Managed Care Contract** document and **HHSC's Uniform Managed Care Manual**:

(i) The HMO will retain all Net Income before Taxes that is equal to or less than 3% of the total STAR, CHIP, and CHIP Perinatal Revenues received by the HMO.
(ii) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 3% but less than or equal to 7% of the total STAR, CHIP, and CHIP Perinatal Revenues received with 75% to the HMO and 25% to HHSC.
(iii) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 7% but less than or equal to 10% of the total STAR, CHIP, and CHIP Perinatal Revenues received with 50% to the HMO and 50% to HHSC.
(iv) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 10% but less than or equal to 15% of the total STAR, CHIP, and CHIP Perinatal Revenues received with 25% to the HMO and 75% to HHSC.
(v) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 15% of the total STAR, CHIP, and CHIP Perinatal Revenues.
(2) Rate Period 4 and thereafter:

Pre-tax Income as a % of Revenues	HMO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

For Rate Period 4 and thereafter, HHSC and the HMO will share the Net Income before Taxes for the STAR, CHIP, and CHIP Perinatal Programs as follows:
(i) The HMO will retain all the Net Income before Taxes that is equal to or less than 3% of the total STAR, CHIP, and CHIP Perinatal Revenues received by the HMO.
(ii) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 3% and less than or equal to 5% of the total STAR, CHIP, and CHIP Perinatal Revenues received, with 80% to the HMO and 20% to HHSC.
(iii) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 5% and less than or equal to 7% of the total STAR, CHIP, and CHIP Perinatal Revenues received, with 60% to the HMO and 40% to HHSC.
(iv) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 7% and less than or equal to 9% of the total STAR, CHIP, and CHIP Perinatal Revenues received, with 40% to the HMO and 60% to HHSC.
(v) HHSC and the HMO will share that portion of the Net Income before Taxes that is over 9% and less than or equal to 12% of the total STAR, CHIP, and CHIP Perinatal Revenues received, with 20% to the HMO and 80% to HHSC.
(vi) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 12% of the total STAR, CHIP, and CHIP Perinatal Revenues.
(c) Net income before taxes.
(1) The HMO must compute the Net Income before Taxes in accordance with the **HHSC Uniform Managed Care Manual's "Cost Principles for Expenses"** and **"FSR Instructions for Completion"** and applicable federal regulations. The Net Income before Taxes will be confirmed by HHSC or its agent for the Rate Year relating to all revenues and expenses incurred pursuant to the Contract. HHSC reserves the right to modify the **"Cost Principles for Expenses"** and **"FSR Instructions for Completion"** found in **HHSC's Uniform Managed Care Manual** in accordance with Section 8.05.
(2) For purposes of calculating Net Income before Taxes, the following items are not Allowable Expenses:
(i) the payment of an Experience Rebate;
(ii) any interest expense associated with late or underpayment of the Experience Rebate;
(iii) financial incentives, including without limitation the Quality Challenge Award described in Attachment B-1, Section 6.3.2.3; and
(iv) financial disincentives, including without limitation: the Performance-based Capitation Rate described in Attachment B-1, Section 6.3.2.2; and the liquidated damages described in Attachment B-5.
(3) Financial incentives are true net bonuses and shall not be reduced by the potential increased Experience Rebate payments. Financial disincentives are true net disincentives, and shall not be offset in whole or part by potential decreases in Experience Rebate payments.
(4) For FSR reporting purposes, financial incentives incurred shall not be reported as an increase in Revenues or as an offset to costs, and any award of such will not increase reported income. Financial disincentives incurred shall not be included as reported expenses, and shall not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.
(d) Carry forward of prior Rate Year losses.
Losses incurred by a STAR, CHIP, or CHIP Perinatal HMO for one Rate Year may be carried forward to the next Rate Year, and applied as an offset against STAR, CHIP, or CHIP Perinatal pre-tax net income. Prior losses may be carried forward for two contiguous Rate Years for this purpose. If the HMO offsets a loss against another STAR, CHIP, or CHIP Perinatal Service Area, only that portion of the loss that was not used as an offset may be carried forward to the next Rate Year. Losses incurred by a STAR, CHIP, CHIP Perinatal HMO cannot be offset against the STAR+PLUS Program.
In the case of a loss in a given Rate Year being carried forward and applied against profits in *both* of the next two Rate Years, the loss must first be applied against the first subsequent Rate Year such that the profit in the first subsequent Rate Year is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent Rate Year. In such case, the revised income in the third Rate Year would be equal to the cumulative income of the three contiguous periods.

(e) Settlements for payment.

(1) There may be one or more HMO payment(s) of the State share of the Experience Rebate on income generated for a given State Fiscal Year under the STAR, CHIP, and CHIP Perinatal Programs. The first scheduled payment (the "Primary Settlement") will equal 100% of the State share of the Experience Rebate as derived from the FSR, and will be paid on the same day the 90-day FSR Report is submitted to HHSC.
The "Primary Settlement," as utilized herein, refers strictly to what should be paid with the 90-day FSR, and does not refer to the first instance in which an HMO may tender a payment. For example, an HMO may submit a 90-day FSR indicating no Experience Rebate is due, but then submit a 334-day FSR with a higher income and a corresponding Experience Rebate payment. In such case, this initial payment would be subsequent to the Primary Settlement.

(2) The next scheduled payment will be an adjustment to the Primary Settlement, if required, and will be paid on the same day that the 334-day FSR Report is submitted to HHSC if the adjustment is a payment from the HMO to HHSC. Section 10.11(f) describes the interest expenses associated with any payment after the Primary Settlement.
An HMO may make non-scheduled payments at any time to reduce the accumulation of interest under Section 10.11(f). For any nonscheduled payments prior to the 334-day FSR, the MCO is not required to submit a revised FSR, but is required to submit an Experience Rebate calculation form and an adjusted summary page of the FSR. The FSR summary page is labeled "Summary Income Statements (Dollars), All Coverage Groups Combined (FSR, Part I)."

(3) HHSC or its agent may audit or review the FSRs. If HHSC determines that corrections to the FSRs are required, based on an HHSC audit/review or other documentation acceptable to HHSC, then HHSC will make final adjustments. Any payment resulting from an audit or final adjustment will be due from the HMO within 30 days of the earlier of:

(i) the date of the management representation letter resulting from the audit; or
(ii) the date of any invoice issued by HHSC.
Payment within this 30-day timeframe will not relieve the HMO of any interest payment obligation that may exist under Section 10.11(f).

(4) In the event that any Experience Rebates and/or corresponding interest payments owed to the State are not paid by the required due dates, then HHSC may offset such amounts from any future Capitation Payments, or collect such sums directly from the HMO. HHSC may adjust the Experience Rebate if HHSC determines the HMO has paid amounts for goods or services that are not reasonable, necessary, and allowable in accordance with the **HHSC**

Uniform Managed Care Manual's "Cost Principles for Expenses," the HHSC **"FSR Instructions for Completion,"** the Federal Acquisition Regulations (FAR), or other applicable federal or state regulations. HHSC has final authority in auditing and determining the amount of the Experience Rebate.

(f) Interest on Experience Rebate.

(1) Interest on *any* Experience Rebate owed to HHSC will be charged beginning 35 days after the due date of the Primary Settlement, as described in Section 10.11(e)(1). Thus, any Experience Rebate due or paid on or after the Primary Settlement will accrue interest starting at 35 days after the due date for the 90-day FSR Report. For example, any Experience Rebate payment (s) made in conjunction with the 334-day FSR, or as a result of audit findings, will accrue interest back to 35 days after the due-date for submission of the 90-day FSR.
The HMO has the option of preparing an additional FSR based on 120 days of claims run-out (a "120- day FSR"). If a 120-day FSR, and an Experience Rebate payment based on it, are received by HHSC before the interest commencement date above, then such a payment would be counted as part of the Primary Settlement.

(2) If an audit or adjustment determines a downward revision of income after an interest payment has previously been required for the same State Fiscal Year, then HHSC will recalculate the interest and, if necessary, issue a full or partial refund or credit to the HMO.

(3) Any interest obligations that are incurred pursuant to Section 10.11 that are not timely paid will be subject to accumulation of interest as well, at the same rate as applicable to the underlying Experience Rebate.

(4) All interest assessed pursuant to Section 10.11 will continue to accrue until such point as a payment is received by HHSC, at which point interest on the amount received will stop accruing. If a balance remains at that point that is subject to interest, then the balance will continue to accrue interest. If interim payments are made, then any interest that may be due will only be charged on amounts for the time period during which they remained unpaid. By way of example only, if $100,000 is subject to interest commencing on a given day, and a payment is received for $75,000 45 days after the start of interest, then the $75,000 will be subject to 45 days of interest, and the $25,000 balance will continue to accrue interest until paid. The accrual of interest as defined under Section 10.11 (f) will not stop during any period of dispute. If a dispute is resolved in the HMO's favor, then interest will only be assessed on the revised unpaid amount.

(5) If the HMO incurs an interest obligation pursuant to Section 10.11 for an Experience Rebate payment due on or after September 1, 2008, HHSC will assess such interest at 12% per annum, compounded daily. If any interest rate stipulated hereunder is found by a court of competent jurisdiction to be outside the range deemed legal and enforceable, then in such specific case the rate hereunder will be adjusted as little as possible so as to be deemed legal and enforceable.

(6) Any such interest expense incurred pursuant to Section 10.11 is not an Allowable Expense for reporting purposes on the FSR.

Section 10.11.1 ***STAR+PLUS Experience Rebate***

(a) HMO's duty to pay.
At the end of each Rate Period beginning with Rate Period 1, the HMO must pay an Experience Rebate to HHSC for the STAR+PLUS Program if the HMO's Net Income before Taxes is greater than the percentage set forth below of the total Revenue for the period in STAR+PLUS. The STAR+PLUS Experience Rebate is calculated in accordance with the tiered rebate method set forth below based on the consolidated Net Income before Taxes for all of the HMO's STAR+PLUS Service Areas included within the scope of the Contract, as measured by any positive amount on the Financial-Statistical Report (FSR) as reviewed and confirmed by HHSC.

(b) Graduated STAR+PLUS Experience Rebate Sharing Method.

(1) Rate Period 1.

Pre-tax Income as a % of Revenues	HMO Share	HHSC Share
< 3%	50%	50%
> 3%	75%	25%

For Rate Period 1, HHSC and the HMO will share the Net Income before Taxes for the STAR+PLUS Program as follows, unless HHSC provides the HMO an Experience Rebate Reward in accordance with Section 6 of **Attachment B-1** to the **HHSC Managed Care Contract** document and **HHSC's Uniform Managed Care Manual**:
(i) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is equal to or less than 3% of the total STAR+PLUS Revenues received with 50% to the HMO and 50% to HHSC.
(ii) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 3% of the total STAR+PLUS Revenues received with 75% to the HMO and 25% to HHSC.
(2) Rate Periods 2 and 3

(2) Rate Periods 2 and 3

Pre-tax Income as a % of Revenues	HMO Share	HHSC Share
≤ 2%	100%	0%
> 2% and ≤ 6%	75%	25%
> 6% and ≤ 10%	50%	50%
> 10% and ≤ 15%	25%	75%
> 15%	0%	100%

For Rate Periods 2 and 3, HHSC and the HMO will share the Net Income before Taxes for the STAR+PLUS Program as follows, unless HHSC provides the HMO an Experience Rebate Reward in accordance with Section 6 of **Attachment B-1** to the **HHSC Managed Care Contract** document and **HHSC's Uniform Managed Care Manual**:
(i) The STAR+PLUS HMO will retain all the Net Income before Taxes that is equal to or less than 2% of the total STAR+PLUS Revenues received by the HMO.
(ii) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 2% and less than or equal to 6% of the total STAR+PLUS Revenues received with 75% to the HMO and 25% to HHSC.
(iii) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 6% and less than or equal to 10% of the total STAR+PLUS Revenues received with 50% to the HMO and 50% to HHSC.
(iv) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 10% and less than or equal to 15% of the total STAR+PLUS Revenues received with 25% to the HMO and 75% to HHSC.
(v) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 15% of the total Revenues.

(3) Rate Period 4 and after.

Pre-tax Income as a % of Revenues	HMO Share	HHSC Share
≤ 3%	100%	0%
> 3% and ≤ 5%	80%	20%
> 5% and ≤ 7%	60%	40%
> 7% and ≤ 9%	40%	60%
> 9% and ≤ 12%	20%	80%
> 12%	0%	100%

For Rate Period 4 and thereafter, HHSC and the HMO will share the Net Income before Taxes for the STAR+PLUS Program as follows:
(i) The STAR+PLUS HMO will retain all the Net Income before Taxes that is equal to or less than 3% of the total STAR+PLUS Revenues received by the HMO.
(ii) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 3% and less than or equal to 5% of the total STAR+PLUS Revenues received, with 80% to the HMO and 20% to HHSC.
(iii) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 5% and less than or equal to 7% of the total STAR+PLUS Revenues received, with 60% to the HMO and 40% to HHSC.
(iv) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 7% and less than or equal to 9% of the total STAR+PLUS Revenues received, with 40% to the HMO and 60% to HHSC.
(v) HHSC and the STAR+PLUS HMO will share that portion of the Net Income before Taxes that is over 9% and less than or equal to 12% of the total STAR+PLUS Revenues received, with 20% to the HMO and 80% to HHSC.
(vi) HHSC will be paid the entire portion of the Net Income before Taxes that exceeds 12% of the total STAR+PLUS Revenues.
(c) Net income before taxes.
1) The HMO must compute the Net Income before Taxes in accordance with the **HHSC Uniform Managed Care Manual's "Cost Principles for Expenses"** and **"FSR Instructions for Completion"** and applicable federal regulations. The Net Income before Taxes will be confirmed by HHSC or its agent for the Rate Year relating to all revenues and expenses incurred pursuant to the Contract. HHSC reserves the right to modify the **"Cost Principles for Expenses"** and **"FSR Instructions for Completion"** found in **HHSC's Uniform Managed Care Manual** in accordance with Section 8.05.
(2) For purposes of calculating Net Income before Taxes, the following items are not Allowable Expenses:
(i) the payment of an Experience Rebate;
(ii) any interest expense associated with late or underpayment of the Experience Rebate;
(iii) financial incentives, including without limitation the Quality Challenge Award described in Attachment B-1, Section 6.3.2.3, and the STAR+PLUS Hospital Inpatient Incentive Shared Savings Award described in Attachment B-1, Section 6.3.2.5.2; and
(iv) financial disincentives, including without limitation: the Performance-based Capitation Rate described in Attachment B-1, Section 6.3.2.2; the STAR+PLUS Hospital Inpatient Disincentive Administrative Fee at Risk described in Attachment B-1, Section 6.3.2.5.1; and the liquidated damages described in Attachment B-5.
(3) Financial incentives are true net bonuses and shall not be reduced by the potential increased Experience Rebate payments. Financial disincentives are true net disincentives, and shall not be offset in whole or part by potential decreases in Experience Rebate payments.
(4) For FSR reporting purposes, financial incentives incurred shall not be reported as an increase in Revenues or as an offset to costs, and any award of such will not increase reported income. Financial disincentives incurred shall not be included as reported expenses, and shall not reduce reported income. The reporting or recording of any of these incurred items will be done on a memo basis, which is below the income line, and will be listed as separate items.
(d) Carry forward of prior Rate Year losses.
Losses incurred by a STAR+PLUS HMO for one Rate Year may be carried forward to the next Rate Year, and applied as an offset against a STAR+PLUS pre-tax net income. Prior losses may be carried forward for two contiguous Rate Years for this purpose. If the HMO offsets a loss against another STAR+PLUS Service Area, only that portion of the loss that was not used as an offset may be carried forward to the next Rate Year. Losses incurred by a STAR+PLUS HMO cannot be offset against the STAR or CHIP Programs.
In the case of

against the first subsequent Rate Year such that the profit in the first subsequent Rate Year is reduced to a zero pre-tax income; any additional loss then remaining unapplied may be carried forward to any profit in the next subsequent Rate Year. In such case, the revised income in the third Rate Year would be equal to the cumulative income of the three contiguous periods.

(e) Settlements for payment; interest.
The processes applied to STAR, CHIP, and CHIP Perinatal Programs under Sections 10.11 (e) and (f) will also be applied to STAR+PLUS, with all applicable references to the STAR, CHIP, and CHIP Perinatal Programs replaced with STAR+PLUS. Any interest accruing under Section 10.11(f) for the STAR, CHIP, CHIP and CHIP Perinatal Programs will be separate and apart from interest accruing for the STAR+PLUS Program.

Section 10.11.2 ***STAR, CHIP, CHIP Perinatal Program, and STAR+PLUS Administrative Expense Cap***.

(a) General requirement.

Effective with SFY 2009, the calculation methodology of Experience Rebates described in Sections 10.11 and 10.11.1 will be adjusted by an Administrative Expense Cap ("Admin Cap.") The Admin Cap is a calculated maximum amount of administrative expense dollars (corresponding to a given FSR) that can be deducted from Revenues for purposes of determining income subject to the Experience Rebate. While Administrative Expenses may be limited by the Admin Cap to determine Experience Rebates, all valid Allowable Expenses will continue to be reported on the Financial Statistical Reports (FSRs). Thus, the Admin Cap does not impact FSR reporting, but may impact any associated Experience Rebate calculation.
Commencing with the Primary Settlement for SFY 2009, and for all pre and post-audit FSRs thereafter, the calculation of any corresponding Experience Rebate due will be subject to limitations on total deductible administrative expenses.

Such limitations will be calculated as follows:
(b) Calculation methodology.
HHSC will determine the administrative expense component of the applicable Capitation Rate structure for each Program and Service Area prior to each applicable Rate Period. At the conclusion of a Rate Period, HHSC will apply that predetermined administrative expense component against the HMO's actually incurred number of Member Months and aggregate premiums received (monthly Capitation Payments plus Delivery Supplemental Payments and/or Bariatric Supplemental Payments if applicable to the Program), to determine the specific Admin Cap, in aggregate dollars, for a given HMO, Service Area, and Program.
For SFY 2009 only, the Admin Cap methodology will include the application of an adjustment factor of 1.05. This factor will have the effect of increasing the Admin Cap. Section 10.11.2(d) demonstrates how HHSC will apply the adjustment factor.

(c) Data sources.
In determining the amount of Experience Rebate payment to include in the Primary Settlement (or in conjunction with any subsequent payment or settlement), the HMO will need to make the appropriate calculation, in order to assess the impact, if any, of the Admin Cap.

(1) The total premiums paid by HHSC (earned by the HMO), and corresponding Member Months, will be taken from the relevant FSR (or audit report) for the Rate Period.

(2) There are two components of the administrative expense portion of the Capitation Rate structure: the percentage rate to apply against the total premiums paid (the "percentage of premium" within the administrative expenses), and, the dollar rate per Member Month (the "fixed amount" within the administrative expenses). These will be taken from the supporting details associated with the official notification of final Capitation Rates, as supplied by HHSC. This notification is sent to the HMOs during the annual rate setting process via email, labeled as "the final rate exhibits for your health plan." The email has one or more spreadsheet files attached, which are particular to the given HMO. The spreadsheet(s) show the fixed amount and percentage of premium components for the administrative component of the Capitation Rate.

The components of the administrative expense portion of the Capitation Rate can also be found on HHSC's Medicaid website, under "Rate Analysis for Managed Care Services." Under each Program, there is a separate Rate Setting document for each Rate Period that describes the development of the Capitation Rates. Within each such document, there is a section entitled "Administrative Fees," where it refers to "the amount allocated for administrative expenses."

In cases where the administrative expense portion of the Capitation Rate refers to "the greater of (a) [one set of factors], and (b) [another set of factors]," then the Admin Cap will be calculated each way, and the larger of the two results will be the Admin Cap utilized for the determination of any Experience Rebates due.

(d) Separate calculations, by FSR.
Each HMO will have a separate Admin Cap for each Program and each Service Area in which it participates. This will require calculating a separate Admin Cap corresponding to each FSR (for annual, or complete period, versions of FSRs only). All administrative expenses reported on an FSR in excess of the calculated corresponding Admin Cap will be subtracted from the total Allowable Expense in the Experience Rebate calculation of income for that Program and Service Area, subject to any consolidation or offset that may apply, as described in Section 10.11.2(e).
By way of example only, HHSC will calculate the Admin Cap for a Rate Period as follows:

1. Multiply the predetermined administrative expense rate structure "fixed amount," or dollar rate per Member Month (for example, $11.00), by the actual number of Member Months for the Program and Service Area during the Rate Period (for example, 70,000):

- $11.00 x 70,000 = $770,000.

2. Multiply the predetermined percent of premiums in the administrative expense rate structure (for example, 5.75%), by the actual aggregate premiums earned for the Program and Service Area during the Rate Period (for example, $6,000,000).

- 5.75% x $6,000,000 = $345,000.

3. For SFY 2009, add the totals of items 1-2 and multiply the sum by the adjustment factor of 1.05. To this product, add applicable premium taxes and maintenance taxes (for example, $112,000), to determine the Admin Cap for the Program and Service Area:

- 1.05($770,000 + $345,000) + $112,000 = $1,282,750.

In this example, $1,282,750 would be the Admin Cap for a single Program in a given Service Area for an HMO in a particular Rate Period.

4. For other SFY 2010 and beyond, add the totals of items 1-2, plus applicable premium taxes and maintenance taxes (for example, $112,000), to determine the Admin Cap for the Program and Service Area:

- $770,000 + $345,000 + $112,000 = $1,227,000.

In this example, $1,227,000 would be the Admin Cap for a single Program in a given Service Area for an HMO in a particular Rate Period.

(e) Consolidation and offsets.
STAR, CHIP, and CHIP Perinatal Program results will be consolidated, but STAR+PLUS Program results will be calculated on a stand-alone basis. For a given HMO, total incurred administrative expenses, as reported on the FSRs for the HMO's Service Areas and/or Programs (excluding STAR+PLUS), will be summed, and compared to the total Admin Caps for the HMO's various Service Areas and Programs (excluding STAR+PLUS). Thus, a STAR, CHIP, or CHIP Perinatal HMO that exceeds its Admin Cap limit in one or more Service Areas or Programs, but does not exceed the Admin Cap in another Service area or Program, may have an offset. Similarly, within STAR+PLUS, HMOs operating in multiple Service Areas will likewise consolidate STAR+PLUS Service Area FSR administrative expense results, and compare that to consolidated STAR+PLUS Admin Caps. The net impact of the Admin Cap across relevant FSRs will be applied to the Experience Rebate calculation.

(f) Impact on Loss carry-forward.
For Experience Rebate calculation purposes, the calculation of any loss carry-forward, as described in Sections 10.11(d) and 10.11.1(d), will be based on the allowable pre-tax loss as determined under the Admin Cap.

(g) HMOs entering a Service Delivery Area or Program.
If an HMO enters a new Service Area or offers a Program that it did not offer in the prior contract year, it will be exempt from the Admin Cap for those Service Areas and Programs for a period of time to be determined by HHSC, up to the first 12 months of operations.

(h) Service Delivery Areas with only one HMO in a Program.
In Service Areas operating with only one HMO for a Program, HHSC may, at its sole discretion, revise the Admin Cap if its application would create an undue hardship on the HMO.

(i) Unforeseen events.
If, in HHSC's sole discretion, it determines that unforeseen events have created significant hardships for one or more HMOs, HHSC may revise or temporarily suspend the Admin Cap as it deems necessary.

Section 10.12 ***Payment by Members.***
(a) Medicaid and CHIP HMOs

STAR and STAR+PLUS HMOs, Network Providers, and Out-of-Network Providers are prohibited from billing or collecting any amount from a Member for Covered Services. This prohibition also applies to CHIP and CHIP Perinatal HMOs, Network Providers, and Out-of-Network Providers, except that
CHIP Network Providers and Out-of-Network Providers may collect copayments authorized in the CHIP State Plan from CHIP Members for Covered Services.
STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMOs must inform Members of costs for non-covered services, and must require its Network Providers to:

(1) inform Members of costs for non-covered services prior to rendering such services; and

(2) obtain a signed Private Pay form from such Members.

(b) CHIP HMOs.

(1) Families that meet the enrollment period cost share limit requirement must report it to the HHSC Administrative Services Contractor. The HHSC Administrative Service Contractor notifies the HMO that a family's cost share limit has been reached. Upon notification from the HHSC Administrative Services Contractor that a family has reached its cost-sharing limit for the term of coverage, the HMO will generate and mail to the CHIP Member a new Member ID card within five days, showing that the CHIP Member's cost-sharing obligation for that term of coverage has been met. No cost-sharing may be collected from these CHIP Members for the balance of their term of coverage.

(2) Providers are responsible for collecting all CHIP Member co-payments at the time of service. Co-payments that families must pay vary according to their income level.

(3) Co-payments do not apply, at any income level, to Covered Services that qualify as well-baby and well-child care services, as defined by 42 C.F.R. §457.520.

(4) Except for costs associated with unauthorized non-emergency services provided to a Member by Out-of-Network providers and for non-covered services, the co-payments outlined in the CHIP Cost Sharing Table in **the HHSC Uniform Managed Care Manual** are the only amounts that a provider may collect from a CHIP-eligible family. As required by 42 C.F.R. §457.515, this includes, without limitation, Emergency Services that are provided at an Out-of-Network facility. Cost sharing for such Emergency Services is limited to the co-payment amounts set forth in the CHIP Cost Sharing Table.

(5) Federal law prohibits charging premiums, deductibles, coinsurance, co-payments, or any other cost-sharing to CHIP Members of Native Americans or Alaskan Natives. The HHSC Administrative Services Contractor will notify the HMO of CHIP Members who are not subject to cost-sharing requirements. The HMO is responsible for educating Providers regarding the cost-sharing waiver for this population.

(6) An HMO's monthly Capitation Payment will not be reduced for a family's failure to make its CHIP premium payment. There is no relationship between the per Member/per month amount owed to the HMO for coverage provided during a month and the family's payment of its CHIP premium obligation for that month.

(c) CHIP Perinatal HMOs Cost-sharing does not apply to CHIP Perinatal Program Members. The exemption from cost-sharing applies through the end of the original 12-month enrollment period.

Section 10.13 ***Restriction on assignment of fees.***
During the term of the Contract, HMO may not, directly or indirectly, assign to any third party any beneficial or legal interest of the HMO in or to any payments to be made by HHSC pursuant to this Contract. This restriction does not apply to fees paid to Subcontractors.

Section 10.14 ***Liability for taxes.***
HHSC is not responsible in any way for the payment of any Federal, state or local taxes related to or incurred in connection with the HMO's performance of this Contract. HMO must pay and discharge any and all such taxes, including any penalties and interest. In addition, HHSC is exempt from Federal excise taxes, and will not pay any personal property taxes or income taxes levied on HMO or any taxes levied on employee wages.

Section 10.15 ***Liability for employment-relatedcharges and benefits.***
HMO will perform work under this Contract as an independent contractor and not as agent or representative of HHSC. HMO is solely and exclusively liable for payment of all employment-related charges incurred in connection with the performance of this Contract, including but not limited to salaries, benefits, employment taxes, workers compensation benefits, unemployment insurance and benefits, and other insurance or fringe benefits for Staff.

Section 10.16 ***No additional consideration.***

(a) HMO will not be entitled to nor receive from HHSC any additional consideration, compensation, salary, wages, charges, fees, costs, or any other type of remuneration for Services and Deliverables provided under the Contract, except by properly authorized and executed Contract amendments.

(b) No other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the HMO to withhold Services and Deliverables due under the Agreement.

(c) HMO will not be entitled by virtue of the Contract to consideration in the form of overtime, health insurance benefits, retirement benefits, disability retirement benefits, sick leave, vacation time, paid holidays, or other paid leaves of absence of any type or kind whatsoever.

Section 10.17 ***Federal Disallowance***
If the federal government recoups money from the state for expenses and/or costs that are deemed unallowable by the federal government, the state has the right to, in turn, recoup payments made to the HMOs for these same expenses and/or costs, even if they had not been previously disallowed by the state and were incurred by the HMO, and any such expenses and/or costs would then be deemed unallowable by the state. If the state retroactively recoups money from the HMOs due to a federal disallowance, the state will recoup the entire amount paid to the HMO for the federally disallowed expenses and/or costs, not just the federal portion.

Section 10.18 ***Required Pass Through of Physician Rate Increases***

(a) Effective September 1, 2007, all HMOs participating in the STAR, STAR+PLUS, CHIP and CHIP Perinatal Programs are required to adjust their physician fee schedules to reflect the physician rate increases funded through Legislative Appropriations during the 80th Regular Legislative Session. The HMOs are required to pass on all appropriated targeted physician rate increases to physicians serving their Members.

(b) The Medicaid Fee Schedule in effect on September 1, 2007 (the "updated Medicaid Fee Schedule") will include the legislatively-mandated physician rate increases based on the age of the Member, under 21 and over 21. The HMO must pay the appropriate rate for the age of the Member on the date of service.

(c) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the HMO pays for physician services based on the Medicaid Fee Schedule, then the HMO must pay for physician services provided on or after September 1, 2007 based on the updated Medicaid Fee Schedule.

(d) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the HMO pays for physician services based on a percentage of the Medicaid Fee Schedule, then the HMO must pay for physician services provided on or after September 1, 2007 based on the same percentage of the updated Medicaid Fee Schedule. By way of example only, if prior to September 1, 2007, the HMO paid for physician services at110% of the Medicaid Fee Schedule, then the HMO will pay for physician services provided on or after September 1, 2007 at 110% of the updated Medicaid Fee Schedule.

(e) If, under the terms of a Network Provider contract in place prior to September 1, 2007, the HMO uses benchmarks other than the Medicaid Fee Schedule (e.g. rates that are a percentage of Medicare) to pay for physician services, then for physician services provided on or after September 1, 2007, the HMO must increase its rates by 25% for services to Members under 21 and by 10% for Members age 21 and over. The HMO must provide HHSC with a copy of both the prior and new Network Provider agreements and demonstrate how the new rates are 125% or 110%, depending on the age of the Member, of the former rates.

(f) The HMO's Chief Executive Officer will attest that the HMO has appropriately increased physician reimbursements as required above. HHSC will perform sample audits to verify payments to physicians are in accordance with this Contract requirement.

Section 10.19 ***Bariatric Supplemental Payment for STAR and STAR+PLUS HMOs.***

(a) For dates of service from September 1, 2008 to August 31, 2011, STAR and STAR+PLUS HMOs will receive a Bariatric Supplemental Payment (BSP) from HHSC for each properly reported and documented bariatric surgery recorded under the group of procedure codes defined as allowable for bariatric reimbursement, as designated in the Texas Medicaid Providers Procedures Manual, including Texas Medicaid Bulletins. The amount of the one-time per surgery BSP payment is identified in the **HHSC Managed Care Contract**.

(1) HMO must submit a monthly BSP Report as described in **Attachment B-1, Section 8** to the **HHSC Managed Care Contract**, in the format and timeframe prescribed in **HHSC's Uniform Managed Care Manual**.

(2) HHSC will pay the Bariatric Supplemental Payment within twenty (20) Business Days after receipt of a complete and accurate report from the HMO.

(3) The HMO will not be entitled to Bariatric Supplemental Payments for surgeries that are not reported to HHSC within 210 days after the date of bariatric surgery, or within thirty (30) days from the date of discharge from the hospital for the stay related to the bariatric surgery, whichever is later. HHSC may grant an exception to this requirement, at its discretion, if the HMO is able to able to demonstrate that the medical service provider did not file a claim for payment to the HMO within the deadline described herein.

(4) HMO must maintain complete claims and adjudication disposition documentation, including paid and denied amounts for eachbariatric surgery. The HMO must submit such documentation to HHSC within five (5) Business Days after receiving a written request from HHSC.

(b) For dates of service on or after September 1, 2011, STAR and STAR+PLUS HMOs will not receive BSPs for bariatric surgeries. Instead, effective September 1, 2011, all funding for bariatric surgeries will be included in the STAR and STAR+PLUS capitation rates.

Article 11. Disclosure & Confidentiality of Information
Section 11.01 ***Confidentiality.***

(a) HMO and all Subcontractors, consultants, or agents under the Contract must treat all information that is obtained through performance of the Services under the Contract, including, but not limited to, information relating to applicants or recipients of HHSC Programs as Confidential Information to the extent that confidential treatment is provided under law and regulations.

(b) HMO is responsible for understanding the degree to which information obtained through performance of this Contract is confidential under State and Federal law, regulations, or administrative rules.

(c) HMO and all Subcontractors, consultants, or agents under the Contract may not use any information obtained through performance of this Contract in any manner except as is necessary for the proper discharge of obligations and securing of rights under the Contract.

(d) HMO must have a system in effect to protect all records and all other documents deemed confidential under this Contract maintained in connection with the activities funded under the Contract. Any disclosure or transfer of Confidential Information by HMO, including information required by HHSC, will be in accordance with applicable law. If the HMO receives a request for information deemed confidential under this Contract, the HMO will immediately notify HHSC of such request, and will make reasonable efforts to protect the information from public disclosure.

(e) In addition to the requirements expressly stated in this Section, HMO must comply with any policy, rule, or reasonable requirement of HHSC that relates to the safeguarding or disclosure of information relating to Members, HMO'S operations, or HMO's performance of the Contract.

(f) In the event of the expiration of the Contract or termination of the Contract for any reason, all Confidential Information disclosed to and all copies thereof made by the HMOI shall be returned to HHSC or, at HHSC's option, erased or destroyed. HMO shall provide HHSC certificates evidencing such destruction.

(g) The obligations in this Section shall not restrict any disclosure by the HMO pursuant to any applicable law, or by order of any court or government agency, provided that the HMO shall give prompt notice to HHSC of such order.

(h) With the exception of confidential Member information, Confidential Information shall not be afforded the protection of the Contract if such data was:

(1) Already known to the receiving Party without restrictions at the time of its disclosure by the furnishing Party;

(2) Independently developed by the receiving Party without reference to the furnishing Party's Confidential Information;

(3) Rightfully obtained by the other Party without restriction from a third party after its disclosure by the furnishing Party;

(4) Publicly available other than through the fault or negligence of the other Party; or

(5) Lawfully released without restriction to anyone.

Section 11.02 ***Disclosure of HHSC's Confidential Information.***

(a) HMO will immediately report to HHSC any and all unauthorized disclosures or uses of HHSC's Confidential Information of which it or its Subcontractor(s), consultant(s), or agent(s) is aware or has knowledge. HMO acknowledges that any publication or disclosure of HHSC's Confidential Information to others may cause immediate and irreparable harm to HHSC and may constitute a violation of State or federal laws. If HMO, its Subcontractor(s), consultant(s), or agent(s) should publish or disclose such Confidential Information to others without authorization, HHSC will immediately be entitled to injunctive relief or any other remedies to which it is entitled under law or equity. HHSC will have the right to recover from HMO all damages and liabilities caused by or arising from HMO's, its Subcontractors', consultants', or agents' failure to protect HHSC's Confidential Information. HMO will defend with counsel approved by HHSC, indemnify and hold harmless HHSC from all damages, costs, liabilities, and expenses (including without limitation reasonable attorneys' fees and costs) caused by or arising from HMO's or its Subcontractors', consultants' or agents' failure to protect HHSC's Confidential Information. HHSC will not unreasonably withhold approval of counsel selected by the HMO.

(b) HMO will require its Subcontractor(s), consultant(s), and agent(s) to comply with the terms of this provision.

Section 11.03 ***Member Records***

(a) HMO must comply with the requirements of state and federal laws, including the HIPAA requirements set forth in **Section 7.07**, regarding the transfer of Member Records.

(b) If at any time during the Contract Term this Contract is terminated, HHSC may require the transfer of Member Records, upon written notice to HMO, to another entity, as consistent with federal and state laws and applicable releases.

(c) The term "Member Record" for this Section means only those administrative, enrollment, case management and other such records maintained by HMO and is not intended to include patient records maintained by participating Network Providers.

Section 11.04 ***Requests for public information.***

(a) HHSC agrees that it will promptly notify HMO of a request for disclosure of information filed in accordance with the Texas Public Information Act, Chapter 552 of the Texas Government Code, that consists of the HMO'S confidential information, including without limitation, information or data to which HMO has a proprietary or commercial interest. HHSC will deliver a copy of the request for public information to HMO.

(b) With respect to any information that is the subject of a request for disclosure, HMO is required to demonstrate to the Texas Office of Attorney General the specific reasons why the requested information is confidential or otherwise excepted from required public disclosure under law. HMO will provide HHSC with copies of all such communications.

(c) To the extent authorized under the Texas Public Information Act, HHSC agrees to safeguard from disclosure information received from HMO that the HMO believes to be confidential information. HMO must clearly mark such information as confidential information or provide written notice to HHSC that it considers the information confidential.

Section 11.05 ***Privileged Work Product.***

(a) HMO acknowledges that HHSC asserts that privileged work product may be prepared in anticipation of litigation and that HMO is performing the Services with respect to privileged work product as an agent of HHSC, and that all matters related thereto are protected from disclosure by the Texas Rules of Civil Procedure, Texas Rules of Evidence, Federal Rules of Civil Procedure, or Federal Rules of Evidence.

(b) HHSC will notify HMO of any privileged work product to which HMO has or may have access. After the HMO is notified or otherwise becomes aware that such documents, data, database, or communications are privileged work product, only HMO personnel, for whom such access is necessary for the purposes of providing the Services, may have access to privileged work product.

(c) If HMO receives notice of any judicial or other proceeding seeking to obtain access to HHSC's privileged work product, HMO will:

(1) Immediately notify HHSC; and

(2) Use all reasonable efforts to resist providing such access.

(d) If HMO resists disclosure of HHSC's privileged work product in accordance with this Section, HHSC will, to the extent authorized under Civil Practices and Remedies Code or other applicable State law, have the right and duty to:

(1) represent HMO in such resistance;

(2) to retain counsel to represent HMO; or

(3) to reimburse HMO for reasonable attorneys' fees and expenses incurred in resisting such access.

(e) If a court of competent jurisdiction orders HMO to produce documents, disclose data, or otherwise breach the confidentiality obligations imposed in the Contract, or otherwise with respect to maintaining the confidentiality, proprietary nature, and secrecy of privileged work product, HMO will not be liable for breach of such obligation.

Section 11.06 ***Unauthorized acts.***
Each Party agrees to:

(1) Notify the other Party promptly of any unauthorized possession, use, or knowledge, or attempt thereof, by any person or entity that may become known to it, of any HHSC Confidential Information or any information identified by the HMO as confidential or proprietary;

(2) Promptly furnish to the other Party full details of the unauthorized possession, use, or knowledge, or attempt thereof, and use reasonable efforts to assist the other Party in investigating or preventing the reoccurrence of any unauthorized possession, use, or knowledge, or attempt thereof, of Confidential Information;

(3) Cooperate with the other Party in any litigation and investigation against third Parties deemed necessary by such Party to protect its proprietary rights; and

(4) Promptly prevent a reoccurrence of any such unauthorized possession, use, or knowledge such information.

Section 11.07 ***Legal action.***
Neither party may commence any legal action or proceeding in respect to any unauthorized possession, use, or knowledge, or attempt thereof by any person or entity of HHSC's Confidential Information or information identified by the HMO as confidential or proprietary, which action or proceeding identifies the other Party information without such Party's consent.

Section 11.08 ***Information Security***
The HMO and all Subcontractors, consultants, or agents must comply with all applicable laws, rules, and regulations regarding information security, including without limitation the following:

(1) Health and Human Services Enterprise Information Security Standards and Guidelines;

(2) Title 1, Sections 202.1 and 202.3 through 202.28, Texas Administrative Code;

(3) The Health Insurance Portability and Accountability Act of 1996 (HIPAA); and

(4) The Health Information Technology for Economic and Clinical Health Act (HITECH Act).

Article 12. Remedies & Disputes
Section 12.01 ***Understanding and expectations.***
The remedies described in this Section are directed to HMO's timely and responsive performance of the Services and production of Deliverables, and the creation of a flexible and responsive relationship between the Parties. The HMO is expected to meet or exceed all HHSC objectives and standards, as set forth in the Contract. All areas of responsibility and all Contract requirements will be subject to performance evaluation by HHSC. Performance reviews may be conducted at the discretion of HHSC at any time and may relate to any responsibility and/or requirement. Any and all responsibilities and/or requirements not fulfilled may be subject to remedies set forth in the Contract.

Section 12.02 ***Tailored remedies.***

(a) Understanding of the Parties. HMO agrees and understands that HHSC may pursue tailored contractual remedies for noncompliance with the Contract. At any time and at its discretion, HHSC may impose or pursue one or more remedies for each item of noncompliance and will determine remedies on a case-by-case basis. HHSC's pursuit or non-pursuit of a tailored remedy does not constitute a waiver of any other remedy that HHSC may have at law or equity.

(b) Notice and opportunity to cure for non-material breach.

(1) HHSC will notify HMO in writing of specific areas of HMO performance that fail to meet performance expectations, standards, or schedules set forth in the Contract, but that, in the determination of HHSC, do not result in a material deficiency or delay in the implementation or operation of the Services.

(2) HMO will, within five (5) Business Days (or another date approved by HHSC) of receipt of written notice of a non-material deficiency, provide the HHSC Project Manager a written response that:

(A) Explains the reasons for the deficiency, HMO's plan to address or cure the deficiency, and the date and time by which the deficiency will be cured; or

(B) If HMO disagrees with HHSC's findings, its reasons for disagreeing with HHSC's findings.

(3) HMO's proposed cure of a non-material deficiency is subject to the approval of HHSC. HMO's repeated commission of non-material deficiencies or repeated failure to resolve any such deficiencies may be regarded by HHSC as a material deficiency and entitle HHSC to pursue any other remedy provided in the Contract or any other appropriate remedy HHSC may have at law or equity.

(c) Corrective action plan.

(1) At its option, HHSC may require HMO to submit to HHSC a written plan (the "Corrective Action Plan") to correct or resolve a material breach of this Contract, as determined by HHSC.

(2) The Corrective Action Plan must provide:

(A) A detailed explanation of the reasons for the cited deficiency;

(B) HMO's assessment or diagnosis of the cause; and

(C) A specific proposal to cure or resolve the deficiency.

(3) The Corrective Action Plan must be submitted by the deadline set forth in HHSC's request for a Corrective Action Plan. The Corrective Action Plan is subject to approval by HHSC, which will not unreasonably be withheld.

(4) HHSC will notify HMO in writing of HHSC's final disposition of HHSC's concerns. If HHSC accepts HMO's proposed Corrective Action Plan, HHSC may:

(A) Condition such approval on completion of tasks in the order or priority that HHSC may reasonably prescribe;

(B) Disapprove portions of HMO's proposed Corrective Action Plan; or

(C) Require additional or different corrective action(s).

Notwithstanding the submission and acceptance of a Corrective Action Plan, HMO remains responsible for achieving all written performance criteria.

(5) HHSC's acceptance of a Corrective Action Plan under this Section will not:

(A) Excuse HMO's prior substandard performance;

(B) Relieve HMO of its duty to comply with performance standards; or

(C) Prohibit HHSC from assessing additional tailored remedies or pursuing other appropriate remedies for continued substandard performance.

(d) Administrative remedies.

(1) At its discretion, HHSC may impose one or more of the following remedies for each item of material noncompliance and will determine the scope and severity of the remedy on a case-by-case basis:

(A) Assess liquidated damages in accordance with **Attachment B-5** to the **HHSC Managed Care Contract**, "Liquidated Damages Matrix;"

(B) Conduct accelerated monitoring of the HMO. Accelerated monitoring includes more frequent or more extensive monitoring by HHSC or its agent;

(C) Require additional, more detailed, financial and/or programmatic reports to be submitted by HMO;

(D) Decline to renew or extend the Contract;

(E) Appoint temporary management under the circumstances described in 42 C.F.R §438.706;

(F) Initiate disenrollment of a Member or Members;

(G) Suspend enrollment of Members;

(H) Withhold or recoup payment to HMO;

(I) Require forfeiture of all or part of the HMO's bond; or

(J) Terminate the Contract in accordance with **Section 12.03**, ("Termination by HHSC").

(2) For purposes of the Contract, an item of material noncompliance means a specific action of HMO that:

(A) Violates a material provision of the Contract;

(B) Fails to meet an agreed measure of performance; or

(C) Represents a failure of HMO to be reasonably responsive to a reasonable request of HHSC relating to the Services for information, assistance, or support within the timeframe specified by HHSC.

(3) HHSC will provide notice to HMO of the imposition of an administrative remedy in accordance with this Section, with the exception of accelerated monitoring, which may be unannounced. HHSC may require HMO to file a written response in accordance with this Section.

(4) The Parties agree that a State or Federal statute, rule, regulation, or Federal guideline will prevail over the provisions of this Section unless the statute, rule, regulation, or guidelines can be read together with this Section to give effect to both.

(e) Damages.

(1) HHSC will be entitled to actual and consequential damages resulting from the HMO'S failure to comply with any of the terms of the Contract. In some cases, the actual damage to HHSC or State of Texas as a result of HMO'S failure to meet any aspect of the responsibilities of the Contract and/or to meet specific performance standards set forth in the Contract are difficult or impossible to determine with precise accuracy. Therefore, liquidated damages will be assessed in writing against and paid by the HMO in accordance with and for failure to meet any aspect of the responsibilities of the Contract and/or to meet the specific performance standards identified by the HHSC in **Attachment B-5 to the HHSC Managed Care Contract, "**Deliverables/Liquidated Damages Matrix." Liquidated damages will be assessed if HHSC determines such failure is the fault of the HMO (including the HMO'S Subcontractors and/or consultants) and is not materially caused or contributed to by HHSC or its agents. If at any time, HHSC determines the HMO has not met any aspect of the responsibilities of the Contract and/or the specific performance standards due to mitigating circumstances, HHSC reserves the right to waive all or part of the liquidated damages. All such waivers must be in writing, contain the reasons for the waiver, and be signed by the appropriate executive of HHSC.

(2) The liquidated damages prescribed in this Section are not intended to be in the nature of a penalty, but are intended to be reasonable estimates of HHSC's projected financial loss and damage resulting from the HMO's nonperformance, including financial loss as a result of project delays. Accordingly, in the event HMO fails to perform in accordance with the Contract, HHSC may assess liquidated damages as provided in this Section.

(3) If HMO fails to perform any of the Services described in the Contract, HHSC may assess liquidated damages for each occurrence of a liquidated damages event, to the extent consistent with HHSC's tailored approach to remedies and Texas law.

(4) HHSC may elect to collect liquidated damages:

(A) Through direct assessment and demand for payment delivered to HMO; or

(B) By deduction of amounts assessed as liquidated damages as set-off against payments then due to HMO or that become due at any time after assessment of the liquidated damages. HHSC will make deductions until the full amount payable by the HMO is received by HHSC.

(f) Equitable Remedies

(1) HMO acknowledges that, if HMO breaches (or attempts or threatens to breach) its material obligation under this Contract, HHSC may be irreparably harmed. In such a circumstance, HHSC may proceed directly to court to pursue equitable remedies.

(2) If a court of competent jurisdiction finds that HMO breached (or attempted or threatened to breach) any such obligations, HMO agrees that without any additional findings of irreparable injury or other conditions to injunctive relief, it will not oppose the entry of an appropriate order compelling performance by HMO and restraining it from any further breaches (or attempted or threatened breaches).

(g) Suspension of Contract

(1) HHSC may suspend performance of all or any part of the Contract if:

(A) HHSC determines that HMO has committed a material breach of the Contract;

(B) HHSC has reason to believe that HMO has committed, assisted in the commission of Fraud, Abuse, Waste, malfeasance, misfeasance, or nonfeasance by any party concerning the Contract;

(C) HHSC determines that the HMO knew, or should have known of, Fraud, Abuse, Waste, malfeasance, or nonfeasance by any party concerning the Contract, and the HMO failed to take appropriate action; or

(D) HHSC determines that suspension of the Contract in whole or in part is in the best interests of the State of Texas or the HHSC Programs.

(2) HHSC will notify HMO in writing of its intention to suspend the Contract in whole or in part. Such notice will:

(A) Be delivered in writing to HMO;

(B) Include a concise description of the facts or matter leading to HHSC's decision; and

(C) Unless HHSC is suspending the contract for convenience, request a Corrective Action Plan from HMO or describe actions that HMO may take to avoid the contemplated suspension of the Contract.

Section 12.03 ***Termination by HHSC.***
This Contract will terminate upon the Expiration Date. In addition, prior to completion of the Contract Term, all or a part of this Contract may be terminated for any of the following reasons:

(a) Termination in the best interest of HHSC. HHSC may terminate the Contract without cause at any time when, in its sole discretion, HHSC determines that termination is in the best interests of the State of Texas. HHSC will provide reasonable advance written notice of the termination, as it deems appropriate under the circumstances. The termination will be effective on the date specified in HHSC's notice of termination.

(b) Termination for cause. HHSC reserves the right to terminate this

Contract, in whole or in part, upon the following conditions:
(1) *Assignment for the benefit of creditors, appointment of receiver, or inability to pay debts*. HHSC may terminate this Contract at any time if HMO:

(A) Makes an assignment for the benefit of its creditors;

(B) Admits in writing its inability to pay its debts generally as they become due; or

(C) Consents to the appointment of a receiver, trustee, or liquidator of HMO or of all or any part of its property.

(2) *Failure to adhere to laws, rules, ordinances, or orders.* HHSC may terminate this Contract if a court of competent jurisdiction finds HMO failed to adhere to any laws, ordinances, rules, regulations or orders of any public authority having jurisdiction and such violation prevents or substantially impairs performance of HMO's duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(3) Breach *of confidentiality*. HHSC may terminate this Contract at any time if HMO breaches confidentiality laws with respect to the Services and Deliverables provided under this Contract.

(4) *Failure to maintain adequate personnel or resources.* HHSC may terminate this Contract if, after providing notice and an opportunity to correct, HHSC determines that HMO has failed to supply personnel or resources and such failure results in HMO's inability to fulfill its duties under this Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

(5) *Termination for gifts and gratuities.*

(A) HHSC may terminate this Contract at any time following the determination by a competent judicial or quasi-judicial authority and HMO's exhaustion of all legal remedies that HMO, its employees, agents or representatives have either offered or given any thing of value to an officer or employee of HHSC or the State of Texas in violation of state law.

(B) HMO must include a similar provision in each of its Subcontracts and shall enforce this provision against a Subcontractor who has offered or given any thing of value to any of the persons or entities described in this Section, whether or not the offer or gift was in HMO's behalf.

(C) Termination of a Subcontract by HMO pursuant to this provision will not be a cause for termination of the Contract unless:

(1) HMO fails to replace such terminated Subcontractor within a reasonable time; and

(2) Such failure constitutes cause, as described in this Subsection 12.03(b).

(D) For purposes of this Section, a "thing of value" means any item of tangible or intangible property that has a monetary value of more than $50.00 and includes, but is not limited to, cash, food, lodging, entertainment, and charitable contributions. The term does not include contributions to holders of public office or candidates for public office that are paid and reported in accordance with State and/or Federal law.

(6) *Termination for non-appropriation of funds*. Notwithstanding any other provision of this Contract, if funds for the continued fulfillment of this Contract by HHSC are at any time not forthcoming or are insufficient, through failure of any entity to appropriate funds or otherwise, then HHSC will have the right to terminate this Contract at no additional cost and with no penalty whatsoever by giving prior written notice documenting the lack of funding. HHSC will provide at least thirty (30) days advance written notice of such termination. HHSC will use reasonable efforts to ensure appropriated funds are available.

(7) *Judgment and execution.*

(A) HHSC may terminate the Contract at any time if judgment for the payment of money in excess of $500,000.00 that is not covered by insurance, is rendered by any court or governmental body against HMO, and HMO does not:

(1) Discharge the judgment or provide for its discharge in accordance with the terms of the judgment;

(2) Procure a stay of execution of the judgment within thirty (30) days from the date of entry thereof; or

(3) Perfect an appeal of such judgment and cause the execution of such judgment to be stayed during the appeal, providing such financial reserves as may be required under generally accepted accounting principles.

(B) If a writ or warrant of attachment or any similar process is issued by any court against all or any material portion of the property of HMO, and such writ or warrant of attachment or any similar process is not released or bonded within thirty (30) days after its entry, HHSC may terminate the Contract in accordance with this Section.

(8) *Termination for insolvency.*

(A) HHSC may terminate the Contract at any time if HMO:

(1) Files for bankruptcy;

(2) Becomes or is declared insolvent, or is the subject of any proceedings related to its liquidation, insolvency, or the appointment of a receiver or similar officer for it;

(3) Makes an assignment for the benefit of all or substantially all of its creditors; or

(4) Enters into an Contract for the composition, extension, or readjustment of substantially all of its obligations.

(B) HMO agrees to pay for all reasonable expenses of HHSC including the cost of counsel, incident to:

(1) The enforcement of payment of all obligations of the HMO by any action or participation in, or in connection with a case or proceeding under Chapters 7, 11, or 13 of the United States Bankruptcy Code, or any successor statute;

(2) A case or proceeding involving a receiver or other similar officer duly appointed to handle the HMO's business; or

(3) A case or proceeding in a State court initiated by HHSC when previous collection attempts have been unsuccessful.

(9) *Termination for HMO'S material breach of the Contract.*

HHSC will have the right to terminate the Contract in whole or in part if HHSC determines, at its sole discretion, that HMO has materially breached the Contract. HHSC will provide at least thirty (30) days advance written notice of such termination.

Section 12.04 ***Termination by HMO.***

(a) Failure to pay. HMO may terminate this Contract if HHSC fails to pay the HMO undisputed charges when due as required under this Contract. Retaining premium, recoupment, sanctions, or penalties that are allowed under this Contract or that result from the HMO's failure to perform or the HMO's default under the terms of this Contract is not cause for termination. Termination for failure to pay does not release HHSC from the obligation to pay undisputed charges for services provided prior to the termination date. If HHSC fails to pay undisputed charges when due, then the HMO may submit a notice of intent to terminate for failure to pay in accordance with the requirements of **Subsection 12.04(d)**. If HHSC pays all undisputed amounts then due within thirty (30)days after receiving the notice of intent to terminate, the HMO cannot proceed with termination of the Contract under this Article.

(b) Change to HHSC Uniform Managed Care Manual.

HMO may terminate this agreement if the Parties are unable to resolve a dispute concerning a material and substantive change to the HHSC Uniform Managed Care Manual (a change that materially and substantively alters the HMO's ability to fulfill its obligations under the Contract). HMO must submit a notice of intent to terminate due to a material and substantive change in the HHSC Uniform Managed Care Manual no later than thirty (30) days after the effective date of the policy change. HHSC will not enforce the policy change during the period of time
between the receipt of the notice of intent to terminate and the effective date of termination.

(c) Change to Capitation Rate. If HHSC proposes a modification to the Capitation Rate that is unacceptable to the HMO, the HMO may terminate the Contract. HMO must submit a written notice of intent to terminate due to a change in the Capitation Rate no later than thirty (30) days after HHSC's notice of the proposed change. HHSC will not enforce the rate change during the period of time between the receipt of the notice of intent to terminate and the effective date of termination.

(d) Notice of intent to terminate.

In order to terminate the Contract pursuant to this Section, HMO must give HHSC at least ninety (90) days written notice of intent to terminate. The termination date will be calculated as the last day of the month following ninety (90) days from the date the notice of intent to terminate is received by HHSC.

Section 12.05 ***Termination by mutual agreement.***
This Contract may be terminated by mutual written agreement of the Parties.

Section 12.06 ***Effective date of termination.***
Except as otherwise provided in this Contract, termination will be effective as of the date specified in the notice of termination.

Section 12.07 ***Extension of termination effective date.***
The Parties may extend the effective date of termination one or more times by mutual written agreement.

Section 12.08 ***Payment and other provisions atContract termination.***

(a) In the event of termination pursuant to this Article, HHSC will pay the Capitation Payment for Services and Deliverables rendered through the effective date of termination. All pertinent provisions of the Contract will form the basis of settlement.

(b) HMO must provide HHSC all reasonable access to records, facilities, and documentation as is required to efficiently and expeditiously close out the Services and Deliverables provided under this Contract.

(c) HMO must prepare a Turnover Plan, which is acceptable to and approved by HHSC. The Turnover Plan will be implemented during the time period between receipt of notice and the termination date.

Section 12.09 ***Modification of Contract in the event of remedies.***
HHSC may propose a modification of this Contract in response to the imposition of a remedy under this Article. Any modifications under this Section must be reasonable, limited to the matters causing the exercise of a remedy, in writing, and executed in accordance with **Article 8**. HMO must negotiate such proposed modifications in good faith.

Section 12.10 ***Turnover assistance.***
Upon receipt of notice of termination of the Contract by HHSC, HMO will provide any turnover assistance reasonably necessary to enable HHSC or its designee to effectively close out the Contract and move the work to another vendor or to perform the work itself.

Section 12.11 ***Rights upon termination or expiration of Contract.***
In the event that the Contract is terminated for any reason, or upon its expiration, HHSC will, at HHSC's discretion, retain ownership of any and all associated work products, Deliverables and/or documentation in whatever form that they exist.

Section 12.12 ***HMO responsibility for associated costs.***
If HHSC terminates the Contract for Cause, the HMO will be responsible to HHSC for all reasonable costs incurred by HHSC, the State of Texas, or any of its administrative agencies to replace the HMO. These costs include, but are not limited to, the costs of procuring a substitute vendor and the cost of any claim or litigation that is reasonably attributable to HMO's failure to perform any Service in accordance with the terms of the Contract

Section 12.13 ***Dispute resolution.***

(a) General agreement of the Parties. The Parties mutually agree that the interests of fairness, efficiency, and good business practices are best served when the Parties employ all reasonable and informal means to resolve any dispute under this Contract. The Parties express their mutual commitment to using all reasonable and informal means of resolving disputes prior to invoking a remedy provided elsewhere in this Section.

(b) Duty to negotiate in good faith. Any dispute that in the judgment of any Party to this Contract may materially or substantially affect the performance of any Party will be reduced to writing and delivered to the other Party. The Parties must then negotiate in good faith and use every reasonable effort to resolve such dispute and the Parties shall not resort to any formal proceedings unless they have reasonably determined that a negotiated resolution is not possible. The resolution of any dispute disposed of by Contract between the Parties shall be reduced to writing and delivered to all Parties within ten (10) Business Days.

(c) Claims for breach of Contract.

(1) *General requirement.* HMO's claim for breach of this Contract will be resolved in accordance with the dispute resolution process established by HHSC in accordance with Chapter 2260, Texas Government Code.

(2) *Negotiation of claims*. The Parties expressly agree that the HMO's claim for breach of this Contract that the Parties cannot resolve in the ordinary course of business or through the use of all reasonable and informal means will be submitted to the negotiation process provided in Chapter 2260, Subchapter B, Texas Government Code.

(A) To initiate the process, HMO must submit written notice to HHSC that specifically states that HMO invokes the provisions of Chapter 2260, Subchapter B, Texas Government Code. The notice must comply with the requirements of Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(B) The Parties expressly agree that the HMO's compliance with Chapter 2260, Subchapter B, Texas Government Code, will be a condition precedent to the filing of a contested case proceeding under Chapter 2260, Subchapter C, of the Texas Government Code.

(3) *Contested case proceedings*. The contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be HMO's sole and exclusive process for seeking a remedy for any and all alleged breaches of contract by HHSC if the Parties are unable to resolve their disputes under Subsection (c)(2) of this Section.

The Parties expressly agree that compliance with the contested case process provided in Chapter 2260, Subchapter C, Texas Government Code, will be a condition precedent to seeking consent to sue from the Texas Legislature under Chapter 107, Civil Practices & Remedies Code. Neither the execution of this Contract by HHSC nor any other conduct of any representative of HHSC relating to this Contract shall be considered a waiver of HHSC's sovereign immunity to suit.

(4) *HHSC rules.* The submission, processing and resolution of HMO's claim is governed by the rules adopted by HHSC pursuant to Chapter 2260, Texas Government Code, found at Title 1, Chapter 392, Subchapter B of the Texas Administrative Code.

(5) *HMO's duty to perform.* Neither the occurrence of an event constituting an alleged breach of contract nor the pending status of any claim for breach of contract is grounds for the suspension of performance, in whole or in part, by HMO of any duty or obligation with respect to the performance of this Contract. Any changes to the Contract as a result of a dispute resolution will be implemented in accordance with **Article 8** ("Amendments and Modifications").

Section 12.14 ***Liability of HMO.***

(a) HMO bears all risk of loss or damage to HHSC or the State due to:

(1) Defects in Services or Deliverables;

(2) Unfitness or obsolescence of Services or Deliverables; or

(3) The negligence or intentional misconduct of HMO or its employees, agents, Subcontractors, or representatives.

(b) HMO must, at the HMO's own expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC and State employees, officers, directors, contractors and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys' fees, and expenses from any claim or action for property damage, bodily injury or death, to the extent caused by or arising from the negligence or intentional misconduct of the HMO and its employees, officers, agents, or Subcontractors. HHSC will not unreasonably withhold approval of counsel selected by HMO.

(c) HMO will not be liable to HHSC for any loss, damages or liabilities attributable to or arising from the failure of HHSC or any state agency to perform a service or activity in connection with this Contract.

Section 12.15 ***Pre-termination Process.***
The following process will apply when HHSC terminates the Agreement for any reason set forth in Section 12.03(b), "Termination for Cause," other than Subpart 6, "Termination for Non-appropriation of Funds." HHSC will provide the HMO with reasonable advance written notice of the proposed termination, as it deems appropriate under the circumstances. The notice will include the reason for the proposed termination, the proposed effective date of the termination, and the time and place where the parties will meet regarding the proposed termination. During this meeting, the HMO may present written information explaining why HHSC should not affirm the proposed termination. HHSC's Associate Commissioner for Medicaid and CHIP will consider the written information, if any, and will provide the HMO with a written notice of HHSC's final decision affirming or reversing the termination. An affirming decision will include the effective date of termination.

The pre-termination process described herein will not limit or otherwise reduce the parties' rights and responsibilities under Section 12.13, "Dispute Resolution;" however, HHSC's final decision to terminate is binding and is not subject to review by the State Office of Administrative Hearings under Chapter 2260, Texas Government Code.

Article 13. Assurances & Certifications
Section 13.01 ***Proposal certifications.***
HMO acknowledges its continuing obligation to comply with the requirements of the following certifications contained in its Proposal, and will immediately notify HHSC of any changes in circumstances affecting these certifications:

(1) Federal lobbying;

(2) Debarment and suspension;

(3) Child support; and

(4) Nondisclosure statement.

Section 13.02 ***Conflicts of interest.***

(a) Representation. HMO agrees to comply with applicable state and federal laws, rules, and regulations regarding conflicts of interest in the performance of its duties under this Contract. HMO warrants that it has no interest and will not acquire any direct or indirect interest that

would conflict in any manner or degree with its performance under this Contract.

(b) General duty regarding conflicts of interest. HMO will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain. HMO will operate with complete independence and objectivity without actual, potential or apparent conflict of interest with respect to the activities conducted under this Contract with the State of Texas.

Section 13.03 ***Organizational conflicts of interest.***
(a) Definition. An organizational conflict of interest is a set of facts or circumstances, a relationship, or other situation under which a HMO, or a Subcontractor has past, present, or currently planned personal or financial activities or interests that either directly or indirectly:

(1) Impairs or diminishes the HMO's, or Subcontractor's ability to render impartial or objective assistance or advice to HHSC; or

(2) Provides the HMO or Subcontractor an unfair competitive advantage in future HHSC procurements (excluding the award of this Contract).

(b) Warranty. Except as otherwise disclosed and approved by HHSC prior to the Effective Date of the Contract, HMO warrants that, as of the Effective Date and to the best of its knowledge and belief, there are no relevant facts or circumstances that could give rise to an organizational conflict of interest affecting this Contract. HMO affirms that it has neither given, nor intends to give, at any time hereafter, any economic opportunity, future employment, gift, loan, gratuity, special discount, trip, favor, or service to a public servant or any employee or representative of same, at any time during the procurement process or in connection with the procurement process except as allowed under relevant state and federal law.

(c) Continuing duty to disclose.

(1) HMO agrees that, if after the Effective Date, HMO discovers or is made aware of an organizational conflict of interest, HMO will immediately and fully disclose such interest in writing to the HHSC project manager. In addition, HMO must promptly disclose any relationship that might be perceived or represented as a conflict after its discovery by HMO or by HHSC as a potential conflict. HHSC reserves the right to make a final determination regarding the existence of conflicts of interest, and HMO agrees to abide by HHSC's decision.

(2) The disclosure will include a description of the action(s) that HMO has taken or proposes to take to avoid or mitigate such conflicts.

(d) Remedy. If HHSC determines that an organizational conflict of interest exists, HHSC may, at its discretion, terminate the Contract pursuant to **Subsection 12.03(b)(9).** If HHSC determines that HMO was aware of an organizational conflict of interest before the award of this Contract and did not disclose the conflict to the contracting officer, such nondisclosure will be considered a material breach of the Contract. Furthermore, such breach may be submitted to the Office of the Attorney General, Texas Ethics Commission, or appropriate State or Federal law enforcement officials for further action.

(e) Flow down obligation. HMO must include the provisions of this Section in all Subcontracts for work to be performed similar to the service provided by HMO, and the terms "Contract," "HMO," and "project manager" modified appropriately to preserve the State's rights.

Section 13.04 ***HHSC personnel recruitment prohibition.***
HMO has not retained or promised to retain any person or company, or utilized or promised to utilize a consultant that participated in HHSC's development of specific criteria of the RFP or who participated in the selection of the HMO for this Contract. Unless authorized in writing by HHSC, HMO will not recruit or employ any HHSC professional or technical personnel who have worked on projects relating to the subject matter of this Contract, or who have had any influence on decisions affecting the subject matter of this Contract, for two (2) years following the completion of this Contract.

Section 13.05 ***Anti-kickback provision.***
HMO certifies that it will comply with the Anti-Kickback Act of 1986, 41 U.S.C. §51-58 and Federal Acquisition Regulation 52.203-7, to the extent applicable.

Section 13.06 ***Debt or back taxes owed to State of Texas.***
In accordance with Section 403.055 of the Texas Government Code, HMO agrees that any payments due to HMO under the Contract will be first applied toward any debt and/or back taxes HMO owes State of Texas. HMO further agrees that payments will be so applied until such debts and back taxes are paid in full.

Section 13.07 ***Certification regarding status of license, certificate, or permit.***
Article IX, Section 163 of the General Appropriations Act for the 1998/1999 state fiscal biennium prohibits an agency that receives an appropriation under either Article II or V of the General Appropriations Act from awarding a contract with the owner, operator, or administrator of a facility that has had a license, certificate, or permit revoked by another Article II or V agency. HMO certifies it is not ineligible for an award under this provision.

Section 13.08 ***Outstanding debts and judgments.***
HMO certifies that it is not presently indebted to the State of Texas, and that HMO is not subject to an
outstanding judgment in a suit by State of Texas against HMO for collection of the balance. For purposes of this Section, an indebtedness is any amount sum of money that is due and owing to the State of Texas and is not currently under dispute. A false statement regarding HMO's status will be treated as a material breach of this Contract and may be grounds for termination at the option of HHSC.

Article 14. Representations & Warranties
Section 14.01 ***Authorization.***

(a) The execution, delivery and performance of this Contract has been duly authorized by HMO and no additional approval, authorization or consent of any governmental or regulatory agency is required to be obtained in order for HMO to enter into this Contract and perform its obligations under this Contract.

(b) HMO has obtained all licenses, certifications, permits, and authorizations necessary to perform the Services under this Contract and currently is in good standing with all regulatory agencies that regulate any or all aspects of HMO's performance of this Contract. HMO will maintain all required certifications, licenses, permits, and authorizations during the term of this Contract.

Section 14.02 ***Ability to perform.***
HMO warrants that it has the financial resources to fund the capital expenditures required under the Contract without advances by HHSC or assignment of any payments by HHSC to a financing source.

Section 14.03 ***Minimum Net Worth.***
The HMO has, and will maintain throughout the life of this Contract, minimum net worth to the greater of (a) $1,500,000; (b) an amount equal to the sum of twenty-five dollars ($25) times the number of all enrollees including Members; or (c) an amount that complies with standards adopted by TDI. Minimum net worth means the excess total admitted assets over total liabilities, excluding liability for subordinated debt issued in compliance with Chapter 843 of the Texas Insurance Code.

Section 14.04 ***Insurer solvency.***

(a) The HMO must be and remain in full compliance with all applicable state and federal solvency requirements for basic-service health maintenance organizations, including but not limited to, all reserve requirements, net worth standards, debt-to-equity ratios, or other debt limitations. In the event the HMO fails to maintain such compliance, HHSC, without limiting any other rights it may have by law or under the Contract, may terminate the Contract.

(b) If the HMO becomes aware of any impending changes to its financial or business structure that could adversely impact its compliance with the

requirements of the Contract or its ability to pay its debts as they come due, the HMO must notify HHSC immediately in writing.
(c) The HMO must have a plan and take appropriate measures to ensure adequate provision against the risk of insolvency as required by TDI. Such provision must be adequate to provide for the following in the event of insolvency:

(1) continuation of Covered Services, until the time of discharge, to Members who are confined on the date of insolvency in a hospital or other inpatient facility;

(2) payments to unaffiliated health care providers and affiliated healthcare providers whose Contracts do not contain Member "hold harmless" clauses acceptable to the TDI;

(3) continuation of Covered Services for the duration of the Contract Period for which a capitation has been paid for a Member;

(4) provision against the risk of insolvency must be made by establishing adequate reserves, insurance or other guarantees in full compliance with all financial requirements of TDI and the Contract.

Should TDI determine that there is an immediate risk of insolvency or the HMO is unable to provide Covered Services to its Members, HHSC, without limiting any other rights it may have by law, or under the Contract, may terminate the Contract.

Section 14.05 ***Workmanship and performance.***

(a) All Services and Deliverables provided under this Contract will be provided in a manner consistent with the standards of quality and integrity as outlined in the Contract.

(b) All Services and Deliverables must meet or exceed the required levels of performance specified in or pursuant to this Contract.

(c) HMO will perform the Services and provide the Deliverables in a workmanlike manner, in accordance with best practices and high professional standards used in well-managed operations performing services similar to the services described in this Contract.

Section 14.06 ***Warranty of deliverables.***
HMO warrants that Deliverables developed and delivered under this Contract will meet in all material respects the specifications as described in the Contract during the period following its acceptance by HHSC, through the term of the Contract, including any subsequently negotiated by HMO and HHSC. HMO will promptly repair or replace any such Deliverables not in compliance with this warranty at no charge to HHSC.

Section 14.07 ***Compliance with Contract.***
HMO will not take any action substantially or materially inconsistent with any of the terms and conditions set forth in this Contract without the express written approval of HHSC.

Section 14.08 ***Technology Access***

(a) HMO expressly acknowledges that State funds may not be expended in connection with the purchase of an automated information system unless that system meets certain statutory requirements relating to accessibility by persons with visual impairments. Accordingly, HMO represents and warrants to HHSC that this technology is capable, either by virtue of features included within the technology or because it is readily adaptable by use with other technology, of:

(1) Providing equivalent access for effective use by both visual and non-visual means;

(2) Presenting information, including prompts used for interactive communications, in formats intended for non-visual use; and

(3) Being integrated into networks for obtaining, retrieving, and disseminating information used by individuals who are not blind or visually impaired.

(b) For purposes of this Section, the phrase "equivalent access" means a substantially similar ability to communicate with or make use of the technology, either directly by features incorporated within the technology or by other reasonable means such as assistive devices or services that would constitute reasonable accommodations under the Americans with Disabilities Act or similar State or Federal laws. Examples of methods by which equivalent access may be provided include, but are not limited to, keyboard alternatives to mouse commands and other means of navigating graphical displays, and customizable display appearance.

(c) In addition, all technological solutions offered by the HMO must comply with the requirements of Texas Government Code §531.0162. This includes, but is not limited to providing technological solutions that meet federal accessibility standards for persons with disabilities, as applicable.

Article 15. Intellectual Property
Section 15.01 ***Infringement and misappropriation.***

(a) HMO warrants that all Deliverables provided by HMO will not infringe or misappropriate any right of, and will be free of any claim of, any third person or entity based on copyright, patent, trade secret, or other intellectual property rights.

(b) HMO will, at its expense, defend with counsel approved by HHSC, indemnify, and hold harmless HHSC, its employees, officers, directors, contractors, and agents from and against any losses, liabilities, damages, penalties, costs, fees, including without limitation reasonable attorneys' fees and expenses, from any claim or action against HHSC that is based on a claim of breach of the warranty set forth in the preceding paragraph. HHSC will promptly notify HMO in writing of the claim, provide HMO a copy of all information received by HHSC with respect to the claim, and cooperate with HMO in defending or settling the claim. HHSC will not unreasonably withhold, delay or condition approval of counsel selected by the HMO.

(c) In case the Deliverables, or any one or part thereof, is in such action held to constitute an infringement or misappropriation, or the use thereof is enjoined or restricted or if a proceeding appears to HMO to be likely to be brought, HMO will, at its own expense, either:

(1) Procure for HHSC the right to continue using the Deliverables; or

(2) Modify or replace the Deliverables to comply with the Specifications and to not violate any intellectual property rights.

If neither of the alternatives set forth in (1) or (2) above are available to the HMO on commercially reasonable terms, HMO may require that HHSC return the allegedly infringing Deliverable(s) in which case HMO will refund all amounts paid for all such Deliverables.

Section 15.02 ***Exceptions.***
HMO is not responsible for any claimed breaches of the warranties set forth in Section 15.01 to the extent caused by:

(a) Modifications made to the item in question by anyone other than HMO or its Subcontractors, or modifications made by HHSC or its contractors working at HMO's direction or in accordance with the specifications; or

(b) The combination, operation, or use of the item with other items if HMO did not supply or approve for use with the item; or

(c) HHSC's failure to use any new or corrected versions of the item made available by HMO.

Section 15.03 ***Ownership and Licenses***

(a) Definitions.

For purposes of this Section 15.03, the following terms have the meanings set forth below:

(1) "**Custom Software**" means any software developed by the HMO: for HHSC; in connection with the Contract; and with funds received from HHSC. The term does not include HMO Proprietary Software or Third Party Software.

(2) "**HMO Proprietary Software**" means software:

(i) developed by the HMO prior to the Effective Date of the Contract, or (ii) software developed by the HMO after the Effective Date of the Contract that is not developed: for HHSC; in connection with the Contract; and with funds received from HHSC.

(3) "**Third Party Software**" means software that is: developed for general commercial use; available to the public; or not developed for HHSC. Third Party Software includes without limitation: commercial off-the-shelf software; operating system software; and application software, tools, and utilities.

(b) Deliverables. The Parties agree that any Deliverable, including without limitation the Custom Software, will be the exclusive property of HHSC.

(c) Ownership rights.

(1) HHSC will own all right, title, and interest in and to its Confidential Information and the Deliverables provided by the HMO, including without limitation the Custom Software and associated documentation. For purposes of this Section 15.03, the Deliverables will not include HMO Proprietary Software or Third Party Software. HMO will take all actions necessary and transfer ownership of the Deliverables to HHSC, including, without limitation, the Custom Software and associated documentation prior to Contract termination.

(2) HMO will furnish such Deliverables, upon request of HHSC, in accordance with applicable State law. All Deliverables, in whole and in part, will be deemed works made for hire of HHSC for all purposes of copyright law, and copyright will belong solely to HHSC. To the extent that any such Deliverable does not qualify as a work for hire under applicable law, and to the extent that the Deliverable includes materials subject to copyright, patent, trade secret, or other proprietary right protection, HMO agrees to assign, and hereby assigns, all right, title, and interest in and to Deliverables, including without limitation all copyrights, inventions, patents, trade secrets, and other proprietary rights therein (including renewals thereof) to HHSC.

(3) HMO will, at the expense of HHSC, assist HHSC or its nominees to obtain copyrights, trademarks, or patents for all such Deliverables in the United States and any other countries. HMO agrees to execute all papers and to give all facts known to it necessary to secure United States or foreign country copyrights and patents, and to transfer or cause to transfer to HHSC all the right, title, and interest in and to such Deliverables. HMO also agrees not to assert any moral rights under applicable copyright law with regard to such Deliverables.

(d) License Rights HHSC will have a royalty-free and non-exclusive license to access the HMO Proprietary Software and associated documentation during the term of the Contract. HHSC will also have ownership and unlimited rights to use, disclose, duplicate, or publish all information and data developed, derived, documented, or furnished by HMO under or resulting from the Contract. Such data will include all results, technical information, and materials developed for and/or obtained by HHSC from HMO in the performance of the Services hereunder, including but not limited to all reports, surveys, plans, charts, recordings (video and/or sound), pictures, drawings, analyses, graphic representations, computer printouts, notes and memoranda, and documents whether finished or unfinished, which result from or are prepared in connection with the Services performed as a result of the Contract.

(e) Proprietary Notices HMO will reproduce and include HHSC's copyright and other proprietary notices and product identifications provided by HMO on such copies, in whole or in part, or on any form of the Deliverables.

(f) State and Federal Governments In accordance with 45 C.F.R. §95.617, all appropriate State and Federal agencies will have a royalty-free, nonexclusive, and irrevocable license to reproduce, publish, translate, or otherwise use, and to authorize others to use for Federal Government purposes all materials, the Custom Software and modifications thereof, and associated documentation designed, developed, or installed with federal financial participation under the Contract, including but not limited to those materials covered by copyright, all software source and object code, instructions, files, and documentation.

Article 16. Liability
Section 16.01 ***Property damage.***

(a) HMO will protect HHSC's real and personal property from damage arising from HMO's, its agent's, employees' and Subcontractors' performance of the Contract, and HMO will be responsible for any loss, destruction, or damage to HHSC's property that results from or is caused by HMO's, its agents', employees' or Subcontractors' negligent or wrongful acts or omissions. Upon the loss of, destruction of, or damage to any property of HHSC, HMO will notify the HHSC Project Manager thereof and, subject to direction from the Project Manager or her or his designee, will take all reasonable steps to protect that property from further damage.

(b) HMO agrees to observe and encourage its employees and agents to observe safety measures and proper operating procedures at HHSC sites at all times.

(c) HMO will distribute a policy statement to all of its employees and agents that directs the employee or agent to promptly report to HHSC or to HMO any special defect or unsafe condition encountered while on HHSC premises. HMO will promptly report to HHSC any special defect or an unsafe condition it encounters or otherwise learns about.

Section 16.02 ***Risk of Loss.***
During the period Deliverables are in transit and in possession of HMO, its carriers or HHSC prior to being accepted by HHSC, HMO will bear the risk of loss or damage thereto, unless such loss or damage is caused by the negligence or intentional misconduct of HHSC. After HHSC accepts a Deliverable, the risk of loss or damage to the Deliverable will be borne by HHSC, except loss or damage attributable to the negligence or intentional misconduct of HMO's agents, employees or Subcontractors.

Section 16.03 ***Limitation of HHSC's Liability.***
HHSC WILL NOT BE LIABLE FOR ANY INCIDENTAL, INDIRECT, SPECIAL, OR CONSEQUENTIAL DAMAGES UNDER CONTRACT, TORT (INCLUDING NEGLIGENCE), OR OTHER LEGAL THEORY. THIS WILL APPLY REGARDLESS OF THE CAUSE OF ACTION AND EVEN IF HHSC HAS BEEN ADVISED OF THE POSSIBILITY OF SUCH DAMAGES.
HHSC'S LIABILITY TO HMO UNDER THE CONTRACT WILL NOT EXCEED THE TOTAL CHARGES TO BE PAID BY HHSC TO HMO UNDER THE CONTRACT, INCLUDING CHANGE ORDER PRICES AGREED TO BY THE PARTIES OR OTHERWISE ADJUDICATED.
HMO's remedies are governed by the provisions in Article 12.

Article 17. Insurance & Bonding
Section 17.01 ***Insurance Coverage.***

(a) Statutory and General Coverage

HMO will maintain, at the HMO's expense, the following insurance coverage:
(1) Business Automobile Liability Insurance for all owned, non-owned, and hired vehicles for bodily injury and property damage;
(2) Comprehensive General Liability Insurance of at least $1,000,000.00 per occurrence and $5,000,000.00 in the aggregate (including Bodily Injury coverage of $100,000.oo per each occurrence and Property Damage Coverage of $25,000.00 per occurrence); and
(3) If HMO's current Comprehensive General Liability insurance coverage does not meet the above stated requirements, HMO will obtain Umbrella Liability Insurance to compensate for the difference in the coverage amounts. If Umbrella Liability Insurance is provided, it shall follow the form of the primary coverage.

(b) Professional Liability Coverage.
(1) HMO must maintain, or cause its Network Providers to maintain, Professional Liability Insurance for each Network Provider of $100,000.00 per occurrence and $300,000.00 in the aggregate, or the limits required by the hospital at which the Network Provider has admitting privileges.
(2) HMO must maintain an Excess Professional Liability (Errors and Omissions) Insurance Policy for the greater of $3,000,000.00 or an amount (rounded to the nearest $100,000.00) that represents the number of Members enrolled in the HMO in the first month of the applicable State Fiscal Year multiplied by $150.00, not to exceed $10,000,000.00.

(c) General Requirements for All Insurance Coverage
(1) Except as provided herein, all exceptions to the Contract's insurance requirements must be approved in writing by HHSC. HHSC's written approval is not required in the following situations:

(A) An HMO or a Network Provider is not required to obtain the insurance coverage described in Section 17.01 if the HMO or Network Provider qualifies as a state governmental unit or municipality under the Texas Tort Claims Act, and is required to comply with, and subject to the provisions of, the Texas Tort Claims Act.

(B) An HMO may waive the Professional Liability Insurance requirement described in Section 17.01(b)(1) for a Network Provider of Community-based Long Term Care Services. An HMO may not waive this requirement if the Network Provider provides other Covered Services in addition to Community-based Long Term Care Services, or if a Texas licensing entity requires the Network Provider to carry such Professional Liability coverage. An HMO that waives the Professional Liability Insurance requirement for a Network Provider pursuant to this provision is not required to obtain such coverage on behalf of the Network Provider.

(2) HMO or the Network Provider is responsible for any and all deductibles stated in the insurance policies.
(3)Insurance coverage must be issued by insurance companies authorized to conduct business in the State of Texas.
(4) With the exception of Professional Liability Insurance maintained by Network Providers, all insurance coverage must name HHSC as an additional insured. In addition, with the exception of Professional Liability Insurance maintained by Network Providers and Business Automobile Liability Insurance, all insurance coverage must name HHSC as a loss payee.
(5) Insurance coverage kept by the HMO must be maintained in full force at all times during the Term of the Contract, and until HHSC's final acceptance of all Services and Deliverables. Failure to maintain such insurance coverage will constitute a material breach of this Contract.
(6) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must have extended reporting periods of two years. When policies are renewed or replaced, the policy retroactive date must coincide with, or precede, the Contract Effective Date.
(7) With the exception of Professional Liability Insurance maintained by Network Providers, the insurance policies described in this Section must provide that prior written notice to be given to HHSC at least thirty (30) calendar days before coverage is reduced below minimum HHSC contractual requirements, canceled, or non-renewed. HMO must submit a new coverage binder to HHSC to ensure no break in coverage.
(8) The Parties expressly understand and agree that any insurance coverages and limits furnished by HMO will in no way expand or limit HMO's liabilities and responsibilities specified within the Contract documents or by applicable law.
(9) HMO expressly understands and agrees that any insurance maintained by HHSC will apply in excess of and not contribute to insurance provided by HMO under the Contract.
(10) If HMO, or its Network Providers, desire additional coverage, higher limits of liability, or other modifications for its own protection, HMO or its Network Providers will be responsible for the acquisition and cost of such additional protection. Such additional protection will not be an Allowable Expense under this Contract.
(11) HMO will require all insurers to waive their rights of subrogation against HHSC for claims arising from or relating to this Contract.

(d) Proof of Insurance Coverage
(1) Except as provided in Section 17.01(d)(2), the HMO must furnish the HHSC Project Manager original Certificates of Insurance evidencing the required insurance coverage on or before the Effective Date of the Contract. If insurance coverage is renewed during the Term of the Contract, the HMO must furnish the HHSC Project Manager renewal certificates of insurance, or such similar evidence, within five (5) Business Days of renewal. The failure of HHSC to obtain such evidence from HMO will not be deemed to be a waiver by HHSC and HMO will remain under continuing obligation to maintain and provide proof of insurance coverage.
(2) The HMO is not required to furnish the HHSC Project Manager proof of Professional Liability Insurance maintained by Network Providers on or before the Effective Date of the Contract, but must provide such information upon HHSC's request during the Term of the Contract.

Section 17.02 ***Performance Bond.***
(a) Beginning with State Fiscal Year (SFY) 2010, the HMO must obtain a performance bond with a one (1) year term. The performance bond must be renewable and renewal must occur no later than the first day of each subsequent State Fiscal Year. The performance bond must continue to be in effect for one (1) year following the expiration of the final renewal period. HMO must obtain and maintain the performance bonds in the form prescribed by HHSC and approved by TDI, naming HHSC as Obligee, securing HMO's faithful performance of the terms and conditions of this Contract. The performance bonds must comply with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. At least one performance bond must be issued. The amount of the performance bond(s) should total $100,000.00 for each HMO Program within each Service Area that the HMO covers under this Contract. Performance bonds must be issued by a surety licensed by TDI, and specify cash payment as the sole remedy. HMO must deliver each renewal prior to the first day of the State Fiscal Year.

(b) Since the CHIP Perinatal Program is a sub-program of the CHIP Program, neither a separate performance bond for the CHIP Perinatal Program nor a combined performance bond for the CHIP and CHIP Perinatal Programs is required. The same bond that the HMO obtains for its CHIP Program within a particular Service Area also will cover the HMO's CHIP Perinatal Program, if applicable, in that same Service Area.

(c) HHSC will release performance bonds received for SFYs preceding 2010 upon completion of HHSC's audit of the 334-day FSR for the SFY.

Section 17.03 ***TDI Fidelity Bond***
The HMO will secure and maintain throughout the life of the Contract a fidelity bond in compliance with Chapter 843 of the Texas Insurance Code and 28 T.A.C. §11.1805. The HMO must promptly provide HHSC with copies of the bond and any amendments or renewals thereto.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version Attachment B-1, Section 6
Revision	1.1	June 30, 2006	Revised version of the Attachment B-1, Section 6, that includes provisions applicable to MCOs participating in the STAR+PLUS Program. Section 6.3.2.1, Experience Rebate Reward, is modified to delete references to the selected performance indicators and the Quality Challenge Pool. Section 6.3.2.2, Performance-Based Capitation Rate, is modified to include STAR+PLUS and to add Additional STAR+PLUS Performance Indicators. Section 6.3.2.3, Quality Challenge Award, is modified to include STAR+PLUS. Section 6.3.2.5, STAR+PLUS Hospital Inpatient Performance Based Capitation Rate: Hospital Inpatient Stay Cost Incentives and Disincentives, is added. Section 6.3.2.5.1, STAR+PLUS Hospital Inpatient Disincentive – Administrative Fee at Risk, is added. Section 6.3.2.5.2, STAR+PLUS Hospital Inpatient Incentive – Shared Savings Award, is added.
Revision	1.2	September 1, 2006	Revised version of the Attachment B-1, Section 6, that includes provisions applicable to MCOs participating in the STAR and CHIP Programs. Section 6.3.2.2, Performance-Based Capitation Rate, modifies the standard performance indicator for the Behavioral Health Hotline to change the maximum abandonment rate from 5% to 7% (except in the Dallas Core Service Area). Section 6.3.2.3, Quality Challenge Award, is modified to reflect the new start date for the Quality Challenge Award, which will not be implemented until State Fiscal Year 2008.
Revision	1.3	September 1, 2006	Revised version of the Attachment B-1, Section 6, that includes provisions applicable to MCOs participating in the CHIP Perinatal Program. Section 6.3.2.1 modified to clarify that the Experience Rebate Reward incentive may apply to the CHIP Perinatal Program at a later date. Section 6.3.2.2 modified to clarify that the Performance-based Capitation Rate will not apply for the CHIP Perinatal Program in SFY 2007.
Revision	1.4	September 1, 2006	Contract amendment did not revise Attachment B-1 Section 6 – Premium Payment, Incentives, and Disincentives
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-1 Section 6 – Premium Payment, Incentives, and Disincentives
Revision	1.6	February 1, 2007	Revised version of the Attachment B-1, Section 6, that includes provisions applicable to MCOs participating in the STAR+PLUS Program. Section 6.3.2.5 is modified to clarify the months included in Rate Period 1.
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-1 Section 6 – Premium Payment, Incentives, and Disincentives
Revision	1.8	September 1, 2007	Section 6.3 is modified as a result of SB 10 legislation and the Frew litigation to prohibit HMOs from passing down financial disincentives or sanctions to providers. Section 6.3.1.1 is modified as a result of the Frew litigation to allow HHSC to post information regarding poor HMO performance on the HHSC website. Section 6.3.2.2 is modified to clarify language regarding the Performance Indicator Dashboard and the reapportionment of points for the 1% at-risk premium. Section 6.3.2.3 is modified as a result of the Frew litigation to clarify language. New Section 6.3.2.6 is added as a result of the Frew litigation to clarify requirements for additional incentives and disincentives.
Revision	1.9	December 1, 2007	Section 6.3.2.3 is modified to outline the calculation methodology for STAR, STAR+PLUS, and CHIP.
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-1 Section 6 - Premium Payment, Incentives, and Disincentives.
Revision	1.11	September 1, 2008	Contract amendment did not revise Attachment B-1 Section 6 - Premium Payment, Incentives, and Disincentives.
Revision	1.12	March 1, 2009	Section 6.2.1 is modified to add Bariatric Supplemental Payments.
Revision	1.13	September 1, 2009	Section 6.3.2.2 is modified to remove the list of performance indicators. Section 6.3.2.5.1 is amended to clarify the 22% reduction. Section 6.3.2.7 Frew Incentives and Disincentives is added. Section 6.3.2.8 Nursing Facility Utilization Disincentive – 1% At-Risk Performance Indicator is added
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-1 Section 6 - Premium Payment, Incentives, and Disincentives
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-1 Section 6 - Premium Payment, Incentives, and Disincentives
Revision	1.16	September 1, 2010	Section 6.3.2.7 reference to "Frew v. Hawkins" changed to "Frew v. Suehs".
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-1 Section 6 - Premium Payment, Incentives, and Disincentives
Revision	1.18	March 1, 2011	Section 6.3.2.8 is modified to remove "1% At-Risk Performance Indicator" from the section name, and to clarify that nursing facility utilization will be

			measured in the Performance Based Capitation Rate and the Quality Challenge Award.
Revision	1.19	September 1, 2011	Section 6.3.2.2 is revised to exempt the Contiguous Expansion counties for the 2011 calendar year. Section 6.3.2.3 is revised to exempt the Contiguous Expansion counties for the 2011 calendar year.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment B-1 Section 6 - Premium Payment, Incentives, and Disincentives

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

6. Premium Payment, Incentives, and Disincentives

This section documents how the Capitation Rates are developed and describes performance incentives and disincentives related to HHSC's value-based purchasing approach. For further information, HMOs should refer to the HHSC **Uniform Managed Care Contract Terms and Conditions**.

Under the HMO Contracts, health care coverage for Members will be provided on a fully insured basis. The HMO must provide the Services and Deliverables, including Covered Services to enrolled Members in order for monthly Capitation Payments to be paid by HHSC. Attachment B-1, **Section 8** includes the HMO's financial responsibilities regarding out-of-network Emergency Services and Medically Necessary Covered Services not available through Network Providers.

6.1 Capitation Rate Development

Refer to **Attachment A**, **HHSC Uniform Managed Care Contract Terms & Conditions, Article 10, "Terms & Conditions of Payment,"** for information concerning Capitation Rate development.

6.2 Financial Payment Structure and Provisions

HHSC will pay the HMO monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Member Months times the applicable monthly Capitation Rate by Member Rate Cell. The HMO must provide the Services and Deliverables, including Covered Services to Members, described in the Contract for monthly Capitation Payments to be paid by HHSC.

The HMO must understand and expressly assume the risks associated with the performance of the duties and responsibilities under the Contract, including the failure, termination, or suspension of funding to HHSC, delays or denials of required approvals, cost of claims incorrectly paid by the HMO, and cost overruns not reasonably attributable to HHSC. The HMO must further agree that no other charges for tasks, functions, or activities that are incidental or ancillary to the delivery of the Services and Deliverables will be sought from HHSC or any other state agency, nor will the failure of HHSC or any other party to pay for such incidental or ancillary services entitle the HMO to withhold Services or Deliverables due under the Contract.

6.2.1 Capitation Payments

The HMO must refer to the **HHSC Uniform Managed Care Contract Terms & Conditions** for information and Contract requirements on the:

1) Time and Manner of Payment,
2) Adjustments to Capitation Payments,
3) Delivery Supplemental Payment and Bariatric Supplemental Payments, and
4) Experience Rebate.

6.3 Performance Incentives and Disincentives

HHSC introduces several financial and non-financial performance incentives and disincentives through this Contract. These incentives and disincentives are subject to change by HHSC over the course of the Contract Period. The methodologies required to implement these strategies will be refined by HHSC after collaboration with contracting HMOs through a new incentives workgroup to be established by HHSC. HMO is prohibited from passing down financial disincentives and/or sanctions imposed on the HMO to health care providers, except on an individual basis and related to the individual provider's inadequate performance.

6.3.1 Non-financial Incentives

6.3.1.1 Performance Profiling

HHSC intends to distribute information on key performance indicators to HMOs on a regular basis, identifying an HMO's performance, and comparing that performance to other HMOs, and HHSC standards and/or external Benchmarks. HHSC will recognize HMOs that attain superior performance and/or improvement by publicizing their achievements. For example, HHSC may post information concerning exceptional performance on its website, where it will be available to both stakeholders and members of the public. Likewise, HHSC may post its final determination regarding poor performance or HMO peer group performance comparisons on its website, where it will be available to both stakeholders and members of the public.

6.3.1.2 Auto-assignment Methodology for Medicaid HMOs

HHSC may also revise its auto-assignment methodology during the Contract Period for new Medicaid Members who do not select an HMO (Default Members). The new assignment methodology would reward those HMOs that demonstrate superior performance and/or improvement on one or more key dimensions of performance. In establishing the assignment methodology, HHSC will employ a subset of the performance indicators contained within the **Performance Indicator Dashboard**. At present, HHSC intends to recognize those HMOs that exceed the minimum geographic access standards defined within **Attachment B-1, Section 8 and the Performance Indicator Dashboard.** HHSC may also use its assessment of HMO performance on annual quality improvement goals (described in **Attachment B-1, Section 8**) in developing the assignment methodology. The methodology would disproportionately assign Default Members to the HMO(s) in a given Service Area that performed comparably favorably on the selected performance indicators.

HHSC anticipates that it will not implement a performance-based auto-assignment algorithm before September 1, 2007. HHSC will invite HMO comments on potential approaches prior to implementation of the new performance-based auto-assignment algorithm.

6.3.2 Financial Incentives and Disincentives

6.3.2.1 Experience Rebate Reward

HHSC historically has required HMOs to provide HHSC with an Experience Rebate (see the **Uniform Managed Care Contract Terms and Conditions, Article 10.11)** when there has been an aggregate excess of Revenues over Allowable Expenses. During the Contract Period, should the HMO experience an aggregate excess of Revenues over Allowable Expenses across STAR and CHIP HMO Programs and Service Areas, HHSC will allow the HMO to retain that portion of the aggregate excess of Revenues over Allowable Expenses that is equal to or less than 3.5% of the total Revenue for the period should the HMO demonstrate superior performance on selected performance indicators. The retention of 3.5% of revenue exceeds the retention of 3.0% of revenue that would otherwise be afforded to a HMO without demonstrated superior performance on these performance indicators relative to other HMOs. HHSC will develop the methodology for determining the level of performance necessary for an HMO to retain the additional 0.5% of revenue after consultation with HMOs. The finalized methodology will be added to the **Uniform Managed Care Manual**.

HHSC will calculate the Experience Rebate Reward after it has calculated the HMO's at-risk Capitation Rate payment, as described below in **Section 6.3.2.2**. HHSC will calculate whether a HMO is eligible for the Experience Rebate Reward prior to the 90-day Financial Statistical Report (FSR) filing.

HHSC anticipates that it will not implement the incentive for Rate Period 1 of the Contract. HHSC will invite HMO comments on potential approaches prior to implementation of the new performance-based Experience Rebate Reward. HHSC may also implement this incentive option for the STAR+PLUS and CHIP Perinatal programs in the future.

6.3.2.2 Performance-Based Capitation Rate

Beginning in State Fiscal Year 2007 of the Contract, HHSC will place each STAR and CHIP HMO at risk for 1% of the Capitation Rate(s). Beginning in State Fiscal Year 2008 of the Contract, HHSC will also place each STAR+PLUS HMO at risk for 1% of the Capitation Rate(s). HHSC retains the right to vary the percentage of the Capitation Rate placed at risk in a given Rate Period. HHSC will not place CHIP Perinatal HMOs at risk for 1% of the Capitation Rate(s) in State Fiscal Year 2007, but reserves this right in subsequent State Fiscal Years. The monthly Capitation Rate(s) paid for eligible and enrolled STAR and STAR+PLUS Members in the Expansion Counties will be excluded from Performance-Based 1% at risk calculations for Calendar Year 2011.

As noted in Section 6.2, HHSC will pay the HMO monthly Capitation Payments based on the number of eligible and enrolled Members. HHSC will calculate the monthly Capitation Payments by multiplying the number of Member months times the applicable monthly Capitation Rate by Member rate cell. At the end of each Rate Period, HHSC will evaluate if the HMO has demonstrated that it has fully met the performance expectations for which the HMO is at risk. Should the HMO fall short on some or all of the performance expectations, HHSC will adjust a future monthly Capitation Payment by an appropriate portion of the 1% at-risk amount. HMOs will be able to earn variable percentages up to 100% of the 1% at-risk Capitation Rate. HHSC's objective is that all HMOs achieve performance levels that enable them to receive the full at-risk amount.

HHSC will determine the extent to which the HMO has met the performance expectations by assessing the HMO's performance for each applicable HMO Program relative to performance targets for the rate period. HHSC will conduct separate accounting for each HMO Program's at-risk Capitation Rate amount.

HHSC will identify no more than 10 at-risk performance indicators for each HMO Program. Some of the performance indicators will be standard across the HMO Programs while others may apply to only one of the HMO Programs.

HHSC's at-risk performance indicators may include periods of data collection, and associated points are detailed in the **HHSC Uniform Managed Care Manual.** The minimum percentage targets were developed based, in part, on the HHSC HMO Program objective of ensuring access to care and quality of care, past performance of the HHSC HMOs, and performance of Medicaid and CHIP HMOs nationally on HEDIS and CAHPS measures of plan performance.

Failure to timely provide HHSC with necessary data related to the calculation of the performance indicators will result in HHSC's assignment of a zero percent performance rate for each related performance indicator.

For any Member survey-based indicators that are included in the 1% at-risk premium that yield response rates deemed by HHSC to be too low to yield credible data, HHSC will reapportion points across the remaining measures.

Actual plan rates will be rounded to the nearest whole number. HHSC will calculate performance assessment for the at-risk portion of the capitation payments by summing all earned points and converting them to a percentage. For example, an HMO that earns 92 points will earn 92% of the at-risk Capitation Rate. HHSC will apply the premium assessment of 8% of the at-risk Capitation Rate as a reduction to the monthly Capitation Payment ninety days after the end of the contract period.

HMOs will report actual Capitation Payments received on the Financial Statistical Report (FSR). Actual Capitation Payments received include all of the at-risk Capitation Payment paid to the HMO. Any performance assessment based on performance for a contract period will appear on the second final (334-day) FSR for that contract period.

HHSC will evaluate the performance-based Capitation Rate methodology annually in consultation with HMOs. HHSC may then modify the methodology it deems necessary and appropriate to motivate, recognize, and reward HMOs for performance. The methodologies for Rate Periods 1 and 2 will be included in the **HHSC Uniform Managed Care Manual**.

6.3.2.3 Quality Challenge Award

Data collection for the Quality Challenge Award will begin on September 1, 2006; however, the Quality Challenge Award will not be implemented until State Fiscal Year 2008. Should one or more HMOs be unable to earn the full amount of the performance-based at-risk portion of the Capitation Rate, HHSC will reallocate the funds through the HMO Program's Quality Challenge Award. HHSC will use these funds to reward HMOs that demonstrate superior clinical quality, service delivery, access to care, and/or Member satisfaction. HHSC will determine the number of HMOs that will receive Quality Challenge Award funds annually based on the amount of the funds to be reallocated. Separate Quality Challenge Award payments will be made for each of the HMO Programs. The Expansion Counties are not included in the calculations for the Quality Challenge Award for Calendar Year 2011 for the STAR and STAR+PLUS Programs.

As with the performance-based Capitation Rate, each HMO will be evaluated separately for each HMO Program. HHSC intends to evaluate HMO performance annually on some combination of performance indicators in order to determine which HMOs demonstrate superior performance. In no event will a distribution from the Quality Challenge Award, plus any other incentive payments made in accordance with the HMO Contract, when combined with the Capitation Rate payments, exceed 105% of the Capitation Rate payments to an HMO.

Information about the data collection period to be used and each indicator that will be considered for any specific time period can be found in the **HHSC Uniform Managed Care Manual**.

HHSC will calculate the HMOs' degree of compliance with the Quality Challenge Award indicators based on Encounter Data and other information supplied by the HMOs. Failure to provide timely and accurate information will result in HHSC's assignment of a zero percent performance rate for each applicable Quality Challenge Award indicator.

HHSC will evaluate the Quality Challenge Award methodology annually in consultation with HMOs. HHSC will make methodology modifications annually as it deems necessary and appropriate to motivate, recognize, and reward HMOs for superior performance based on available Quality Challenge Award funds and/or other performance incentives applicable to the award. HHSC will include the Quality Challenge Award methodology and any modifications in the **HHSC Uniform Managed Care Manual**.

6.3.2.4 Remedies and Liquidated Damages
All areas of responsibility and all requirements in the Contract will be subject to performance evaluation by HHSC. Any and all responsibilities or requirements not fulfilled may have remedies and HHSC will assess either actual or liquidated damages. Refer to **Attachment A, HHSC Uniform Managed Care Contract Terms and Conditions** and **Attachment B-5** for performance standards that carry liquidated damage values.

6.3.2.5 STAR+PLUS Hospital Inpatient Performance-Based Capitation Rate: Hospital Inpatient Stay Cost Incentives & Disincentives

Effective as of the STAR+PLUS Operational Start Date, HHSC will place at-risk a portion of the HMO's Medicaid-Only Capitation Rate. Settlements for Inpatient Stay costs will be calculated by the State after the end of each State Fiscal Year (SFY) using three (3) months of completed Hospital paid data for the preliminary settlement and 11 months of completed data for the final settlement. The SFY 2006 Fee-for-Service (FFS) Inpatient Hospital per-member-per-month (PMPM) rate will be projected for Rate Period 1 (February 1, 2007 through August 31, 2007) for the first settlement. Adjustments for the projection will include trending and risk adjustment. The base and final inpatient hospital PMPM rate will be calculated separately for each HMO, Service Area, and Rate Cell. Harris County is excluded from the Harris Service Area calculations.

6.3.2.5.1 STAR+PLUS Hospital Inpatient Disincentive - Administrative Fee at Risk
For Rate Period One, the STAR+PLUS HMOs must achieve a 22% reduction in projected FFS Hospital Inpatient Stay costs, for the Medicaid-Only population. HMOs achieving savings beyond 22% will be eligible for the STAR+PLUS Shared Savings Award described in **Section 6.3.2.5.2**. The HMO will be at-risk for savings less than 22%.

The maximum risk to the HMO will be equal to 50% of the difference between 15% Hospital inpatient savings and 22% Hospital inpatient savings. The disincentive for savings above 15%, but still less than 22% will be equal to 50% of the difference between the level of achieved savings and 22%. HHSC retains the right to implement

6.3.2.5.2 STAR+PLUS Hospital Inpatient Incentive – Shared Savings Award

HMOs that exceed the 22% reduction in Inpatient Stay costs incurred by STAR+PLUS Members specified in **Section 6.3.2.5.1** will be eligible to obtain a 20% share of the savings achieved beyond the 22% target. HHSC will determine the extent to which the HMO has met and exceeded the performance expectation in the manner described within **Section 6.3.2.5**. Should HHSC determine that the HMO exceeded the 22% target, HHSC will adjust a future monthly Capitation Payment upward by 20% of the calculated savings. This shared savings award is limited to 5% of the HMO's capitation in accordance with Federal Balance Budget Act requirements and is calculated off of total of STAR+PLUS Capitation Payment. An HMO will be subject to contractual remedies and determined ineligible for the award, if a HHSC audit reveals that the HMO has inappropriately averted Medically Necessary Inpatient Stay admissions and potentially endangered Member safety.

6.3.2.6 Additional Incentives and Disincentives

HHSC will evaluate all performance-based incentives and disincentive methodologies annually and in consultation from the HMOs. HHSC may then modify the methodologies as needed, as funds become available, or as mandated by court decree, statute, or rule in an effort to motivate, recognize, and reward HMOs for performance.

Information about the data collection period to be used, performance indicators selected or developed, or HMO ranking methodologies used for any specific time period will be found in the **HHSC Uniform Managed Care Manual**.

6.3.2.7 Frew Incentives and Disincentives

As required by the "Frew vs. Suehs Corrective Action Order: Managed Care," this Contract includes a system of incentives and disincentives associated with the Medicaid Managed Care Texas Health Steps Medical Checkups Reports and Children of Migrant Farm Workers Reports. These incentives and disincentives apply to Medicaid HMOs.

The incentives and disincentives and corresponding methodology are set forth in the **Uniform Managed Care Manual**.

6.3.2.8 Nursing Facility Utilization Disincentive – 1% At-Risk Performance Indicator

Effective March 1, 2009, nursing facility services are no longer included in the Capitation Rates for STAR+PLUS HMOs. As a result of this change, HHSC has developed the following disincentive to prevent inappropriate admission to nursing facilities. For SFY 2010, the rate of nursing facility admissions for Medicaid-only STAR+PLUS Members will be part of the Performance Indicator Dashboard (see **Section 6.3.2.2**).

In each of the HMO's STAR+PLUS Service Areas, HHSC will determine whether there has been a statistically significant increase in nursing facility admissions by comparing that HMO's rate of admission of Medicaid-only STAR+PLUS Members in SFY 2008 to that HMO's rate of admission of Medicaid-only STAR+PLUS Members in SFY 2010. Members who are admitted to a nursing facility and then discharged back into the community within 120 days of admission will not be included in the analysis.

HHSC reserves the right to include a nursing facility utilization disincentive in the Performance Indicator Dashboard for State Fiscal Years following 2010.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version Attachment B-1, Section 7
Revision	1.1	June 30, 2006	Revised version of the Attachment B-1, Section 7, that includes provisions applicable to MCOs participating in the STAR+PLUS Program. Sections 7.1 to 7.3 modified to include STAR+PLUS.
Revision	1.2	September 1, 2006	Revised version of the Attachment B-1, Section 7, that includes provisions applicable to MCOs participating in the STAR and CHIP Programs. Section 7.3.1.7, Operations Readiness, changes reference from “Operational Date” to “Effective Date.”
Revision	1.3	September 1, 2006	Revised version of the Attachment B-1, Section 7, that includes provisions applicable to MCOs participating in the CHIP Perinatal Program. Sections 7.2, 7.3, and 7.3.1.2 through 7.3.1.7 modified to include the CHIP Perinatal Program.
Revision	1.4	September 1, 2006	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.7	July 1, 2007	Section 7.3.1.9 is modified to add a cross-reference to Attachment B-1, Sections 8.1.1.2 and 8.1.18.
Revision	1.8	September 1, 2007	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.11	September 1, 2008	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.13	September 1, 2009	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.16	September 1, 2010	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.18	March 1, 2011	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.19	September 1, 2011	Contract amendment did not revise Attachment B-1 Section 7 – Transition Phase Requirements
Revision	1.20	January 1, 2012	

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

7. Transition Phase Requirements

7.1 Introduction

This Section presents the scope of work for the Transition Phase of the Contract, which includes those activities that must take place between the time of Contract award and the Operational Start Date.

The Transition Phase will include a Readiness Review of each HMO, which must be completed successfully prior to a HMO’s Operational Start Date for each applicable HMO Program. HHSC may, at its discretion, postpone the Operational Start Date of the Contract for any such HMO that fails to satisfy all Transition Phase requirements.

If for any reason, a HMO does not fully meet the Readiness Review prior to the Operational Start Date, and HHSC has not approved a delay in the Operational Start Date or approved a delay in the HMO’s compliance with the applicable Readiness Review requirement, then HHSC shall impose remedies and either actual or liquidated damages. If the HMO is a current HMO Contractor, HHSC may also freeze enrollment into the HMO’s plan for any of its HMO Programs. Refer to the **HHSC Uniform Managed Care Contract Terms and Conditions (Attachment A)** and the **Liquidated Damages Matrix (Attachment B-5)** for additional information.

7.2 Transition Phase Scope for HMOs

STAR, STAR+PLUS and CHIP HMOs must meet the Readiness Review requirements established by HHSC no later than 90 days prior to the Operational Start Date for each applicable HMO Program. CHIP Perinatal HMOS must meet the Readiness Review requirements established by HHSC not later than 60 days prior to the Operational Start Date for the CHIP Perinatal Program. HMO agrees to provide all materials required to complete the readiness review by the dates established by HHSC and its Contracted Readiness Review Vendor.

7.3 Transition Phase Schedule and Tasks

The Transition Phase will begin after both Parties sign the Contract. The start date for the STAR and CHIP Transition Phase is November 15, 2005. The start date for the STAR+PLUS Transition Phase is June 30, 2006. The start date for the CHIP Perinate Transition Phase is September 1, 2006.

The Transition Phase must be completed no later than the agreed upon Operational Start Date(s) for each HMO Program and Service Area. The HMO may be subject to liquidated damages for failure to meet the agreed upon Operational Start Date (see **Attachment B-5**).

7.3.1 Transition Phase Tasks

The HMO has overall responsibility for the timely and successful completion of each of the Transition Phase tasks. The HMO is responsible for clearly specifying and requesting information needed from HHSC, other HHSC contractors, and Providers in a manner that does not delay the schedule or work to be performed.

7.3.1.1 Contract Start-Up and Planning

HHSC and the HMO will work together during the initial Contract start-up phase to:

- define project management and reporting standards;
- establish communication protocols between HHSC and the HMO;

- establish contacts with other HHSC contractors;

- establish a schedule for key activities and milestones; and

- clarify expectations for the content and format of Contract Deliverables.

The HMO will be responsible for developing a written work plan, referred to as the Transition/Implementation Plan, which will be used to monitor progress throughout the Transition Phase. An updated and detailed Transition /Implementation Plan will be due to HHSC.

7.3.1.2 Administration and Key HMO Personnel

No later than the Effective Date of the Contract, the HMO must designate and identify Key HMO Personnel that meet the requirements in **HHSC Uniform Managed Care Contract Terms & Conditions, Article 4.** The HMO will supply HHSC with resumes of each Key HMO Personnel as well as organizational information that has changed relative to the HMO's Proposal, such as updated job descriptions and updated organizational charts, (including updated Management Information System (MIS) job descriptions and an updated MIS staff organizational chart), if applicable. If the HMO is using a Material Subcontractor(s), the HMO must also provide the organizational chart for such Material Subcontractor(s).

No later than the Contract execution date, STAR+PLUS HMOs must update the information above and provide any additional information as it relates to the STAR+PLUS Program.

No later than the Contract execution date, CHIP Perinatal HMOs must update the information above and provide any additional information as it relates to the CHIP Perinatal Program.

7.3.1.3 Financial Readiness Review

In order to complete a Financial Readiness Review, HHSC will require that HMOs update information submitted in their proposals. Note: STAR+PLUS and/or CHIP Perinatal HMOs who have already submitted proposal updates for HHSC's review for STAR and/or CHIP, must either verify that the information has not changed and that it applies to STAR+PLUS and/or the CHIP Perinatal Program or provide updated information for STAR+PLUS by July 10, 2006 and for the CHIP Perinatal Program by September 1, 2006. This information will include the following:

Contractor Identification and Information

1. The Contractor's legal name, trade name, or any other name under which the Contractor does business, if any.

2. The address and telephone number of the Contractor's headquarters office.

3. A copy of its current Texas Department of Insurance Certificate of Authority to provide HMO or ANHC services in the applicable Service Area(s). The Certificate of Authority must include all counties in the Service Area(s) for which the Contractor is proposing to serve HMO Members.

4. Indicate with a "Yes-HMO", "Yes-ANHC" or "No" in the applicable cell(s) of the Column B of the following chart whether the Contractor is currently certified by TDI as an HMO or ANHC in **all** counties in each of the CSAs in which the Contractor proposes to participate in one or more of the HHSC HMO Programs. If the Contractor is not proposing to serve a CSA for a particular HMO Program, the Contractor should leave the applicable cells in the table empty.

Table 2: TDI Certificate of Authority in Proposed HMO Program CSAs

Column A	Column B	Column C
Core Service Area (CSA)	**TDI Certificate of Authority**	**Counties/Partial Counties without a TDI Certificate of Authority**
Bexar		
Dallas		
El Paso		
Harris		
Lubbock		
Nueces		
Tarrant		
Travis		
Webb		

If the Contractor is **not** currently certified by TDI as an HMO or ANHC in any one or more counties in a proposed CSA, the Contractor must identify such entire counties in Column C for each CSA. For each county listed in Column C, the Contractor must document that it applied to TDI for such certification of authority prior to the submission of a Proposal for this RFP. The Contractor shall indicate the date that it applied for such certification and the status of its application to get TDI certification in the relevant counties in this section of its submission to HHSC.

5. For Contractors serving any CHIP and CHIP Perinatal OSAs, indicate with a "Yes-HMO", "Yes-ANHC" or "No" in the applicable cell(s) of the Column C of the following chart whether the Contractor is currently certified by TDI as an HMO or ANHC in the entire county in the OSA. If the Contractor is not proposing to serve an OSA, the Contractor should leave the applicable cells in the table empty.

Table 3: TDI Certificate of Authority in Proposed HMO Program OSAs

CHIP Program

Column A	Column B	Column C
Core Service Area (CSA)	**Affiliated CHIP OSA**	**TDI Certificate of Authority**
Bexar		
El Paso		
Harris		
Lubbock		
Nueces		
Travis		

CHIP Perinatal Program

Column A	Column B	Column C
Core Service Area (CSA)	**Affiliated CHIP OSA**	**TDI Certificate of Authority**
Bexar		
El Paso		
Harris		
Lubbock		
Nueces		
Travis		

For each county listed in Column C, the Contractor must document that it applied to TDI for such certification of authority prior to the submission of a Proposal for this RFP. The Contractor shall indicate the date that it applied for such certification and the status of its application to get TDI certification in the relevant counties in this section of its submission to HHSC.

6. If the Contractor proposes to participate in STAR or STAR+PLUS and seeks to be considered as an organization meeting the requirements of Section §533.004(a) or (e) of the Texas Government Code, describe how the Contractor meets the requirements of §§533.004(a)(1), (a)(2), (a)(3), or (e) for each proposed Service Areas.
7. The type of ownership (proprietary, partnership, corporation).
8. The type of incorporation (for profit, not-for-profit, or non-profit) and whether the Contractor is publicly or privately owned.
9. If the Contractor is an Affiliate or Subsidiary, identify the parent organization.
10. If any change of ownership of the Contractor's company is anticipated during the 12 months following the Proposal due date, the Contractor must describe the circumstances of such change and indicate when the change is likely to occur.
11. The name and address of any sponsoring corporation or others who provide financial support to the Contractor and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.
12. The name and address of any health professional that has at least a five percent financial interest in the Contractor and the type of financial interest.
13. The names of officers and directors.
14. The state in which the Contractor is incorporated and the state(s) in which the Contractor is licensed to do business as an HMO. The Contractor must also indicate the state where it is commercially domiciled, if applicable.
15. The Contractor's federal taxpayer identification number.
16. The Contractor's Texas Provider Identifier (TPI) number if the Contractor is Medicaid-enrolled in Texas.
17. Whether the Contractor had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the Contractor must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Contractor must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.
18. A current Certificate of Good Standing issued by the Texas Comptroller of Public Accounts, or an explanation for why this form is not applicable to the Contractor.
19. Whether the Contractor has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation status, and if it has or is, indicate:
    - its current NCQA or URAC accreditation status;

    - if NCQA or URAC accredited, its accreditation term effective dates; and

• if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Contractor.

Material Subcontractor Information

A Material Subcontractor means any entity retained by the HMO to provide all or part of the HMO Administrative Services where the value of the subcontracted HMO Administrative Service(s) exceeds $100,000 per fiscal year. HMO Administrative Services are those services or functions other than the direct delivery of Covered Services necessary to manage the delivery of and payment for Covered Services. HMO Administrative Services include but are not limited to Network, utilization, clinical and/or quality management, service authorization, claims processing, Management Information System (MIS) operation and reporting. The term Material Subcontractor does not include Providers in the HMO's Provider Network.

Contractors must submit the following for each proposed Material Subcontractor, if any:

1. A signed letter of commitment from each Material Subcontractor that states the Material Subcontractor's willingness to enter into a Subcontractor agreement with the Contractor and a statement of work for activities to be subcontracted. Letters of Commitment must be provided on the Material Subcontractor's official company letterhead and signed by an official with the authority to bind the company for the subcontracted work. The Letter of Commitment must state, if applicable, the company's certified HUB status.
2. The Material Subcontractor's legal name, trade name, or any other name under which the Material Subcontractor does business, if any.
3. The address and telephone number of the Material Subcontractor's headquarters office.
4. The type of ownership (e.g., proprietary, partnership, corporation).
5. The type of incorporation (i.e., for profit, not-for-profit, or non-profit) and whether the Material Subcontractor is publicly or privately owned.
6. If a Subsidiary or Affiliate, the identification of the parent organization.
7. The name and address of any sponsoring corporation or others who provide financial support to the Material Subcontractor and type of support, e.g., guarantees, letters of credit, etc. Indicate if there are maximum limits of the additional financial support.
8. The name and address of any health professional that has at least a five percent (5%) financial interest in the Material Subcontractor and the type of financial interest.
9. The state in which the Material Subcontractor is incorporated, commercially domiciled, and the state(s) in which the organization is licensed to do business.
10. The Material Subcontractor's Texas Provider Identifier if Medicaid-enrolled in Texas.
11. The Material Subcontractor's federal taxpayer identification number.
12. Whether the Material Subcontractor had a contract terminated or not renewed for non-performance or poor performance within the past five years. In such instance, the Contractor must describe the issues and the parties involved, and provide the address and telephone number of the principal terminating party. The Contractor must also describe any corrective action taken to prevent any future occurrence of the problem leading to the termination.
13. Whether the Material Subcontractor has ever sought, or is currently seeking, National Committee for Quality Assurance (NCQA) or American Accreditation HealthCare Commission (URAC) accreditation or certification status, and if it has or is, indicate:
    - its current NCQA or URAC accreditation or certification status;
    - if NCQA or URAC accredited or certified, its accreditation or certification term effective dates; and
    - if not accredited, a statement describing whether and when NCQA or URAC accreditation status was ever denied the Material Subcontractor.

Organizational Overview

1. Submit an organizational chart (labeled Chart A), showing the corporate structure and lines of responsibility and authority in the administration of the Bidder's business as a health plan.

2. Submit an organizational chart (labeled Chart B) showing the Texas organizational structure and how it relates to the proposed Service Area(s), including staffing and functions performed at the local level. If Chart A represents the entire organizational structure, label the submission as Charts A and B.

3. Submit an organizational chart (labeled Chart C) showing the Management Information System (MIS) staff organizational structure and how it relates to the proposed Service Area(s) including staffing and functions performed at the local level.

4. If the Bidder is proposing to use a Material Subcontractor(s), the Bidder shall include an organizational chart demonstrating how the Material Subcontractor(s) will be managed within the Bidder's Texas organizational structure, including the primary individuals at the Bidder's organization and at each Material Subcontractor organization responsible for overseeing such Material Subcontract. This information may be included in Chart B, or in a separate organizational chart(s).

5. Submit a brief narrative explaining the organizational charts submitted, and highlighting the key functional responsibilities and reporting requirements of each organizational unit relating to the Bidder's proposed management of the HMO Program(s), including its management of any proposed Material Subcontractors.

Other Information

1. Briefly describe any regulatory action, sanctions, and/or fines imposed by any federal or Texas regulatory entity or a regulatory entity in another state within the last 3 years, including a description of any letters of deficiencies, corrective actions, findings of non-compliance, and/or sanctions. Please indicate which of these actions or fines, if any, were related to Medicaid or CHIP programs. HHSC may, at its option, contact these clients or regulatory agencies and any other individual or organization whether or not identified by the Contractor.

2. No later than ten (10) days after the Contract Effective Date, submit documentation that demonstrates that the HMO has secured the required insurance and bonds in accordance with TDI requirements and Attachment B-1, Section 8.

3. Submit annual audited financial statement for fiscal years 2004 and 2005 (2005 to be submitted no later than six months after the close of the fiscal year).

4. Submit an Affiliate Report containing a list of all Affiliates and for HHSC's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the HMO by the Affiliate. Those should include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the HMO for such services during the Contract Period.

7.3.1.4 System Testing and Transfer of Data

The HMO must have hardware, software, network and communications systems with the capability and capacity to handle and operate all MIS systems and subsystems identified in **Attachment B-1, Section 8.1.18**. For example, the HMO's MIS system must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as indicated in **Section 8.1.18.4**.

During this Readiness Review task, the HMO will accept into its system any and all necessary data files and information available from HHSC or its contractors. The HMO will install and test all hardware, software, and telecommunications required to support the Contract. The HMO will define and test modifications to the HMO's system(s) required to support the business functions of the Contract.

The HMO will produce data extracts and receive all electronic data transfers and transmissions. STAR and CHIP HMOs must be able to demonstrate the ability to produce an EQRO (currently, Institute for Child Health Policy (ICHP)) encounter file by April 1, 2006, and the 837-encounter file by August 1, 2006. STAR+PLUS HMOs must be able to demonstrate the ability to produce the STAR+PLUS encounter file by the STAR+PLUS Operational Start Date and the 837- encounter file by September 1, 2007. CHIP Perinatal HMOs who have already demonstrated the ability to produce an EQRO encounter file and 837-encounter file for the CHIP Program are not required to produce separate files for the CHIP Perinatal Program.

If any errors or deficiencies are evident, the HMO will develop resolution procedures to address problems identified. The HMO will provide HHSC, or a designated vendor, with test data files for systems and interface testing for all external interfaces. This includes testing of the required telephone lines for Providers and Members and any necessary connections to the HHSC Administrative Services Contractor and the External Quality Review Organization. The HHSC Administrative Services Contractor will provide enrollment test files to new HMOs that do not have previous HHSC enrollment files. The HMO will demonstrate its system capabilities and adherence to Contract specifications during readiness review.

7.3.1.5 System Readiness Review

The HMO must assure that systems services are not disrupted or interrupted during the Operations Phase of the Contract. The HMO must coordinate with HHSC and other contractors to ensure the business and systems continuity for the processing of all health care claims and data as required under this contract.

The HMO must submit to HHSC, descriptions of interface and data and process flow for each key business processes described in **Section 8.1.18.3**, System-wide Functions.

The HMO must clearly define and document the policies and procedures that will be followed to support day-to-day systems activities. The HMO must develop, and submit for State review and approval, the following information by December 14, 2005 for STAR and CHIP, by July 31, 2006 for STAR+PLUS:

1. Joint Interface Plan.

2. Disaster Recovery Plan

3. Business Continuity Plan

4. Risk Management Plan, and

5. Systems Quality Assurance Plan.

Separate plans are not required for CHIP Perinatal HMOs.

7.3.1.6 Demonstration and Assessment of System Readiness

The HMO must provide documentation on systems and facility security and provide evidence or demonstrate that it is compliant with HIPAA. The HMO shall also provide HHSC with a summary of all recent external audit reports, including findings and corrective actions, relating to the HMO's proposed systems, including any SAS70 audits that have been conducted in the past three years. The HMO shall promptly make additional information on the detail of such system audits available to HHSC upon request.

In addition, HHSC will provide to the HMO a test plan that will outline the activities that need to be performed by the HMO prior to the Operational Start Date of the Contract. The HMO must be prepared to assure and demonstrate system readiness. The HMO must execute system readiness test cycles to include all external data interfaces, including those with Material Subcontractors.

HHSC, or its agents, may independently test whether the HMO's MIS has the capacity to administer the STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO business, as applicable to the HMO. This Readiness Review of a HMO's MIS may include a desk review and/or an onsite review. HHSC may request from the HMO additional documentation to support the provision of STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO Services, as applicable to the HMO. Based in part on the HMO's assurances of systems readiness, information contained in the Proposal, additional documentation submitted by the HMO, and any review conducted by HHSC or its agents, HHSC will assess the HMO's understanding of its responsibilities and the HMO's capability to assume the MIS functions required under the Contract.

The HMO is required to provide a Corrective Action Plan in response to any Readiness Review deficiency no later than ten (10) calendar days after notification of any such deficiency by HHSC. If the HMO documents to HHSC's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.1.7 Operations Readiness

The HMO must clearly define and document the policies and procedures that will be followed to support day-to-day business activities related to the provision of STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO Services, including coordination with contractors. The HMO will be responsible for developing and documenting its approach to quality assurance.
Readiness Review. Includes all plans to be implemented in one or more Service Areas on the anticipated Operational Start Date. At a minimum, the HMO shall, for each HMO Program:

1. Develop new, or revise existing, operations procedures and associated documentation to support the HMO's proposed approach to conducting operations activities in compliance with the contracted scope of work.
2. Submit to HHSC, a listing of all contracted and credentialed Providers, in a HHSC approved format including a description of additional contracting and credentialing activities scheduled to be completed before the Operational Start Date.
3. Prepare and implement a Member Services staff training curriculum and a Provider training curriculum.
4. Prepare a Coordination Plan documenting how the HMO will coordinate its business activities with those activities performed by HHSC contractors and the HMO's Material Subcontractors, if any. The Coordination Plan will include identification of coordinated activities and protocols for the Transition Phase.
5. Develop and submit to HHSC the draft Member Handbook, draft Provider Manual, draft Provider Directory, and draft Member Identification Card for HHSC's review and approval. The materials must at a minimum meet the requirements specified in **Section 8.1.5** and include the Critical Elements to be defined in the **HHSC Uniform Managed Care Manual**.
6. Develop and submit to HHSC the HMO's proposed Member complaint and appeals processes for Medicaid, CHIP, and CHIP Perinatal as applicable to the HMO's Program participation.
7. Provide sufficient copies of the final Provider Directory to the HHSC Administrative Services Contractor in sufficient time to meet the enrollment schedule.
8. Demonstrate toll-free telephone systems and reporting capabilities for the Member Services Hotline, the Behavioral Health Hotline, and the Provider Services Hotline.
9. Submit a written Fraud and Abuse Compliance Plan to HHSC for approval no later than 30 days after the Contract Effective Date. See **Section 8.1.19**, Fraud and Abuse, for the requirements of the plan, including new requirements for special investigation units. As part of the Fraud and Abuse Compliance Plan, the HMO shall:

- designate executive and essential personnel to attend mandatory training in fraud and abuse detection, prevention and reporting. Executive and essential fraud and abuse personnel means HMO staff persons who supervise staff in the following areas: data collection, provider enrollment or disenrollment, encounter data, claims processing, utilization review, appeals or grievances, quality assurance and marketing, and who are directly involved in the decision-making and administration of the fraud and abuse detection program within the HMO. The training will be conducted by the Office of Inspector General, Health and Human Services Commission, and will be provided free of charge. The HMO must schedule and complete training no later than 90 days after the Effective Date.

- designate an officer or director within the organization responsible for carrying out the provisions of the Fraud and Abuse Compliance Plan.

- The HMO is held to the same requirements and must ensure that, if this function is subcontracted to another entity, the subcontractor also meets all the requirements in this section and the Fraud and Abuse section as stated in **Attachment B-1, Section 8**.

- Note: STAR+PLUS HMOs who have already submitted and received HHSC's approval for their Fraud and Abuse Compliance Plans must submit acknowledgement that the HMO's approved Fraud and Abuse Compliance Plan also applies to the STAR+PLUS program, or submit a revised Fraud and Abuse Compliance Plan for HHSC's approval, with an explanation of changes to be made to incorporate the STAR+PLUS program into the plan, by July 10, 2006.

- CHIP Perinatal HMOs who have already submitted and received HHSC's approval for their Fraud and Abuse Compliance Plans must submit acknowledgement that the HMO's approved Fraud and Abuse Compliance Plan also applies to the CHIP Perinatal Program, or submit a revised Fraud and Abuse Compliance Plan for HHSC's approval, with an explanation of changes to be made to incorporate the CHIP Perinatal program into the plan, by September 15, 2006.

- Complete hiring and training of STAR+PLUS Service Coordination staff, no later than 45 days prior to the STAR+PLUS Operational Start Date.

During the Readiness Review, HHSC may request from the HMO certain operating procedures and updates to documentation to support the provision of STAR, STAR+PLUS, CHIP, and/or CHIP Perinatal HMO Services. HHSC will assess the HMO's understanding of its responsibilities and the HMO's capability to assume the functions required under the Contract, based in part on the HMO's assurances of operational readiness, information contained in the Proposal, and in Transition Phase documentation submitted by the HMO.

The HMO is required to promptly provide a Corrective Action Plan and/or Risk Mitigation Plan as requested by HHSC in response to Operational Readiness Review deficiencies identified by the HMO or by HHSC or its agent. The HMO must promptly alert HHSC of deficiencies, and must correct a deficiency or provide a Corrective Action Plan and/or Risk Mitigation Plan no later than ten (10) calendar days after HHSC's notification of deficiencies. If the Contractor documents to HHSC's satisfaction that the deficiency has been corrected within ten (10) calendar days of such deficiency notification by HHSC, no Corrective Action Plan is required.

7.3.1.8 Assurance of System and Operational Readiness

In addition to successfully providing the Deliverables described in **Section 7.3.1**, the HMO must assure HHSC that all processes, MIS systems, and staffed functions are ready and able to successfully assume responsibilities for operations prior to the Operational Start Date. In particular, the HMO must assure that Key HMO Personnel, Member Services staff, Provider Services staff, and MIS staff are hired and trained, MIS systems and interfaces are in place and functioning properly, communications procedures are in place, Provider Manuals have been distributed, and that Provider training sessions have occurred according to the schedule approved by HHSC.

7.3.1.9 Post-Transition

The HMO will work with HHSC, Providers, and Members to promptly identify and resolve problems identified after the Operational Start Date and to communicate to HHSC, Providers, and Members, as applicable, the steps the HMO is taking to resolve the problems.

If a HMO makes assurances to HHSC of its readiness to meet Contract requirements, including MIS and operational requirements, but fails to satisfy requirements set forth in this Section, or as otherwise required pursuant to the Contract, HHSC may, at its discretion do any of the following in accordance with the severity of the non-compliance and the potential impact on Members and Providers:

1. freeze enrollment into the HMO's plan for the affected HMO Program(s) and Service Area(s);

2. freeze enrollment into the HMO's plan for all HMO Programs or for all Service Areas of an affected HMO Program;

3. impose contractual remedies, including liquidated damages; or

4. pursue other equitable, injunctive, or regulatory relief.

Refer to **Attachment B-1, Sections 8.1.1.2** and **8.1.18** for additional information regarding HMO Readiness Reviews during the Operations Phase.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version Attachment B-1, Section 8
Revision	1.1	June 30, 2006	Revised version of the Attachment B-1, Section 8, that includes provisions applicable to MCOs participating in the STAR+PLUS Program. Section 8.1.1.1, Performance Evaluation, is modified to include STAR+PLUS Performance Improvement Goals. Section 8.1.2, Covered Services, is modified to include Functionally Necessary Community Long-term Care Services for STAR+PLUS. Section 8.1.2.1 Value-Added Services, is modified to add language allowing for the HMO to distinguish between the Dual Eligible and non-Dual Eligible populations. Section 8.1.2.2 Case-by-Case Added Services, is modified to clarify for STAR+Plus members it is based on functionality. Section 8.1.3, Access to Care, is modified to include STAR+PLUS Functional Necessity and 1915(c) Nursing Facility Waiver clarifications. Section 8.1.4, Provider Network, is modified to include STAR+PLUS. Section 8.1.4.2, Primary Care Providers, is modified to include STAR+PLUS Section 8.1.4.8, Provider Reimbursement, is modified to include Functionally Necessary Long-term care services for STAR+PLUS. Section 8.1.7.7, Provider Profiling, is modified to include STAR+PLUS. Sections 8.1.12 and 8.1.12.2, Services for People with Special Health Care Needs, are modified to include STAR+PLUS. Section 8.1.13, Service Management for Certain Populations, is modified to include STAR+PLUS. Section 8.1.14, Disease Management, is modified to include STAR+PLUS. Section 8.2, Additional Medicaid HMO Scope of Work, is modified to include STAR+PLUS. Section 8.3, Additional STAR+PLUS Scope of Work, is added.
Revision	1.2	September 1, 2006	Revised version of Attachment B-1, Section 8, that includes provisions applicable to MCOs participating in the STAR and CHIP Programs. Section 8.1.1.1, Performance Evaluation, is modified to clarify that the HMOs goals are Service Area and Program specific; when the percentages for Goals 1 and 2 are to be negotiated; and when Goal 3 is to be negotiated. Section 8.1.2.1, Value-Added Services, is modified to add language allowing for the addition of two Value-added Services during the Transition Phase of the Contract and to clarify the effective dates for Value Added Services for the Transition Phase and the Operation Phase of the Contract. Section 8.1.3.2, Access to Network Providers, is modified to delete references to Open Panels. Section 8.1.4, Provider Network, is modified to clarify that "Out-of-Network reimbursement arrangements" with certain providers must be in writing. Section 8.1.5.1, Member Materials, is modified to clarify the date that the member ID card and the member handbook are to be sent to members. Section 8.1.5.6, Member Hotline, is modified to clarify the hotline performance requirements. Section 8.1.17.2, Financial Reporting Requirements, is modified to clarify that the Bonus Incentive Plan refers to the Employee Bonus Incentive Plan. It has also been modified to clarify the reports and deliverable due dates and to change the name of the Claims Summary Lag Report and clarify that the report format has been moved to the Uniform Managed Care Manual. Section 8.1.18.5, Claims Processing Requirements, is modified to revise the claims processing requirements and move many of the specifics to the Uniform Managed Care Manual. Section 8.1.20, Reporting Requirements, is modified to clarify the reports and deliverable due dates. Section 8.1.20.2, Reports, is modified to delete the Claims Data Specifications Report, amend the All Claims Summary Report, and add two new provider-related reports to the contract. Section 8.2.2.10, Cooperation with Immunization Registry, is added to comply with legislation, SB 1188 sec. 6(e)(1), 79th Legislature, Regular Session, 2005. Section 8.2.2.11, Case Management for Children and Pregnant Women, is added. Section 8.2.5.1, Provider Complaints, is modified to include the 30-day resolution requirement. Section 8.2.10.2, Non-Reimbursed Arrangements with Local Public Health Entities, is modified to update the requirements and delete the requirement for an MOU. Section 8.2.11, Coordination with Other State Health and Human Services (HHS) Programs, is modified to update the requirements and delete the requirement for an MOU. Section 8.4.2, CHIP Provider Complaint and Appeals, is modified to include the 30-day resolution requirement.
Revision	1.3	September 1, 2006	Revised version of Attachment B-1, Section 8, that includes provisions applicable to MCOs participating in the CHIP Perinatal Program. Section 8.1.1.1, Performance Evaluation, is modified to clarify that HHSC will negotiate and implement Performance Improvement Goals for the first full State Fiscal Year following the CHIP Perinatal Operational Start Date Section 8.1.2, Covered Services is amended to: (a) clarify that Fee For Service will pay the Hospital costs for CHIP Perinate Newborns; (b) add a reference to new Attachment B-2.2 concerning covered services; (c) add CHIP Perinate references where appropriate. Section 8.1.2.2 Case-by-Case Added Services, is modified to clarify that this does not apply to the CHIP Perinatal Program. Section 8.1.3, Access to Care, is amended to include emergency services limitations. Section 8.1.3.2, Access to Network Providers, is amended to include the Provider access standards for the CHIP Perinatal Program. Section 8.1.4.2 Primary Care Providers, is modified to clarify the development of the PCP networks between the CHIP Perinates and the CHIP Perinate Newborns. Section 8.1.4.6 Provider Manual, Materials and Training, modified to include the CHIP Perinatal Program Section 8.1.4.9 Termination of Provider Contracts modified to include the CHIP Perinatal Program. Section 8.1.5.2 Member Identification (ID) Card, modified to include the CHIP Perinatal Program. Section 8.1.5.3 Member Handbook, modified to include the CHIP Perinatal Program. Section 8.1.5.4 Provider Directory, modified to include the CHIP Perinatal Program. Section 8.1.5.6 Member Hotline, modified to include the CHIP Perinatal Program. Section 8.1.5.7 Member Education, modified to include the CHIP Perinatal Program. Section 8.1.5.9 Member Complaint and Appeal Process, modified to include the CHIP Perinatal Program. Section 8.1.7.7, Provider Profiling, is modified to include the CHIP Perinatal Program. Section 8.1.12, Services for People with Special Health Care Needs, modified to clarify between CHIP Perinatal Program and CHIP Perinatal Newborn. Section 8.1.13, Service Management for Certain Populations, modified to clarify the CHIP Perinatal Program. Section 8.1.15, Behavioral Health (BH) Network and Services, modified to clarify between CHIP Perinatal and Perinate members. Section 8.1.17.2, Financial Reporting Requirements, modified to include the CHIP Perinatal Program. Section 8.1.18.3, System-wide Functions, modified to include the CHIP Perinatal Program. Section 8.1.18.5, Claims Processing Requirements, modified to include the CHIP Perinatal Program. Section 8.1.19, Fraud and Abuse, modified to include the CHIP Perinatal Program Section 8.1.20.2, Provider Termination Report and Provider Network Capacity Report, is modified to include the CHIP Perinatal Program. Section 8.5, Additional Scope of Work for CHIP Perinatal Program HMOs, is added to Attachment B-1.
Revision	1.4	September 1, 2006	Contract amendment did not revise Attachment B-1, Section 8-Operations Phase Requirements.
Revision	1.5	January 1, 2007	Revised version of the Attachment B-1, Section 8, that includes provisions applicable to MCOs participating in the STAR and STAR+PLUS Program. Section 8.1.2 is modified to include a reference to STAR and STAR+PLUS covered services. Section 8.1.20.2 is modified to update the references to the Uniform Managed Care Manual for the "Summary Report of Member Complaints and Appeals" and the "Summary Report of Provider Complaints." Section 8.2.2.5 is modified to require the Provider to coordinate with the Regional Health Authority.

			Section 8.2.4 is amended to clarify cost settlements and encounter rates for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) for STAR and STAR+PLUS service areas. Section 8.3.2.4 is amended to clarify the timeframe for initial STAR+PLUS assessments. Section 8.3.3 is amended to: (1) clarify the use of the DHS Form 2060; (2) require the HMO to complete the Individual Service Plan (ISP), Form 3671 for each Member receiving 1915(c) Nursing Facility Waiver Services; (3) require HMOs to complete Form 3652 and Form 3671annually at reassessment; (4) allow the HMOs to administer the Minimum Data Set for Home Care (MDS-HC) instrument for non-waiver STAR+PLUS Members over the course of the first year of operation; (5) allow HMOs to submit other supplemental assessment instruments. Section 8.3.4 is modified to include the criteria for participation in 1915(c) nursing facility waiver services. Section 8.3.4.3 is amended to remove the six-month timeframe for Nursing Facility Cost Ceiling. Deletes provision stating DADS Commissioner may grant exceptions in individual cases. Section 8.3.5 is amended to delete the requirement that HMOs use the Consumer Directed Services option for the delivery of Personal Attendant Services. The new language provides HMOs with three options for delivering these services. The options are described in the following new subsections: 8.3.5.1, Personal Attendant Services Delivery Option – Self-Directed Model; 8.3.5.2, Personal Attendant Services Delivery Option – Agency Model, Self-Directed; and 8.3.5.3, Personal Attendant Services Delivery Option – Agency Model. Section 8.3.7.3 is modified to reflect the changes made by the HMO workgroup regarding enhanced payments for attendant care. The section also includes a reference to new Attachment B-7, which contains the HMO's methodology for implementing and paying the enhanced payments.
Revision	1.6	February 1, 2007	Revised version of the Attachment B-1, Section 8, that includes provisions applicable to MCOs participating in the STAR+PLUS and CHIP Perinatal Programs. Section 8.1 is modified to clarify the Operational Start Date of the STAR+PLUS Program. Section 8.1.3.2 is modified to allow exceptions to hospital access standards on a case-by-case basis only for HMOs participating in the CHIP Perinatal Program. Section 8.3.3 is modified to clarify when the 12-month period begins for the STAR+PLUS HMOs to complete the MDS-HC instruments for non-1915(c) Nursing Facility Waiver Members who are receiving Community-based Long-term Care Services.
Revision	1.7	July 1, 2007	New Section 8.1.1.2 is added to require the HMOs to pay for any additional readiness reviews beyond the original ones conducted before the Operational Start Date. Section 8.1.5.5 is modified to add a requirement that all HMOs must list Home Health Ancillary providers on their websites, with an indicator for Pediatric services. Section 8.1.17.2 is modified to remove the requirement that the Claims Lag Report separate claims by service categories. Section 8.1.18 is modified to update the cross-references to sections of the contract addressing remedies and damages and to add cross-references to sections of the contract addressing Readiness Reviews. Section 8.1.18.5 is modified to require the HMO to make an electronic funds transfer payment process available when processing claims for Medically Necessary covered STAR+PLUS services. Section 8.1.19 is modified to comply with a new federal law that requires entities that receive or make Medicaid payments of at least $5 million annually to educate employees, contractors and agents and to implement policies and procedures for detecting and preventing fraud, waste and abuse. Section 8.1.20.2 is modified to require Provider Termination Reports for STAR+PLUS as required by the Dashboard. The amendment also requires Claims Summary Reports be submitted by claim type. Section 8.2.7.5 is modified to comply with the settlement agreement in the *Alberto N*. litigation. Section 8.3.4.3 is modified to remove references to the cost cap for 1915(c) Nursing Facility Waiver services.
Revision	1.8	September 1, 2007	Section 8.1.2.1 is modified to reflect legislative changes required by SB 10. Section 8.1.3.2 is modified to reflect legislative changes required by SB 10. Section 8.1.5.6 is modified to comply with the Frew litigation corrective action plans. New Section 8.1.5.6.1 is added to comply with the Frew litigation corrective action plans. Section 8.1.5.7 is modified to comply with the Frew litigation corrective action plans. Section 8.1.11 is modified to delete language included in error and to clarify the coverage for children in foster care. Section 8.1.13 is added to comply with the Frew litigation corrective action plans. Section 8.1.17.2 is modified to reflect legislative changes required by SB 10. Section 8.1.20.2 is modified to comply with the Frew litigation corrective action plans by adding two new reports: Medicaid Medical Check-ups Report and Medicaid FWC Report. Section 8.2.2.3 is modified to comply with Frew litigation correction action plans. New Section 8.2.2.12 is added to comply with the Frew litigation correction action plans to enhance care for children of Migrant Farmworkers. Section 8.2.4 is modified to clarify cost settlement requirements and encounter and payment reporting requirements for the Nueces Service Area and the STAR+PLUS Service Areas. Section 8.2.7.4 is amended to reflect the new fair hearings process for Medicaid Members that will be effective 9/1/07. Section 8.2.11 is modified to comply with the Frew litigation corrective action plans.
Revision	1.9	December 1, 2007	Section 8.1.17.1 is modified to include provider contracts in the documentation HMOs must provide upon request and the timeframes in which documents must be provided. Section 8.1.17.2 is modified to eliminate the plan's responsibility to submit the actuarial certification on the 90 day FSR. Section 8.1.20.2 is modified to change the name of the Medicaid Medical Check-ups Report to the Medicaid Managed Care Texas Health Steps Medical Checkups Annual Report (90-Day FREW Report) and to clarify the term "not previously enrolled". Section 8.2.2.8 is modified to reflect changes as a result of the Alberto N litigation Second Partial Settlement Agreement. Services for person under age 21 are being carved out of the STAR Program and provided through the Personal Care Services (PCS) benefit in traditional Medicaid Fee-for-Service. Section 8.2.7.4 is modified to clarify the HMO's role in filling out the request for Fair Hearing and to conform to Fair Hearings time requirements. Section 8.2.12 is modified to remove the outdated reference to 42 C.F.R. 434.28. Section 8.3.4 is modified to specify that plan of care at initial determination must be 200% or less of nursing facility cost. Section 8.3.5 is modified to clarify when the HMO must provide PAS information to Members receiving PAS services.
Revision	1.10	March 31, 2008	Section 8.1.4.4 is modified to add language regarding expedited credentialing as required by HB 1594. Section 8.1.12.2 is modified to transfer the Medical Transportation Program back to HHSC. Section 8.1.17 is modified to add a reference to Federal Acquisition Regulations ("FAR"). Section 8.1.20.2 is modified to change the name of the Medicaid FWC Report to the Children of Migrant Farm Workers Annual Report (FWC Annual Report) Section 8.2.4 is modified to include Municipal Health Department's Public Clinics.
Revision	1.11	September 1, 2008	Section 8.1.4 is modified to reflect waiver requirements. Section 8.1.4.2 is modified to remove the "Pediatric and Family" qualifier from Advanced Practice Nurses. Section 8.1.4.7 is modified to require the HMOs to pay all reasonable costs for HHSC to conduct onsite monitoring of the HMO's Provider Hotline functions. Section 8.1.5.6 is modified to require the HMOs to pay all reasonable costs for HHSC to conduct onsite monitoring of the HMO's Member Hotline functions. Section 8.1.14 is modified to require the HMO to coordinate continuity of care for Members in Disease Management who change plans. Section 8.1.15.3 is modified to clarify the first sentence. Section 8.1.18.1 is modified to clarify encounter data submission requirements. Section 8.1.18.2 is modified to require HMOs to follow applicable JIPs and required field submissions. This requirement has been moved from Attachment B-1, Section 8.1.20.2. Section 8.1.20.2 is modified to require the HMOs to submit copies of all internal and external audit reports. The requirement to follow applicable JIPs and required field submissions has been moved to Attachment B-1, Section 8.1.18.2. Section 8.2.1 is modified to add a cross reference to Section 8.1.14 for specific requirements for Members transferring to and from the HMO's DM Program. Section 8.2.2.3.1 is added to require the HMO to educate Texas Health Steps providers on the availability of the Oral Evaluation and Fluoride Varnish (OEVS) Medicaid benefit. Section 8.2.4 is modified to require the HMOs to pay full encounter rates to RHCs on or after September 1, 2008. Section 8.2.7.2 is modified to align contract references to TDI's recodification. Section 8.3.3 is modified to reflect current Waiver requirements and the conversion from the TILE to the RUG assessment instrument. Section 8.3.4.1 is modified to reflect the conversion from the TILE to the RUG assessment instrument. Section 8.3.4.2 is modified to reflect the conversion from the TILE to the RUG assessment instrument. Section 8.3.4.3 is modified to reflect current Waiver requirements and the conversion from the TILE to the RUG assessment instrument.
Revision	1.12	March 1, 2009	Section 8.1.2.1 is modified to conform to timeframes for the Health Plan Comparison Chart process. Section 8.1.4 is modified to include performance standards for out of network utilization. Section 8.1.5.5 is modified to require the HMOs to update their online provider directory at least twice a month. Section 8.1.5.6 is modified to clarify the maximum acceptable hold time. Section 8.1.15.3 is modified to clarify the maximum acceptable hold time and to require the HMOs to pay all reasonable costs for HHSC to conduct onsite monitoring of the HMO's Behavioral Health Hotline functions. Section 8.1.17.2 is modified to add Bariatric Supplemental Payment Reports and to clarify DSH report language. Section 8.1.19 is modified to clarify that a written Fraud and Abuse compliance plan must be submitted annually and to list the legal citations. Section 8.1.20.2 (h) Hotline Reports is modified to correct a contract reference. Section 8.2.2.8 is modified to reflect that Nursing facilities services will be carved out of the capitation payment to the HMOs. Section 8.3.2.7 is modified to reflect a corrective action plan required by CMS to address the funding methodology used by HHSC to pay for nursing facility services used by STAR+PLUS members. Nursing facilities services will be carved out of the capitation payment to the HMOs. Section 8.3.3 is modified to change the name from "Children's Comprehensive Assessment Form (CCAF Form)" to "Personal Care Assessment Form (PCAF Form)", to require PCAF reassessments every 12 months, and to allow HMOs until the end of the ISP period to submit the reassessment paperwork. Section 8.3.4.4 is modified to allow the use of General Revenue to cover costs above the 200% limit.
Revision	1.13	September 1, 2009	All references to "check-ups" are changed to "checkups" All references to "Medicaid Provider Procedures Manual" are changed to "Texas Medicaid Provider Procedures Manual" All references to "THSteps" are changed to "Texas Health Steps" Section 8.1.1.1 is modified to update Goal 3, change SFY2007 to SFY2010, and clarify the applicability of Goals 1 and 2. Section 8.1.2 is modified to delete the reference to the Texas Health Steps Manual. Section 8.1.3.1 is amended to change from checkup requirement from "60" days to "90" days and to replace the reference to the AAP periodicity schedule with the Texas Health Steps periodicity schedule. Section 8.1.3.2 is revised to provide additional clarity as it relates to Qualified Mental Health Providers – Community Services (QMHP-CS). Section 8.1.4.2 is amended to change the reference from the "THSteps Manual" to the "Texas Medicaid Provider Procedures Manual" and to clarify requirements for CHIP and Medicaid. Section 8.1.17.2 is modified to require CHIP and CHIP Perinatal HMOs to submit TPR reports.

			Section 8.1.18.1 is modified in compliance with HB 1218 to require HMOs to submit encounter data not later than the 30th day after the last day of the month in which the claim was adjudicated. Section 8.1.20.2 (j) is modified to remove the references to “annual”, change “check-ups” to checkups”, and change “90-Day FREW Report” to “Frew 90-Day Reports”. Section 8.1.20.2 (l) Frew Quarterly Monitoring Report is added. Section 8.1.20.2 (m) Frew Health Care Provider Training Report is added. Section 8.2.2.2 is amended to prohibit HMO from requiring pre-authorization for family planning services. Section 8.2.2.3 is amended to change from checkup requirement from “60” days to “90” days; change the periodicity schedule from “AAP” to “Texas Health Steps”; remove the reference to the Texas Department of Transportation; add “Corrective Action Orders” to the training requirements; change “DSHS THSteps outreach staff” to “the Texas Health Steps outreach unit”; change “again within two weeks from the time of birth” to “in accordance with the Texas Health Steps periodicity schedule”; change “two-week follow-up” to “newborn follow ups”; to spell out the acronym for ACIP; and change “HCFA 1500” to “CMS 1500”. Section 8.3.2.8 is added to require all STAR+PLUS plans to provide or have applied to provide MA/SNP services in all counties in which they offer STAR+PLUS services. Section 8.3.5 is amended to change the name from “Personal Attendant Services” to “Consumer Directed Services Options” and “In-Home or Out-of-Home Respite” is added as an option. Section 8.3.5.1 is amended to delete “Personal Attendant Services Delivery Option” from the name of the section and “In-Home or Out-of-Home Respite” is added as an option. Section 8.3.5.2 is amended to delete “Personal Attendant Services Delivery Option” from the name of the section and “In-Home or Out-of-Home Respite” is added as an option. Section 8.3.5.3 is amended to delete “Personal Attendant Services Delivery Option” from the name of the section and “In-Home or Out-of-Home Respite” is added as an option. Section 8.3.6.3 is modified to remove references to the DADS enhancement program. Section 8.4.5 Third Party Liability and Recovery is added to clarify the third party recovery requirements for CHIP HMOs. Section 8.4.6 is added to require CHIP HMOs to pay full encounter rates. Section 8.5.4 Dental Coverage for CHIP Perinate Newborn Members is added to clarify that the dental coverage requirements applicable to CHIP Members also apply to CHIP Perinate Newborns. Section 8.5.5 Third Party Liability and Recovery is added to clarify the third party recovery requirements for CHIP Perinatal HMOs. Section 8.5.6 is added to require CHIP Perinatal HMOs to pay full encounter rates.
Revision	1.14	December 1, 2009	Section 17.02(a) is modified to require the single bond per MCO with a defined term and amount beginning in SFY2010. Section 8.1.3.2 is revised to update the TAC citation. Section 8.1.4.4 is amended to add references to 42 C.F.R. §438.12 and 28 T.A.C. §11.1402. Section 8.1.12.2 is modified to remove references to PACT. Section 8.1.17.2 DSH Reports is modified to change the report due dates. Section 8.1.18 is modified to change the notification period from “generally 90 days” to “no later than 180 days prior to the planned change or implementation”. Section 8.1.18.2 is modified to require HMOs to submit their Disaster Recovery Plan, Business Continuity Plan, and Security Plan annually and to require HMOs to include checklists when submitting modified JIPs, Risk Management Plans and Systems Quality Assurance Plans. Section 8.2.2.8 is modified to remove references to PACT and to clarify that for STAR+PLUS, while inpatient stays are non-capitated, mental health inpatient stays are capitated. Section 8.4.6 is modified to omit the CHIP reporting requirement for FQHC and RHC payments. Section 8.5.6 is modified to omit the CHIP Perinatal Program reporting requirement for FQHC and RHC payments.
Revision	1.15	March 1, 2010	Section 8.1.3.1 is revised to conform to THSteps policy regarding timeliness of medical checkups for existing members ages 36 months and older which will be effective 9/1/10. Section 8.1.17.2 Financial Disclosure Report is revised to conform to federal requirements. Section 8.2.2.3 is revised to conform to THSteps policy regarding timeliness of medical checkups for existing members ages 36 months and older which will be effective 9/1/10. Section 8.2.8.2 “Substance Abuse Benefit” is added. This amendment will be effective the later of: September 1, 2010 or upon final approval of the Medicaid State Plan, 1915(b) STAR+PLUS waiver and/or the 1915(b) STAR waiver, as applicable to the HMO Program. Section 8.3.6.5 “STAR+PLUS Handbook” is added.
Revision	1.16	September 1, 2010	All references to “Frew vs. Hawkins” are changed to “Frew vs. Suehs”. Section 8.1.1.1 is modified to establish new Overarching Goals for FY2011 and to remove Service Areas as a category for sub-goals. Section 8.1.1.2 is modified to change the title to “Additional Readiness Reviews and Monitoring Efforts”, to clarify that HHSC may conduct desk and/or onsite reviews as part of its normal Contract monitoring activities, and to require the HMOs to pay all reasonable costs for HHSC to conduct those onsite reviews. Section 8.1.2.1 is modified to conform to timeframes for the Health Plan Comparison Chart process. Section 8.1.4.2 is modified to remove Certified Nurse Midwives and add Advanced Practice Nurses to the list of Providers eligible to be PCPs. Section 8.1.5.5 is modified to require identification of providers that provide long-term services and supports. Section 8.1.17.2 Financial Disclosure Report is revised to clarify federal requirements. Section 8.1.18 is modified to require the HMOs to pay all reasonable costs for HHSC to conduct onsite reviews. Section 8.1.18.5 is modified to conform to the timeframes for notification in Attachment A, Section 4.08(b)(3). New Section 8.1.18.6 is added, as required by Section 6507 of the Patient Protection and Affordable Care Act of 2010 (PPACA). Section 8.1.20.2 (j) is modified to remove “Frew 90-Day Reports” from the name of the report; to clarify what constitutes an Existing Member; and to remove the definition of “New Members”. Section 8.1.20.2 (n) Frew Provider Recognition Report is added. Section 8.2.2.8 is amended to clarify disenrollment for utilizing DADS hospice services and to add Span of Coverage exceptions for STAR and STAR+PLUS members described in Attachment A, Section 5.05(a)(2). Section 8.2.5.1 is modified to add liquidated damages. Section 8.5.2 is modified to clarify that the HMO not the Provider must respond to Providers’ appeals. Section 8.2.7.1 is modified to add liquidated damages. Section 8.2.8.2 “Substance Abuse Benefit” is modified to clarify that this section does not apply to the Dallas Service Area and that HMOs must contract with all qualified interested STPs. This amendment will be effective the later of: September 1, 2010 or upon final approval of the Medicaid State Plan, 1915(b) STAR+PLUS waiver and/or the 1915(b) STAR waiver, as applicable to the HMO Program. Section 8.2.9 is modified to change “date of service” to “date of adjudication”.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-1, Section 8-Operations Phase Requirements.
Revision	1.18	March 1, 2010	Section 8.1.1.1 is modified to change all "Performance Improvement Projects" and to establish new Overarching Goals for FY2011. Section 8.1.3.2 is revised to be consistent with the TDI requirement to allow pregnant Members past the 24th week of pregnancy to remain under the coare of their current OB/GYN, even if provider is Out-of-Network. Section 8.1.4.8 is modified to prohibit Medicaid payments to entities located outside the U.S. in conformance with the Affordable Care Act. Section 8.1.19 is modified to require HMOs to designate a primary and secondary contact for all OIG requests and to outline the process and timeframes for responding to the OIG. Immunization requirements from Section 8.2.2.3 "Texas Health Steps (EPSDT)" are moved to new Section 8.1.21 "Immunizations" as the requirements apply to both Medicaid and CHIP. Section 8.2.1 is revised to conform to the TDI requirement to allow pregnant Members past the 24th week of pregnancy to remain under the care of their current OB/GYN, even if provider is Out-of-Network. Section 8.2.2.3 is modified to reorder requirements and add subsection headings. Additional training requirements are added to the new Section 8.1.21 "Immunizations" as the requirements apply to both Medicaid and CHIP. Section 8.2.2.4 is amended to clarify that the 45 hour and 96 hour limits do not apply to neonatal care. Section 8.2.2.8 is amended to add "Texas Health Steps environmental lead investigation (ELI)". Remainder of list is renumbered. In addition, the section is amended to clarify disenrollment for utilizing DADS hospice services to add Span of Coverage exceptions for STAR and STAR+PLUS members described in Attachment A, Section 5.05(a)(2). Section 8.2.5.1 is revised to add the 98% standard for complaint resolution and to remove the 30 day request for extension requirementfor complaints received directly by the HMO. Section 8.3.1.1 is modified to change the name from 'Community-based Long-Term Care Services Available to all All Members' to "Community-based Long-Term Services and Supports Available to All Members" and to clarify that "Personal Assistance Services" is also called "Primary Home Care" for (b) Waiver Members. Section 8.3.1.2 is revised to change the name from "1915(c) Nursing Facility Waiver Services Available to Members Who Qualify for 1915(c) Nursing Facility Waiver Services" to "1915(c) STAR+PLUS Waiver Services Available to Members Who Qualify for 1915(c) STAR+PLUS Waiver Services" and to update the licensure and certification requirements. Section 8.3.6.6 is added to require STAR+PLUS HMOs to contact Members at least twice a year and to document that contact. Section 8.4.2 is revised to add the 98% standard for complaint resolution.
Revision	1.19	September 1, 2011	Section 8.1.1.1 is modified to remove redundant language.

		Section 8.1.4 is modified to require HMOs to contract with any willing ambulance provider that meets the HMO's credentialing requirements and agrees to the HMO's contract terms and rates. Section 8.1.4.8 is modified to add language for the ACA requirement regarding Healthcare Acquired Conditions (HAC) pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 2702 of ACA prohibits federal payments to States for any amount expended under Medicaid for health care-acquired conditions. Section 8.1.4.8.1 is added pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 2702 of ACA prohibits federal payments to States for any amount expended under Medicaid for health care-acquired conditions. Section 8.1.4.9 is modified to clarify compliance with 42 CFR 438.10(f)(5). Section 8.1.5.6 is modified to add clarification that the HMOs provide oral interpretive services free of charge, as required by 42 CFR 438.10(c)(4). Section 8.1.7.8 is modified to clarify current federal physician incentive plan requirements for Medicaid, and to add these requirements for CHIP. Section 8.1.8, Second Paragraph, is amended to refer to federal regulations regarding medical record content. Section 8.1.9 is modified to clarify the age requirements. Section 8.1.12.1 is modified to clarify that appropriate health care professionals must perform assessments, as required by 42 CFR 438.208(c)(2). Section 8.1.17.2 is modified to add the dates of service for which Bariatric Supplemental Reports are required. Section 8.1.18.5 is modified pursuant to the Patient Protection and Affordable Care Act of 2010 (Pubic Law 111–148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), together known as the Affordable Care Act (ACA). Section 6401(b)(7) of the ACA requires the State to require all ordering or referring providers or other professionals to be enrolled in the program and that the national provider identifier (NPI) of any ordering or referring physician or other professional to be specified on the claims for payments for Medicaid and CHIP. Section 8.1.19 is modified to correct references to the Texas Government Code. Section 8.2.1 is modified to require the HMOs to honor prior authorizations for acute care services and continue Community-based Long Term Care Services for Members in the Expansion Counties. Section 8.2.4 is modified to require the HMOs to pay FQHCs at the full encounter rate effective 9/1/11. Section 8.2.7.1 is modified to remove the requirement to maintain a local telephone number for Member Complaints and to clarify that the HMO provide oral interpretive services free of charge, as required by 42 CFR 438.10(c)(4) . The section is also modified to clarify that the HMO must provide written notice of complaints resolutions that cannot be resolved orally, in accordance with 42 CFR 438.408(d)(1). Section 8.2.7.2 is modified to remove the requirement to maintain a local telephone number for Member Appeals and to clarify that the HMO provide oral interpretive services free of charge, as required by 42 CFR 438.10(c)(4). Section 8.3.2.4 is modified to require the HMOs to honor prior authorizations for Members in the Expansion Counties. Section 8.3.2.8 Prioritization Plan is added. Section 8.3.4.1 is modified to clarify the SPW eligibility process. Section 8.3.4.2 is modified to clarify the MAO eligibility process. Section 8.3.5 is modified to add the new CDS benefits. Section 8.3.5.1 is modified to add the new CDS benefits and the section name is changed from "Self-Directed Model" to "Consumer Directed Option Model". Section 8.3.5.2 is modified to add the new CDS benefits and the section name is changed from "Agency Model, Self-Directed" to "Service Related Option Model". Section 8.3.5.3 is modified to add the new CDS benefits. Section 8.3.6.1 is modified to add training requirements for LTSS Providers in the Expansion Counties. Section 8.3.6.4 is deleted in its entirety.
Revision	1.30	Contract amendment did not revise Attachment B-1, Section 8-Operations Phase Requirements.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

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8. OPERATIONS PHASE REQUIREMENTS

This Section is designed to provide HMOs with sufficient information to understand the HMOs' responsibilities. This Section describes scope of work requirements for the Operations Phase of the Contract.

Section 8.1 includes the general scope of work that applies to the STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMO Programs.

Section 8.2 includes the additional Medicaid scope of work that applies only to the STAR and STAR+PLUS HMOs.

Section 8.3 includes the additional scope of work that applies only to STAR+PLUS HMOs.

Section 8.4 includes the additional scope of work that applies only to CHIP HMOs.

Section 8.5 includes the additional scope of work that applies only to CHIP Perinatal HMOs.
The Section does not include detailed information on the STAR, STAR+PLUS, CHIP, and CHIP Perinatal HMO Program requirements, such as the time frame and format for all reporting requirements. HHSC has included this information in the **Uniform Managed Care Contract Terms and Conditions** (**Attachment A**) and the **Uniform Managed Care Manual**. HHSC reserves the right to modify these documents as it deems necessary using the procedures set forth in the **Uniform Managed Care Contract Terms and Conditions**.

8.1 General Scope of Work

In each HMO Program Service Area, HHSC will select HMOs for each HMO Program to provide health care services to Members. The HMO must be licensed by the Texas Department of Insurance (TDI) as an HMO or an ANHC in all zip codes in the respective Service Area(s).
Coverage for benefits will be available to enrolled Members effective on the Operational Start Date. The Operational Start Date is September 1, 2006 for STAR and CHIP HMOs, January 1, 2007 for CHIP Perinatal HMOs, and February 1, 2007 for the STAR+PLUS HMOs.

8.1.1 Administration and Contract Management
The HMO must comply, to the satisfaction of HHSC, with (1) all provisions set forth in this Contract, and (2) all applicable provisions of state and federal laws, rules, regulations, and waivers.

8.1.1.1 Performance Evaluation
HHSC will implement the following process for SFY 2012 and thereafter. By March 1st each year, HHSC will establish two (2) overarching goals and negotiate a third goal suggested by the MCO for the following SFY. The HMO must identify and propose annual HMO Performance Improvement Projects (PIPs) relating to the overarching goals for the following SFY no later than May 1st each year. The HMO is required to provide three (3) PIPs per HMO program. At least one (1) PIP must be related to an overarching goal established by HHSC. (See **Attachment B-4, Performance Improvement Projects**) The Parties will negotiate such PIPs and one (1) overarching goal which will be incorporated into the Contract. If HHSC and the HMO cannot agree on the PIPs, HHSC will unilaterally select the PIPs.

PIPs will follow CMS protocol. The purpose of health care quality PIPs is to assess and improve processes, and thereby outcomes, of care. In order for such projects to achieve real improvements in care and for interested parties to have confidence in the reported improvements, PIPs must be designed, conducted, and reported in a methodologically sound manner.

CMS protocol describes ten (10) steps to be undertaken when conducting PIPs:

1. select the study topic(s);
2. define the study question(s);
3. select the study indicator(s);
4. use a representative and generalizable study population;
5. use sound sampling techniques (if sampling is used);
6. collect reliable data;
7. implement intervention and improvement strategies;
8. analyze data and interpret study results;
9. plan for real improvement; and
10. achieve sustained improvement.

The HMO must participate in semi-annual Contract Status Meetings (CSMs) with HHSC for the primary purpose of reviewing progress toward the achievement of annual PIPs and Contract requirements. HHSC may request additional CSMs, as it deems necessary to address areas of noncompliance. HHSC will provide the HMO with reasonable advance notice of additional CSMs, generally at least five (5) business days.

The HMO must provide to HHSC, no later than 14 business days prior to each semi-annual CSM, one electronic copy of a written update, detailing and documenting the HMO's progress toward meeting the annual PIPs or other areas of noncompliance.

HHSC will track HMO performance on PIPs. It will also track other key facets of HMO performance through the use of a **Performance Indicator Dashboard (see HHSC's Uniform Managed Care Manual)**. HHSC will compile the Performance Indicator Dashboard based on HMO submissions, data from the External Quality Review Organization (EQRO), and other data available to HHSC. HHSC will share the Performance Indicator Dashboard with the HMO on a quarterly basis.
8.1.1.2 Additional Readiness Reviews and Monitoring Efforts
During the Operations Phase, HHSC may conduct desk and/or onsite reviews as part of its normal Contract monitoring efforts. Additionally, an HMO that chooses to make a change to any operational system or undergo any major transition may be subject to an additional Readiness Review(s). HHSC will determine whether the proposed changes will require a desk review and/or an onsite review. The HMO is responsible for all reasonable travel costs incurred by HHSC or its authorized agent for onsite reviews conducted as part of Readiness Review or HHSC's normal Contract monitoring efforts. For purposes of this section, "reasonable travel costs" include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. This provision does not limit HHSC's ability to collect other costs as damages in accordance with Attachment A, Section 12.02(e), "Damages."
Refer to **Attachment B-1, Section 7** and **Attachment B-1, Section 8.1.18** for additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the HMO's Material Subcontractors.

8.1.2 Covered Services
The HMO is responsible for authorizing, arranging, coordinating, and providing Covered Services in accordance with the requirements of the Contract. The HMO must provide Medically Necessary Covered Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. STAR+PLUS HMOs must also provide Functionally Necessary Community Long-term Care Services to all Members beginning on the Member's date of enrollment regardless of pre-existing conditions, prior diagnosis and/or receipt of any prior health care services. The HMO must not impose any pre-existing condition limitations or exclusions or require Evidence of Insurability to provide coverage to any Member.
The HMO must provide full coverage for Medically Necessary Covered Services to all Members and, for STAR+PLUS Members, Functionally Necessary Community Long-term Care Services, without regard to the Member's:

1. previous coverage, if any, or the reason for termination of such coverage;

2. health status;

3. confinement in a health care facility; or

4. for any other reason.

Please Note:
(STAR HMOs): A Member cannot change from one STAR HMO to another STAR HMO during an inpatient hospital stay. The STAR HMO responsible for the hospital charges for STAR Members at the start of an Inpatient Stay remains responsible for hospital charges until the time of discharge or until such time that there is a loss of Medicaid eligibility. STAR HMOs are responsible for professional charges during every month for which the HMO receives a full capitation for a Member.
(STAR+PLUS HMOs): A Member cannot change from one STAR+PLUS HMO to another STAR+PLUS HMO during an inpatient hospital stay. The STAR+PLUS HMO is responsible for authorization and management of the inpatient hospital stay until the time of discharge, or until such time that there is a loss of Medicaid eligibility. STAR+PLUS HMOs are responsible for professional charges during every month for which the HMO receives a full capitation for a Member.
A Member cannot change from one STAR+PLUS HMO to another STAR+PLUS HMO during a nursing facility stay.
(CHIP HMOs): If a CHIP Member's Effective Date of Coverage occurs while the CHIP Member is confined in a hospital, HMO is responsible for the CHIP Member's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Member is disenrolled while the CHIP Member is confined in a hospital, HMO's responsibility for the CHIP Member's costs of Covered Services terminates on the Date of Disenrollment.
(CHIP Perinatal HMOs): If a CHIP Perinate's Effective Date of Coverage occurs while the CHIP Perinate is confined in a Hospital, HMO is responsible for the CHIP Perinate's costs of Covered Services beginning on the Effective Date of Coverage. If a CHIP Perinate is disenrolled while the CHIP Perinate is confined in a Hospital, HMO's responsibility for the CHIP Perinate's costs of Covered Services terminates on the Date of Disenrollment.
The HMO must not practice discriminatory selection, or encourage segregation among the total group of eligible Members by excluding, seeking to exclude, or otherwise discriminating against any group or class of individuals.

Covered Services for all Medicaid HMO Members are listed in **Attachments B-2 and B-2.1 of the Contract (STAR and STAR+PLUS Covered Services)**. As noted in **Attachments B-2 and B-2.1**, all Medicaid HMOs must provide Covered Services described in the most recent **Texas Medicaid Provider Procedures Manual** (Provider Procedures Manual and in all **Texas Medicaid Bulletins**, which update the Texas Provider Procedures Manual except for those services identified in **Section 8.2.2.8** as non-capitated services. A description of CHIP Covered Services and exclusions is provided in **Attachment B-2 of the Contract**. A description of CHIP Perinatal Program Covered Services and exclusions is provided in **Attachment B-2.2 of the Contract**. Covered Services are subject to change due to changes in federal and state law, changes in Medicaid, CHIP or CHIP Perinatal Program policy, and changes in medical practice, clinical protocols, or technology.

8.1.2.1 Value-added Services
HMOs may propose additional services for coverage. These are referred to as "Value-added Services." Value-added Services may be actual Health Care Services, benefits, or positive incentives that HHSC determines will promote healthy lifestyles and improved health outcomes among Members. Value-added Services that promote healthy lifestyles should target specific weight loss, smoking cessation, or other programs approved by HHSC. Temporary phones, cell phones, additional transportation benefits, and extra home health services may be Value-added Services, if approved by HHSC. Best practice approaches to delivering Covered Services are not considered Value-added Services.
If offered, Value-added Services must be offered to all mandatory STAR, and CHIP and CHIP Perinatal HMO Members within the applicable HMO Program and Service Area. For STAR+PLUS Acute Care services, the HMO may distinguish between the Dual Eligible and non-Dual Eligible populations. Value-added Services do not need to be consistent across more than one HMO Program or across more than one Service Area. Value-added Services that are approved by HHSC during the contracting process will be included in the Contract's scope of services.
The HMO must provide Value-added Services at no additional cost to HHSC. The HMO must not pass on the cost of the Value-added Services to Providers. The HMO must specify the conditions and parameters regarding the delivery of the Value-added Services in the HMO's Marketing Materials and Member Handbook, and must clearly describe any limitations or conditions specific to the Value-added Services.

Transition Phase. During the Transition Phase, HHSC will offer a one-time opportunity for the HMO to propose two additional Value-added Services to its list of current, approved Value-added Services. (See **Attachment B-3, Value-Added Services**). HHSC will establish the requirements and the timeframes for submitting the two additional proposed Value-added Services.
During this HHSC-designated opportunity, the HMO may propose either to add new Value-added Services or to enhance its current, approved Value-added Services. The HMO may propose two additional Value-added Services per HMO Program, and the services do not have to be the same for each HMO Program. HHSC will review the proposed additional services and, if appropriate, will approve the additional Value-added Services, which will be effective on the Operational Start Date. The HMO's Contract will be amended to reflect the additional, approved Value-added Services.
The HMO does not have to add Value-added Services during the HHSC-designated opportunity, but this will be the only time during the Transition Phase for the HMO to add Value-added Services. At no time during the Transition Phase will the HMO be allowed to delete, limit or restrict any of its current, approved Value-added Services.

Operations Phase. During the Operations Phase, Value-added Services can be added or removed only by written amendment of the Contract. HMOs will be given the opportunity to add or enhance Value-added Services twice per State Fiscal Year, with changes to be effective September 1 and March 1. HMOs will also be given the opportunity to delete or reduce Value-added Services once per State Fiscal Year, with changes to be effective September 1. HHSC may allow additional modifications to Value-added Services if Covered Services are amended by HHSC during a State Fiscal Year. This approach allows HHSC to coordinate biannual revisions to HHSC's HMO Comparison Charts for Members. A HMO's request to add, enhance, delete, or reduce a Value-added Service must be submitted to HHSC by April 1 of each year to be effective September 1 for the following contract period. A second request to add or enhance Value-added Services must be submitted to HHSC by October 1 each year to be effective March 1. (For STAR and CHIP, see **Attachment B-3, Value-Added Services**. For STAR+PLUS, see **Attachment B-3.1, STAR+PLUS Value-Added Services**. For CHIP Perinatal, see **Attachment B-3.2, CHIP Perinatal Value-Added Services.**)

A HMO's request to add a Value-added Service must:

a. Define and describe the proposed Value-added Service;

b. Specify the Service Areas and HMO Programs for the proposed Value-added Service;

c. Identify the category or group of mandatory Members eligible to receive the Value-added Service if it is a type of service that is not appropriate for all mandatory Members;

d. Note any limits or restrictions that apply to the Value-added Service;

e. Identify the Providers responsible for providing the Value-added Service;

f. Describe how the HMO will identify the Value-added Service in administrative (Encounter) data;

g. Propose how and when the HMO will notify Providers and mandatory Members about the availability of such Value-added Service;

h. Describe how a Member may obtain or access the Value-added Service; and

i. Include a statement that the HMO will provide such Value-added Service for at least 12 months from the September 1 effective date.

A HMO cannot include a Value-added Service in any material distributed to mandatory Members or prospective mandatory Members until the Parties have amended the Contract to include that Value-added Service. If a Value-added Service is deleted by amendment, the HMO must notify each mandatory Member that the service is no longer available through the HMO. The HMO must also revise all materials distributed to prospective mandatory Members to reflect the change in Value-added Services.

8.1.2.2 Case-by-Case Added Services
Except as provided below, the HMO may offer additional benefits that are outside the scope of services to individual Members on a case-by-case basis, based on Medical Necessity, cost-effectiveness, the wishes of the Member/Member's family, the potential for improved health status of the Member, and for STAR+PLUS Members based on functional necessity.
Section 8.1.2.2, Case-by-Case Added Services, does not apply to the CHIP Perinatal Program.

8.1.3 Access to Care
All Covered Services must be available to Members on a timely basis in accordance with medically appropriate guidelines, and consistent with generally accepted practice parameters, requirements in this Contract. The HMO must comply with the access requirements as established by the Texas Department of Insurance (TDI) for all HMOs doing business in Texas, except as otherwise required by this Contract. Medicaid HMOs must be responsive to the possibility of increased Members due to the phase-out of the PCCM model in Service Areas where adequate HMO coverage exists.
The HMO must provide coverage for Emergency Services to Members 24 hours a day and 7 days a week, without regard to prior authorization or the Emergency Service provider's contractual relationship with the HMO. The HMO's policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws and regulations, whether the provider is in-network or Out-of-Network. A HMO is not responsible for payment for unauthorized non-emergency services provided to a Member by Out-of-Network providers.
The HMO must also have an emergency and crisis Behavioral Health Services Hotline available 24 hours a day, 7 days a week, toll-free throughout the Service Area. The Behavioral Health Services Hotline must meet the requirements described in **Section 8.1.15.** For Medicaid Members, a HMO must provide coverage for Emergency Services in compliance with 42 C.F.R. §438.114, and as described in more detail in **Section 8.2.2.1**. The HMO may arrange Emergency Services and crisis Behavioral Health Services through mobile crisis teams.
For CHIP Members, Emergency Services, including emergency Behavioral Health Services, must be provided in accordance with the Texas Insurance Code and TDI regulations.
For the CHIP Perinatal Program, refer to Attachment B-2.2 for description of emergency services for CHIP Perinates and CHIP Perinate Newborns.
For the STAR, STAR+PLUS, and CHIP Programs, and for CHIP Perinate Newborns, HMO must require, and make best efforts to ensure, that PCPs are accessible to Members 24 hours a day, 7 days a week and that its Network Primary Care Providers (PCPs) have after-hours telephone availability that is consistent with, **Section 8.1.4.** CHIP Perinatal HMOs are not required to establish PCP Networks for CHIP Perinates.
The HMO must provide that if Medically Necessary Covered Services are not available through Network physicians or other Providers, the HMO must, upon the request of a Network physician or other Provider, within the time appropriate to the circumstances relating to the delivery of the services and the condition of the patient, but in no event to exceed five business days after receipt of reasonably requested documentation, allow a referral to a non-network physician or provider. The HMO must fully reimburse the non-network provider in accordance with the Out-of-Network methodology for Medicaid as defined by HHSC, and for CHIP, at the usual and customary rate defined by TDI in 28 T.A.C. Section 11.506.
The Member will not be responsible for any payment for Medically Necessary Covered Services, including Functionally Necessary Covered Services, other than:

(1) HHSC-specified co-payments for CHIP Members, where applicable; and

(2) STAR+PLUS Members who qualify for 1915(c) Nursing Facility Waiver services and enter a 24-hour setting will be required to pay the provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC. If the HMO provides Members who do not qualify for the 1915(c) Nursing Facility Waiver services in a 24-hour setting as an alternative to nursing facility or hospitalization, the Member will be required to pay the provider of care room and board costs and any income in excess of the personal needs allowance, as established by HHSC.

8.1.3.1 Waiting Times for Appointments
Through its Provider Network composition and management, the HMO must ensure that appointments for the following types of Covered Services are provided within the time frames specified below. In all cases below, "day" is defined as a calendar day.

1. Emergency Services must be provided upon Member presentation at the service delivery site, including at non-network and out-of-area facilities;

2. Urgent care, including urgent specialty care, must be provided within 24 hours of request.

3. Routine primary care must be provided within 14 days of request;

4. Initial outpatient behavioral health visits must be provided within 14 days of request;

5. Routine specialty care referrals must be provided within 30 days of request;

6. Pre-natal care must be provided within 14 days of request, except for high-risk pregnancies or new Members in the third trimester, for whom an appointment must be offered within five days, or immediately, if an emergency exists;

7. Preventive health services for adults must be offered to a Member within 90 days of request; and

8. Preventive health services for children, including well-child checkups should be offered to CHIP Members in accordance with the American Academy of Pediatrics (AAP) periodicity schedule. Medicaid HMOs should utilize the Texas Health Steps periodicity schedule. For a New Members under age 21, overdue or upcoming well-child checkups, including Texas Health Steps medical checkups, should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child Members. Effective September 1, 2010, the Texas Health Steps annual medical checkup for an Existing Member age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. For purposes of this requirement, the terms "New Member" and "Existing Member" are defined in Chapter 12.4 of the Uniform Managed Care Manual.

8.1.3.2 Access to Network Providers
The HMO's Network shall have within its Network, PCPs in sufficient numbers, and with sufficient capacity, to provide timely access to regular and preventive pediatric care and Texas Health Steps services to all child Members in accordance with the waiting times for appointments in **Section 8.1.3.1.**

PCP Access: At a minimum, the HMO must ensure that all Members have access to an age-appropriate PCP in the Provider Network with an Open Panel within 30 miles of the Member's residence. For the purposes of assessing compliance with this requirement, an internist who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age 21, and a pediatrician is not considered an age-appropriate choice for a Member age 21 and over. Note: This provision does not apply to CHIP Perinates, but it does apply to CHIP Perinate Newborns.

OB/GYN Access and CHIP Perinatal Program Provider Access: STAR, STAR+PLUS and CHIP Program Network: at a minimum, STAR, STAR+PLUS and CHIP HMOs must ensure that all female Members have access to an OB/GYN in the Provider Network within 75 miles of the Member's residence. (If the OB/GYN is acting as the Member's PCP, the HMO must follow the access requirements for the PCP.) The HMO must allow female Members to select an OB/GYN within its Provider Network. A female Member who selects an OB/GYN must be allowed direct access to the OB/GYN's health care services without a referral from the Member's PCP or a prior authorization. A pregnant Member past the 24th week of pregnancy must be allowed to remain under the Member's current OB/GYN care though the Member's post-partum checkup, even if the OB/GYN provider is, or becomes, Out-of-Network.

CHIP Perinatal Program Network: At a minimum, CHIP Perinatal HMOs must ensure that CHIP Perinates have access to a Provider of perinate services within 75 miles of the Member's residence if the Member resides in an urban area and within 125 miles of the Member's residence if the Member resides in a rural area.

Outpatient Behavioral Health Service Provider Access: At a minimum, the HMO must ensure that all Members except CHIP Perinates have access to an outpatient Behavioral Health Service Provider in the Network within 75 miles of the Member's residence. Outpatient Behavioral Health Service Providers must include Masters and Doctorate-level trained practitioners practicing independently or at community mental health centers, other clinics or at outpatient hospital departments. A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services.

Other Specialist Physician Access: At a minimum, the HMO must ensure that all Members except CHIP Perinates have access to a Network specialist physician within 75 miles of the Member's residence for common medical specialties. For adult Members, common medical specialties shall include general surgery, cardiology, orthopedics, urology, and ophthalmology. For child Members, common medical specialties shall include orthopedics and otolaryngology. In addition, all Members must be allowed to: 1) select an in-network opthalmologist or therapeutic optometrist to provide eye Health Care Services, other than surgery, and 2) have access without a PCP referral to eye Health Care Services from a Network specialist who is an ophthalmologist or therapeutic optometrist for non-surgical services.

Hospital Access: The HMO must ensure that all Members have access to an Acute Care hospital in the Provider Network within 30 miles of the Member's residence. For HMOs participating in the CHIP Perinatal Program, exceptions to this access standard may be requested on a case-by-case basis and must have HHSC approval.

All other Covered Services, except for services provided in the Member's residence: At a minimum, the HMO must ensure that all Members have access to at least one Network Provider for each of the remaining Covered Services described in **Attachment B-2,** within 75 miles of the Member's residence. This access requirement includes, but is not limited to, specialists, specialty hospitals, psychiatric hospitals, diagnostic and therapeutic services, and single or limited service health care physicians or Providers, as applicable to the HMO Program.

The HMO is not precluded from making arrangements with physicians or providers outside the HMO's Service Area for Members to receive a higher level of skill or specialty than the level available within the Service Area, including but not limited to, treatment of cancer, burns, and cardiac diseases. HHSC may consider exceptions to the above access-related requirements when an HMO has established, through utilization data provided to HHSC, that a normal pattern for securing health care services within an area does not meet these standards, or when an HMO is providing care of a higher skill level or specialty than the level which is available within the Service Area such as, but not limited to, treatment of cancer, burns, and cardiac diseases.

8.1.3.3 Monitoring Access
The HMO is required to systematically and regularly verify that Covered Services furnished by Network Providers are available and accessible to Members in compliance with the standards described in **Sections 8.1.3.1 and 8.1.3.2**, and for Covered Services furnished by PCPs, the standards described in **Section 8.1.4.2**.
The HMO must enforce access and other Network standards required by the Contract and take appropriate action with Providers whose performance is determined by the HMO to be out of compliance.

8.1.4 Provider Network
The HMO must enter into written contracts with properly credentialed Providers as described in this Section. The Provider contracts must comply with the **Uniform Managed Care Manual's** requirements.
The HMO must maintain a Provider Network sufficient to provide all Members with access to the full range of Covered Services required under the Contract. The HMO must ensure its Providers and subcontractors meet all current and future state and federal eligibility criteria, reporting requirements, and any other applicable rules and/or regulations related to the Contract.
The Provider Network must be responsive to the linguistic, cultural, and other unique needs of any minority, elderly, or disabled individuals, or other special population in the Service Areas and HMO Programs served by the HMO, including the capacity to communicate with Members in languages other than English, when necessary, as well as with those who are deaf or hearing impaired.

The HMO must seek to obtain the participation in its Provider Network of qualified providers currently serving the Medicaid and CHIP Members in the HMO's proposed Service Area(s). Medicaid HMOs utilizing Out-of-Network providers to render services to their Members must not exceed the utilization standards established in 1 T.A.C. §353.4. HHSC may modify this requirement for Medicaid HMOs that demonstrate good cause for noncompliance, as set forth in §353.4(e)(3).

NOTE: The following Provider descriptions do not require STAR+PLUS HMOs to contract with Hospital providers for Inpatient Stay services. STAR+PLUS HMOs are required, however, to contract with Hospitals for Outpatient Hospital Services , and with Hospital Providers for Inpatient Behavioral Health Services resulting from a behavioral health primary diagnosis.

All Providers: All Providers must be licensed in the State of Texas to provide the Covered Services for which the HMO is contracting with the Provider, and not be under sanction or exclusion from the Medicaid program. All Acute Care Providers serving Medicaid Members must be enrolled as Medicaid providers and have a Texas Provider Identification Number (TPIN). Long-term Care Providers are not required to have a TPIN but must have a LTC Provider number. Providers must also have a National Provider Identifier (NPI) in accordance with the timelines established in 45 C.F.R. Part 162, Subpart D (for most Providers, the NPI must be in place by May 23, 2007.)

Inpatient hospital and medical services: The HMO must ensure that Acute Care hospitals and specialty hospitals are available and accessible 24 hours per day, seven days per week, within the HMO's Network to provide Covered Services to Members throughout the Service Area.

Children's Hospitals/hospitals with specialized pediatric services: The HMO must ensure Members access to hospitals designated as Children's Hospitals by Medicare and hospitals with specialized pediatric services, such as teaching hospitals and hospitals with designated children's wings, so that these services are available and accessible 24 hours per day, seven days per week, to provide Covered Services to Members throughout the Service Area. The HMO must make Out-of-Network reimbursement arrangements with a designated Children's Hospital and/or hospital with specialized pediatric services in proximity to the Member's residence, and such arrangements must be in writing, if the HMO does not include such hospitals in its Provider Network. Provider Directories, Member materials, and Marketing materials must clearly distinguish between hospitals designated as Children's Hospitals and hospitals that have designated children's units.

Trauma: The HMO must ensure Members access to Texas Department of State Health Services (TDSHS) designated Level I and Level II trauma centers within the State or hospitals meeting the equivalent level of trauma care in the HMO's Service Area, or in close proximity to such Service Area. The HMO must make Out-of-Network reimbursement arrangements with the DSHS-designated Level I and Level II trauma centers or hospitals meeting equivalent levels of trauma care, and such arrangements must be in writing, if the HMO does not include such a trauma center in its Provider Network.

Transplant centers: The HMO must ensure Member access to HHSC-designated transplant centers or centers meeting equivalent levels of care. A list of HHSC-designated transplant centers can be found in the Procurement Library in Attachment H. The HMO must make Out-of-Network
reimbursement arrangements with a designated transplant center or center meeting equivalent levels of care in proximity to the Member's residence, and such arrangements must be in writing, if the HMO does not include such a center in its Provider Network.

Hemophilia centers: The HMO must ensure Member access to hemophilia centers supported by the Centers for Disease Control (CDC). A list of these hemophilia centers can be found at http://www.cdc.gov/ncbddd/hbd/htc_list.htm. The HMO must make Out-of-Network reimbursement arrangements with a CDC-supported hemophilia center, and such arrangements must be in writing, if the HMO does not include such a center in its Provider Network.

Physician services: The HMO must ensure that Primary Care Providers are available and accessible 24 hours per day, seven days per week, within the Provider Network. The HMO must contract with a sufficient number of participating physicians and specialists within each Service Area to comply with the access requirements throughout **Section 8.1.3** and meet the needs of Members for all Covered Services.
The HMO must ensure that an adequate number of participating physicians have admitting privileges at one or more participating Acute Care hospitals in the Provider Network to ensure that necessary admissions are made. In no case may there be less than one in-network PCP with admitting privileges available and accessible 24 hours per day, seven days per week for each Acute Care hospital in the Provider Network.
The HMO must ensure that an adequate number of participating specialty physicians have admitting privileges at one or more participating hospitals in the HMO's Provider Network to ensure necessary admissions are made. The HMO shall require that all physicians who admit to hospitals maintain hospital access for their patients through appropriate call coverage.

Laboratory services: The HMO must ensure that in-network reference laboratory services must be of sufficient size and scope to meet the non-emergency and emergency needs of the enrolled population and the access requirements in **Section 8.1.3**. Reference laboratory specimen procurement services must facilitate the provision of clinical diagnostic services for physicians, Providers and Members through the use of convenient reference satellite labs in each Service Area, strategically located specimen collection areas in each Service Area, and the use of a courier system under the management of the reference lab. For Medicaid Members, Texas Health Steps requires that laboratory specimens obtained as part of a Texas Health Steps medical checkup visit must be sent to the TDSHS Laboratory.

Diagnostic imaging: The HMO must ensure that diagnostic imaging services are available and accessible to all Members in each Service Area in accordance with the access standards in **Section 8.1.3**. The HMO must ensure that diagnostic imaging procedures that require the injection or ingestion of radiopaque chemicals are performed only under the direction of physicians qualified to perform those procedures.

Home health services: The HMO must have a contract(s) with a home health Provider so that all Members living within the HMO's Service Area will have access to at least one such Provider for home health Covered Services. (These services are provided as part of the Acute Care Covered Services, not the Community Long-term Care Services.)

Community Long-term Care services: STAR+PLUS HMOs must have contracts with Community Long-term Care service Providers, so that all Members living within the Contractor's Service Area will have access to Medically Necessary and Functionally Necessary Covered Services.

Ambulance providers: The HMO must enter into a Network Provider Agreement with any willing ambulance provider that meets the HMO's credentialing requirements and agrees to the HMO's contract terms and rates.

8.1.4.1 Provider Contract Requirements
The HMO is prohibited from requiring a provider or provider group to enter into an exclusive contracting arrangement with the HMO as a condition for participation in its Provider Network.
The HMO's contract with health care Providers must be in writing, must be in compliance with applicable federal and state laws and regulations, and must include minimum requirements specified in the **Uniform Managed Care Contract Terms and Conditions (Attachment A)** and **HHSC's Uniform Managed Care Manual**.

The HMO must submit model Provider contracts to HHSC for review during Readiness Review. HHSC retains the right to reject or require changes to any model Provider contract that does not comply with HMO Program requirements or the HHSC-HMO Contract.

8.1.4.2 Primary Care Providers
The HMO's PCP Network may include Providers from any of the following practice areas: General Practice; Family Practice; Internal Medicine; Pediatrics; Obstetrics/Gynecology (OB/GYN); Advanced Practice Nurses (APNs) and Physician Assistants (PAs) (when APNs and PAs are practicing under the supervision of a physician specializing in Family Practice, Internal Medicine, Pediatrics or Obstetrics/Gynecology who also qualifies as a PCP under this contract); Federally Qualified Health Centers (FQHCs), Rural Health Clinics (RHCs), and similar community clinics; and specialist physicians who are willing to provide a Medical Home to selected Members with special needs and conditions.
Section 533.005(a)(13), Government Code, requires the HMO to use Advanced Practice Nurses practicing under the supervision of a physician as PCPs in its Provider Network for STAR and STAR+PLUS.
CHIP Perinatal HMOs are not required to develop PCP Networks for CHIP Perinates. CHIP Perinatal HMOs may use the same PCP Network for CHIP Members and CHIP Perinatal Newborns.
An internist or other Provider who provides primary care to adults only is not considered an age-appropriate PCP choice for a Member under age 21. An internist or other Provider who provides primary care to adults and children may be a PCP for children if:

1. the Provider assumes all HMO PCP responsibilities for such Members in a specific age group under age 21,

2. the Provider has a history of practicing as a PCP for the specified age group as evidenced by the Provider's primary care practice including an established patient population under age 20 and within the specified age range, and

3. the Provider has admitting privileges to a local hospital that includes admissions to pediatric units.

A pediatrician is not considered an age-appropriate choice for a Member age 21 and over.
The PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions may be a specialist physician who agrees to provide PCP services to the Member. The specialty physician must agree to perform all PCP duties required in the Contract and PCP duties must be within the scope of the specialist's license. Any interested person may initiate the request through the HMO for a specialist to serve as a PCP for a Member with disabilities, Special Health Care Needs, or Chronic or Complex Conditions. The HMO shall handle such requests in accordance with 28 T.A.C. Part 1, Chapter 11, Subchapter J.
PCPs who provide Covered Services for STAR, CHIP, and CHIP Perinatal Newborns must either have admitting privileges at a Hospital that is part of the HMO's Provider Network or make referral arrangements with a Provider who has admitting privileges to a Network Hospital. STAR+PLUS PCPs must either have admitting privileges at a Medicaid Hospital or make referral arrangements with a Provider who has admitting privileges to a Medicaid Hospital.
The HMO must require, through contract provisions, that PCPs are accessible to Members 24 hours a day, 7 days a week. The HMO is encouraged to include in its Network sites that offer primary care services during evening and weekend hours. The following are acceptable and unacceptable telephone arrangements for contacting PCPs after their normal business hours.
Acceptable after-hours coverage:

1. The office telephone is answered after-hours by an answering service, which meets language requirements of the Major Population Groups and which can contact the PCP or another designated medical practitioner. All calls answered by an answering service must be returned within 30 minutes;

2. The office telephone is answered after normal business hours by a recording in the language of each of the Major Population Groups served, directing the patient to call another number to reach the PCP or another provider designated by the PCP. Someone must be available to answer the designated provider's telephone. Another recording is not acceptable; and

3. The office telephone is transferred after office hours to another location where someone will answer the telephone and be able to contact the PCP or another designated medical practitioner, who can return the call within 30 minutes.

Unacceptable after-hours coverage:

1. The office telephone is only answered during office hours;

2. The office telephone is answered after-hours by a recording that tells patients to leave a message;

3. The office telephone is answered after-hours by a recording that directs patients to go to an Emergency Room for any services needed; and

4. Returning after-hours calls outside of 30 minutes.

The CHIP HMOs must require PCPs, through contract provisions or Provider Manual, to provide children under the age of 21 with preventive services in accordance with the AAP recommendations for CHIP Members and CHIP Perinate Newborns. Medicaid HMOs must
require PCPs, through contract provisions or Provider Manual, to provide children under the age of 21 with preventive services in accordance with the Texas Health Steps periodicity schedule. The HMO must require PCPs, through contract provisions or Provider Manual, to provide adults with preventive services in accordance with the U.S. Preventive Services Task Force requirements. The HMO must make best efforts to ensure that PCPs follow these periodicity requirements for children and adult Members. Best efforts must include, but not be limited to, Provider education, Provider profiling, monitoring, and feedback activities.
The HMO must require PCPs, through contract provisions or Provider Manual, to assess the medical needs of Members for referral to specialty care providers and provide referrals as needed. PCPs must coordinate Members' care with specialty care providers after referral. The HMO must make best efforts to ensure that PCPs assess Member needs for referrals and make such referrals. Best efforts must include, but not be limited to, Provider education activities and review of Provider referral patterns.

8.1.4.3 PCP Notification
The HMO must furnish each PCP with a current list of enrolled Members enrolled or assigned to that Provider no later than five (5) working days after the HMO receives the Enrollment File from the HHSC Administrative Services Contractor each month. The HMO may offer and provide such enrollment information in alternative formats, such as through access to a secure Internet site, when such format is acceptable to the PCP.

8.1.4.4 Provider Credentialing and Re-credentialing
The HMO must review, approve and periodically recertify the credentials of all participating physician Providers and all other licensed Providers who participate in the HMO's Provider Network. The HMO may subcontract with another entity to which it delegates such credentialing activities if such delegated credentialing is maintained in accordance with the National Committee for Quality Assurance (NCQA) delegated credentialing requirements and any comparable requirements defined by HHSC.
At a minimum, the scope and structure of a HMO's credentialing and re-credentialing processes must be consistent with recognized HMO industry standards such as those provided by NCQA and relevant state and federal regulations including 28 T.A.C. §§11.1902, relating to provider credentialing and notice, and as an additional requirement for Medicaid HMOs, 42 C.F.R. §438.12 and 42 C.F.R. §438.214(b). The initial credentialing process, including application and verification of information, must be completed before the effective date of the initial contract with the physician or Provider. The re-credentialing process must occur at least every three years.
The HMO may not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. Additionally, if the HMO declines to include individual or groups of providers in its Network, it must give the affected providers written notice of the reasons for its decision.

The re-credentialing process must take into consideration Provider performance data including, but not be limited to, Member Complaints and Appeals, quality of care, and utilization management.
HMOs must comply with the requirements of Texas Insurance Code Chapter 1452, Subchapter C, regarding expedited credentialing and payment of physicians who have joined medical groups that are already contracted with the HMO.

8.1.4.5 Board Certification Status
The HMO must maintain a policy with respect to Board Certification for PCPs and specialty physicians that encourage participation of board certified PCPs and specialty physicians in the Provider Network. The HMO must make information on the percentage of Board-certified PCPs in the Provider Network and the percentage of Board-certified specialty physicians, by specialty, available to HHSC upon request.

8.1.4.6 Provider Manual, Materials and Training
The HMO must prepare and issue a Provider Manual(s), including any necessary specialty manuals (e.g., behavioral health) to all existing Network Providers. For newly contracted Providers, the HMO must issue copies of the Provider Manual(s) within five (5) working days from inclusion of the Provider into the Network. The Provider Manual must contain sections relating to special requirements of the HMO Program(s) and the enrolled populations in compliance with the requirements of this Contract.
HHSC or its designee must approve the Provider Manual, and any substantive revisions to the Provider Manual, prior to publication and distribution to Providers. The Provider Manual must contain the critical elements defined in the **Uniform Managed Care Manual**. HHSC's initial review of the Provider Manual is part of the Operational Readiness Review described in **Attachment B-1, Section 7**.
The HMO must provide training to all Providers and their staff regarding the requirements of the Contract and special needs of Members. The HMO's Medicaid, CHIP and/or CHIP Perinatal Program training must be completed within 30 days of placing a newly contracted Provider on active status. The HMO must provide on-going training to new and existing Providers as required by the HMO or HHSC to comply with the Contract. The HMO must maintain and make available upon request enrollment or attendance rosters dated and signed by each attendee or other written evidence of training of each Provider and their staff.
The HMO must establish ongoing Provider training that includes, but is not limited to, the following issues:

1. Covered Services and the Provider's responsibilities for providing and/or coordinating such services. Special emphasis must be placed on areas that vary from commercial coverage rules (e.g., Early Intervention services, therapies and DME/Medical Supplies); and for Medicaid, making referrals and coordination with Non-capitated Services;

2. Relevant requirements of the Contract;

3. The HMO's quality assurance and performance improvement program and the Provider's role in such a program; and

4. The HMO's policies and procedures, especially regarding in-network and Out-of-Network referrals.

Provider Materials produced by the HMO, relating to Medicaid Managed Care, the CHIP Program, and/or the CHIP Perinatal Program must be in compliance with State and Federal laws and requirements of the **HHSC Uniform Managed Care Contract Terms and Conditions**. HMO must make available any provider materials to HHSC upon request.

8.1.4.7 Provider Hotline
The HMO must operate a toll-free telephone line for Provider inquiries from 8 a.m. to 5 p.m. local time for the Service Area, Monday through Friday, except for State-approved holidays. The Provider Hotline must be staffed with personnel who are knowledgeable about Covered Services and each applicable HMO Program, and for Medicaid, about Non-capitated Services.
The HMO must ensure that after regular business hours the line is answered by an automated system with the capability to provide callers with operating hours information and instructions on how to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition. The HMO must have a process in place to handle after-hours inquiries from Providers seeking to verify enrollment for a Member with an Urgent Condition or an Emergency Medical Condition, provided, however, that the HMO and its Providers must not require such verification prior to providing Emergency Services.
The HMO must ensure that the Provider Hotline meets the following minimum performance requirements for all HMO Programs and Service Areas:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system is used;

2. no more than one percent of incoming calls receive a busy signal;

3. the average hold time is 2 minutes or less; and

4. the call abandonment rate is 7% or less.

The HMO must conduct ongoing call quality assurance to ensure these standards are met. The Provider Hotline may serve multiple HMO Programs if Hotline staff is knowledgeable about all of the HMO's Programs. The Provider Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Provider Network in such Service Areas.
The HMO must monitor its performance regarding Provider Hotline standards and submit performance reports summarizing call center performance for the Hotline as indicated in **Section**

8.1.20. If the HMO subcontracts with a Behavioral Health Organization (BHO) that is responsible for Provider Hotline functions related to Behavioral Health Services, the BHO's Provider Hotline must meet the requirements in **Section 8.1.4.7**.
If HHSC determines that it is necessary to conduct onsite monitoring of the HMO's Provider Hotline functions, the HMO is responsible for all reasonable costs incurred by HHSC or its authorized agent(s) relating to such monitoring.

8.1.4.8 Provider Reimbursement
The HMO must make payment for all Medically Necessary Covered Services provided to all Members for whom the HMO is paid a capitation. A STAR+PLUS HMO must also make payment for all Functionally Necessary Covered Services provided to all Members for whom the HMO is paid a capitation. The HMO must ensure that claims payment is timely and accurate as described in **Section 8.1.18.5.** The HMO must require tax identification numbers from all participating Providers. The HMO is required to do back-up withholding from all payments to Providers who fail to give tax identification numbers or who give incorrect numbers.

Provider Payments must comply with the requirements of Section 6505 of the Patient Protection and Affordable Care Act (P.L. 111-148), entitled "Prohibition on Payments to Institutions or Entities Located Outside of the United States."

Provider payment must comply with the requirements of Section 2702 of PPACA, entitled "Payment Adjustment for Health Acquired Conditions."

8.1.4.8.1 Provider Preventable Conditions
STAR and STAR+PLUS HMOs must identify Present on Admission (POA) indicators as required in the **Uniform Managed Care Manual,** and STAR and STAR+PLUS HMOs must reduce or deny payments for Provider Preventable Conditions that were not POA using a methodology approved by HHSC in the **Uniform Managed Care Manual.**
8.1.4.9 Termination of Provider Contracts
The HMO must make a good faith effort to give written notice of termination of a Network Provider, within 15 calendar days after receipt or issuance of the termination notice, to each Member who receives his or her primary care from, or who is seen on a regular basis by, the Network Provider. The HMO must send notice to: (1) all Members in a PCP's panel, and (2) all Members who have had two or more visits with the Network Provider for home-based or office-based care in the past 12 months. The HMO must notify HHSC of provider terminations in accordance with UMCM Chapter 5.4.1.1 "Provider Termination Report."

For the CHIP and CHIP Perinatal Programs, the HMO's process for terminating Provider contracts must comply with the Texas Insurance Code and TDI regulations.
8.1.5 Member Services
The HMO must maintain a Member Services Department to assist Members and Members' family members or guardians in obtaining Covered Services for Members. The HMO must maintain employment standards and requirements (e.g., education, training, and experience) for Member Services Department staff and provide a sufficient number of staff for the Member Services Department to meet the requirements of this Section, including Member Hotline response times, and Linguistic Access capabilities, see 8.1.5.6 Member Hotline Requirements.

8.1.5.1 Member Materials
The HMO must design, print and distribute Member identification (ID) cards and a Member Handbook to Members. Within five business days following the receipt of an Enrollment File from the HHSC Administrative Services Contractor, the HMO must mail a Member's ID card and Member Handbook to the Case Head or Account Name for each new Member. When the Case Head or Account Name is on behalf of two or more new Members, the HMO is only required to send one Member Handbook. The HMO is responsible for mailing materials only to those Members for whom valid address data are contained in the Enrollment File.
The HMO must design, print and distribute a Provider Directory to the HHSC Administrative Services Contractor as described in **Section 8.1.5.4.**
Member materials must be at or below a 6th grade reading level as measured by the appropriate score on the Flesch reading ease test. Member materials must be available in English, Spanish, and the languages of other Major Population Groups making up 10% or more of the managed
care eligible population in the HMO's Service Area, as specified by HHSC. HHSC will provide the HMO with reasonable notice when the enrolled population reaches 10% within the HMO's Service Area. All Member materials must be available in a format accessible to the visually impaired, which may include large print, Braille, and audiotapes.
The HMO must submit member materials to HHSC for approval prior to use or mailing. HHSC will identify any required changes to the Member materials within 15 business days. If HHSC has not responded to the Contractor by the fifteenth day, the Contractor may proceed to use the submitted materials. HHSC reserves the right to require discontinuation of any Member materials that violate the terms of the **Uniform Managed Care Terms and Conditions**, including but not limited to "Marketing Policies and Procedures" as described in the **Uniform Managed Care Manual**.

8.1.5.2 Member Identification (ID) Card
All Member ID cards must, at a minimum, include the following information:

1. the Member's name;

2. the Member's Medicaid, CHIP or CHIP Perinatal Program number;

3. the effective date of the PCP assignment (excluding CHIP Perinates);

4. the PCP's name, address (optional for all products), and telephone number (excluding CHIP Perinates);

5. the name of the HMO;

6. the 24-hour, seven (7) day a week toll-free Member services telephone number and BH Hotline number operated by the HMO; and

7. any other critical elements identified in the **Uniform Managed Care Manual**.

The HMO must reissue the Member ID card if a Member reports a lost card, there is a Member name change, if the Member requests a new PCP, or for any other reason that results in a change to the information disclosed on the ID card. CHIP Perinatal HMOs must issue Member ID cards to both CHIP Perinates and CHIP Perinate Newborns.

8.1.5.3 Member Handbook
HHSC must approve the Member Handbook, and any substantive revisions, prior to publication and distribution. As described in **Attachment B-1, Section 7**, the HMO must develop and submit to HHSC the draft Member Handbook for approval during the Readiness Review and must submit a final Member Handbook incorporating changes required by HHSC prior to the Operational Start Date.
The Member Handbook for each applicable HMO Program must, at a minimum, meet the Member materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **Uniform Managed Care Manual**.
CHIP Perinatal HMOs must issue Member Handbooks to both CHIP Perinates and CHIP Perinate Newborns. The Member Handbook for CHIP Perinate Newborns may be the same as that used for CHIP.
The HMO must produce a revised Member Handbook, or an insert informing Members of changes to Covered Services upon HHSC notification and at least 30 days prior to the effective
date of such change in Covered Services. In addition to modifying the Member materials for new Members, the HMO must notify all existing Members of the Covered Services change during the time frame specified in this subsection.

8.1.5.4 Provider Directory
The Provider Directory for each applicable HMO Program, and any substantive revisions, must be approved by HHSC prior to publication and distribution. The HMO is responsible for submitting draft Provider directory updates to HHSC for prior review and approval if changes other than PCP information or clerical corrections are incorporated into the Provider Directory.
As described in **Attachment B-1, Section 7**, during the Readiness Review, the HMO must develop and submit to HHSC the draft Provider Directory template for approval and must submit a final Provider Directory incorporating changes required by HHSC prior to the Operational Start Date. Such draft and final Provider Directories must be submitted according to the deadlines established in **Attachment B-1, Section 7**.
The Provider Directory for each applicable HMO Program must, at a minimum, meet the Member Materials requirements specified by **Section 8.1.5.1** above and must include critical elements in the **Uniform Managed Care Manual**. The Provider Directory must include only Network Providers credentialed by the HMO in accordance with **Section 8.1.4.4**. If the HMO contracts with limited Provider Networks, the Provider Directory must comply with the requirements of 28 T.A.C. §11.1600(b)(11), relating to the disclosure and notice of limited Provider Networks.
CHIP Perinatal HMOs must develop Provider Directories for both CHIP Perinates and CHIP Perinate Newborns. The Provider Directory for CHIP Perinate Newborns may be the same as that used for the CHIP Program.
The HMO must update the Provider Directory on a quarterly basis. The HMO must make such update available to existing Members on request, and must provide such update to the HHSC Administrative Services Contractor at the beginning of each state fiscal quarter. HHSC will consult with the HMOs and the HHSC Administrative Services Contractors to discuss methods for reducing the HMO's administrative costs of producing new Provider Directories, including considering submission of new Provider Directories on a semi-annual rather than a quarterly basis if a HMO has not made major changes in its Provider Network, as determined by HHSC. HHSC will establish weight limits for the Provider Directories. Weight limits may vary by Service Area. HHSC will require HMOs that exceed the weight limits to compensate HHSC for postage fees in excess of the weight limits.
The HMO must send the most recent Provider Directory, including any updates, to Members upon request. The HMO must, at least annually, include written and verbal offers of such Provider Directory in its Member outreach and education materials.

8.1.5.5 Internet Website
The HMO must develop and maintain, consistent with HHSC standards and Section 843.2015 of the Texas Insurance Code and other applicable state laws, a website to provide general information about the HMO's Program(s), its Provider Network, its customer services, and its Complaints and Appeals process. The HMO may develop a page within its existing website to meet the requirements of this section. The HMO must maintain a Provider Directory for its HMO Program on the MCO's website. The HMO must ensure that Members have access to the most current and accurate information concerning the HMO's Network Provider participation. To comply with this requirement, at least twice per month the HMO must update provider information in either: (1) its online Provider Directory, or (2) its online Provider search functionality, if applicable. The online Provider Directory or online Provider search functionality must designate Providers with open versus closed panels. The online Provider Directory or online Provider search functionality must also identify Providers that provide Long-Term Services and Supports (LTSS). All HMOs must list Home Health Ancillary providers on their websites, with an indicator for Pediatric services if provided. The HMO's website must comply with the Marketing Policies and Procedures for each applicable HHSC HMO Program.
The website's HMO Program content must be:

1. Written in Major Population Group languages (which under this contract include only English and Spanish);

2. Culturally appropriate;

3. Written for understanding at the 6th grade reading level; and

4. Be geared to the health needs of the enrolled HMO Program population.

To minimize download and “wait times,” the website must avoid tools or techniques that require significant memory or disk resources or require special intervention on the customer side to install plug-ins or additional software. Use of proprietary items that would require a specific browser are not allowed. HHSC strongly encourages the use of tools that take advantage of efficient data access methods and reduce the load on the server or bandwidth.

8.1.5.6 Member Hotline
The HMO must operate a toll-free hotline that Members can call 24 hours a day, seven (7) days a week. The Member Hotline must be staffed with personnel who are knowledgeable about its HMO Program(s) and Covered Services, between the hours of 8:00 a.m. to 5:00 p.m. local time for the Service Area, Monday through Friday, excluding state-approved holidays.
The HMO must ensure that after hours, on weekends, and on holidays the Member Services Hotline is answered by an automated system with the capability to provide callers with operating hours and instructions on what to do in cases of emergency. All recordings must be in English and in Spanish. A voice mailbox must be available after hours for callers to leave messages. The HMO’s Member Services representatives must return member calls received by the automated system on the next working day.
If the Member Hotline does not have a voice-activated menu system, the HMO must have a menu system that will accommodate Members who cannot access the system through other physical means, such as pushing a button.
The HMO must ensure that its Member Service representatives treat all callers with dignity and respect the callers’ need for privacy. At a minimum, the HMO’s Member Service representatives must be:

1. Knowledgeable about Covered Services;

2. Able to answer non-technical questions pertaining to the role of the PCP, as applicable;

3. Able to answer non-clinical questions pertaining to referrals or the process for receiving authorization for procedures or services;

4. Able to give information about Providers in a particular area;

5. Knowledgeable about Fraud, Abuse, and Waste and the requirements to report any conduct that, if substantiated, may constitute Fraud, Abuse, or Waste in the HMO Program;

6. Trained regarding Cultural Competency;

7. Trained regarding the process used to confirm the status of persons with Special Health Care Needs;

8. For Medicaid members, able to answer non-clinical questions pertaining to accessing Non-capitated Services.

9. For Medicaid Members, trained regarding: a) the emergency prescription process and what steps to take to immediately address problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems.

10. For CHIP Members, able to give correct cost-sharing information relating to premiums, co-pays or deductibles, as applicable. (Cost-sharing does not apply to CHIP Perinates or CHIP Perinate Newborns.)

Hotline services must meet Cultural Competency requirements and must appropriately handle calls from non-English speaking (and particularly, Spanish-speaking) callers, as well as calls from individuals who are deaf or hard-of-hearing. To meet these requirements, the HMO must employ bilingual Spanish-speaking Member Services representatives and must secure the services of other contractors as necessary to meet these requirements. The HMO must provide such oral interpretation services to all Hotline callers free of charge.

The HMO must process all incoming Member correspondence and telephone inquiries in a timely and responsive manner. The HMO cannot impose maximum call duration limits but must allow calls to be of sufficient length to ensure adequate information is provided to the Member. The HMO must ensure that the toll-free Member Hotline meets the following minimum performance requirements for all HMO Programs and Service Areas:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system;

2. no more than one percent (1%) of incoming calls receive a busy signal;

3. at least 80% of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;

4. the call abandonment rate is 7% or less; and

5. the average hold time is 2 minutes or less.

The HMO must conduct ongoing quality assurance to ensure these standards are met.
The Member Services Hotline may serve multiple HMO Programs if Hotline staff is knowledgeable about all of the HMO’s Medicaid and/or CHIP Programs. The Member Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Provider Network in each Service Area.
The HMO must monitor its performance regarding HHSC Member Hotline standards and submit performance reports summarizing call center performance for the Member Hotline as indicated in **Section 8.1.20** and the **Uniform Managed Care Manual.**
If HHSC determines that it is necessary to conduct onsite monitoring of the HMO’s Member Hotline functions, the HMO is responsible for all reasonable costs incurred by HHSC or its authorized agent(s) relating to such monitoring.

8.1.5.6.1 Nurseline
HMO is encouraged to train staff at its 24-hour nurse hotline about: a) emergency prescription process and what steps to take to immediately address Medicaid Members’ problems when pharmacies do not provide a 72-hour supply of emergency medicines; and b) DME processes for obtaining services and how to address common problems. The 24-hour nurse hotline will attempt to respond immediately to problems concerning emergency medicines by means at its disposal, including explaining the rules to Medicaid Members so that they understand their rights and, if need be, by offering to contact the pharmacy that is refusing to fill the prescription to explain the 72-hour supply policy and DME processes.

8.1.5.7 Member Education
The HMO must, at a minimum, develop and implement health education initiatives that educate Members about:

1. How the HMO system operates, including the role of the PCP;

2. Covered Services, limitations and any Value-added Services offered by the HMO;

3. The value of screening and preventive care, and

4. How to obtain Covered Services, including:

    a. Emergency Services;

    b. Accessing OB/GYN and specialty care;

    c. Behavioral Health Services;

    d. Disease Management programs;

    e. Service Coordination, treatment for pregnant women, Members with Special Health Care Needs, including Children with Special Health Care Needs; and other special populations;

    f. Early Childhood Intervention (ECI) Services;

    g. Screening and preventive services, including well-child care (Texas Health Steps medical checkups for Medicaid Members);

    h. For CHIP Members, Member co-payments

    i. Suicide prevention;

    j. Identification and health education related to Obesity; and

    k. Obtaining 72 hour supplies of emergency prescriptions from pharmacies enrolled with HHSC as Medicaid providers.

The HMO must provide a range of health promotion and wellness information and activities for Members in formats that meet the needs of all Members. The HMO must propose, implement, and assess innovative Member education strategies for wellness care and immunization, as well as general health promotion and prevention. The HMO must conduct wellness promotion
programs to improve the health status of its Members. The HMO may cooperatively conduct health education classes for all enrolled Members with one or more HMOs also contracting with HHSC in the Service Area. The HMO must work with its Providers to integrate health education, wellness and prevention training into the care of each Member.
The HMO also must provide condition and disease-specific information and educational materials to Members, including information on its Service Management and Disease Management programs described in **Section 8.1.13 and Section 8.1.** Condition- and disease-specific information must be oriented to various groups within the managed care eligible population, such as children, the elderly, persons with disabilities and non-English speaking Members, as appropriate to the HMO’s Medicaid, CHIP and/or CHIP Perinatal Program(s).

8.1.5.8 Cultural Competency Plan
The HMO must have a comprehensive written Cultural Competency Plan describing how the HMO will ensure culturally competent services, and provide Linguistic Access and Disability-related Access. The Cultural Competency Plan must describe how the individuals and systems within the HMO will effectively provide services to people of all cultures, races, ethnic backgrounds, and religions as well as those with disabilities in a manner that recognizes, values,

affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The HMO must submit the Cultural Competency Plan to HHSC for Readiness Review. Modifications and amendments to the plan must be submitted to HHSC no later than 30 days prior to implementation. The Plan must also be made available to the HMO's Network of Providers.

8.1.5.9 Member Complaint and Appeal Process
The HMO must develop, implement and maintain a system for tracking, resolving, and reporting Member Complaints regarding its services, processes, procedures, and staff. The HMO must ensure that Member Complaints are resolved within 30 calendar days after receipt. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.**
The HMO must develop, implement and maintain a system for tracking, resolving, and reporting Member Appeals regarding the denial or limited authorization of a requested service, including the type or level of service and the denial, in whole or in part, of payment for service. Within this process, the HMO must respond fully and completely to each Appeal and establish a tracking mechanism to document the status and final disposition of each Appeal.
The HMO must ensure that Member Appeals are resolved within 30 calendar days, unless the HMO can document that the Member requested an extension or the HMO shows there is a need for additional information and the delay is in the Member's interest. The HMO is subject to liquidated damages if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.**

Medicaid HMOs must follow the Member Complaint and Appeal Process described in **Section 8.2.6**. CHIP and CHIP Perinatal HMOs must comply with the CHIP Complaint and Appeal Process described in **Sections 8.4.2** and **8.5.2,** respectively.

8.1.6 Marketing and Prohibited Practices
The HMO and its Subcontractors must adhere to the Marketing Policies and Procedures as set forth by HHSC in the Contract, and the **HHSC Uniform Managed Care Manual**.

8.1.7 Quality Assessment and Performance Improvement
The HMO must provide for the delivery of quality care with the primary goal of improving the health status of Members and, where the Member's condition is not amenable to improvement, maintain the Member's current health status by implementing measures to prevent any further decline in condition or deterioration of health status. The HMO must work in collaboration with Providers to actively improve the quality of care provided to Members, consistent with the Quality Improvement Goals and all other requirements of the Contract. The HMO must provide mechanisms for Members and Providers to offer input into the HMO's quality improvement activities.

8.1.7.1 QAPI Program Overview
The HMO must develop, maintain, and operate a quality assessment and performance improvement (QAPI) Program consistent with the Contract, and TDI requirements, including 28 T.A.C. §11.1901(a)(5) and §11.1902. Medicaid HMOs must also meet the requirements of 42 C.F.R. §438.240.
The HMO must have on file with HHSC an approved plan describing its QAPI Program, including how the HMO will accomplish the activities required by this section. The HMO must submit a QAPI Program Annual Summary in a format and timeframe specified by HHSC or its designee. The HMO must keep participating physicians and other Network Providers informed about the QAPI Program and related activities. The HMO must include in Provider contracts a requirement securing cooperation with the QAPI.
The HMO must approach all clinical and non-clinical aspects of quality assessment and performance improvement based on principles of Continuous Quality Improvement (CQI)/Total Quality Management (TQM) and must:

1. Evaluate performance using objective quality indicators;

2. Foster data-driven decision-making;

3. Recognize that opportunities for improvement are unlimited;

4. Solicit Member and Provider input on performance and QAPI activities;

5. Support continuous ongoing measurement of clinical and non-clinical effectiveness and Member satisfaction;

6. Support programmatic improvements of clinical and non-clinical processes based on findings from on-going measurements; and

7. Support re-measurement of effectiveness and Member satisfaction, and continued development and implementation of improvement interventions as appropriate.

8.1.7.2 QAPI Program Structure
The HMO must maintain a well-defined QAPI structure that includes a planned systematic approach to improving clinical and non-clinical processes and outcomes. The HMO must designate a senior executive responsible for the QAPI Program and the Medical Director must have substantial involvement in QAPI Program activities. At a minimum, the HMO must ensure that the QAPI Program structure:

1. Is organization-wide, with clear lines of accountability within the organization;

2. Includes a set of functions, roles, and responsibilities for the oversight of QAPI activities that are clearly defined and assigned to appropriate individuals, including physicians, other clinicians, and non-clinicians;

3. Includes annual objectives and/or goals for planned projects or activities including clinical and non-clinical programs or initiatives and measurement activities; and

4. Evaluates the effectiveness of clinical and non-clinical initiatives.

8.1.7.3 Clinical Indicators
The HMO must engage in the collection of clinical indicator data. The HMO must use such clinical indicator data in the development, assessment, and modification of its QAPI Program.

8.1.7.4 QAPI Program Subcontracting
If the HMO subcontracts any of the essential functions or reporting requirements contained within the QAPI Program to another entity, the HMO must maintain a file of the subcontractors. The file must be available for review by HHSC or its designee upon request.

8.1.7.5 Behavioral Health Integration into QAPI Program
If the HMO provides Behavioral Health Services within the Covered Services as defined in **Attachments B-2, B-2.1, and B-2.2**, it must integrate behavioral health into its QAPI Program and include a systematic and on-going process for monitoring, evaluating, and improving the quality and appropriateness of Behavioral Health Services provided to Members. The HMO must collect data, and monitor and evaluate for improvements to physical health outcomes resulting from behavioral health integration into the Member's overall care.

8.1.7.6 Clinical Practice Guidelines
The HMO must adopt not less than two evidence-based clinical practice guidelines for each applicable HMO Program. Such practice guidelines must be based on valid and reliable clinical evidence, consider the needs of the HMO's Members, be adopted in consultation with contracting health care professionals, and be reviewed and updated periodically, as appropriate. The HMO must develop practice guidelines based on the health needs and opportunities for improvement identified as part of the QAPI Program.

The HMO may coordinate the development of clinical practice guidelines with other HHSC HMOs to avoid providers in a Service Area receiving conflicting practice guidelines from different HMOs.
The HMO must disseminate the practice guidelines to all affected Providers and, upon request, to Members and potential Members.
The HMO must take steps to encourage adoption of the guidelines, and to measure compliance with the guidelines, until such point that 90% or more of the Providers are consistently in compliance, based on HMO measurement findings.
The HMO must employ substantive Provider motivational incentive strategies, such as financial and non-financial incentives, to improve Provider compliance with clinical practice guidelines. The HMO's decisions regarding utilization management, Member education, coverage of services, and other areas included in the practice guidelines must be consistent with the HMO's clinical practice guidelines.

8.1.7.7 Provider Profiling
The HMO must conduct PCP and other Provider profiling activities at least annually. As part of its QAPI Program, the HMO must describe the methodology it uses to identify which and how many Providers to profile and to identify measures to use for profiling such Providers.
Provider profiling activities must include, but not be limited to:

1. Developing PCP and Provider-specific reports that include a multi-dimensional assessment of a PCP or Provider's performance using clinical, administrative, and Member satisfaction indicators of care that are accurate, measurable, and relevant to the enrolled population;

2. Establishing PCP, Provider, group, Service Area or regional Benchmarks for areas profiled, where applicable, including STAR, STAR+PLUS, CHIP and CHIP Perinatal Program-specific Benchmarks, where appropriate; and

3. Providing feedback to individual PCPs and Providers regarding the results of their performance and the overall performance of the Provider Network.

8.1.7.8 Network Management
The HMO must:

1. Use the results of its Provider profiling activities to identify areas of improvement for individual PCPs and Providers, and/or groups of Providers;

2. Establish Provider-specific quality improvement goals for priority areas in which a Provider or Providers do not meet established HMO standards or improvement goals;

3. Develop and implement incentives, which may include financial and non-financial incentives, to motivate Providers to improve performance on profiled measures; and

4. At least annually, measure and report to HHSC on the Provider Network and individual Providers' progress, or lack of progress, towards such improvement goals.

If the HMO implements a physician incentive plan, the plan must comply with the requirements of 42 C.F.R. §438.6(h), §422.208 and §422.210. The HMO cannot make payments under a physician incentive plan if the payments are designed to induce providers to reduce or limit Medically Necessary Covered Services to Members.

If the physician incentive plan places a physician or physician group at a substantial financial risk for services not provided by the physician or physician group, the HMO must ensure adequate stop-loss protection and conduct and submit annual Member surveys no later than five (5) Business Days after the HMO finalizes the survey results (refer to 42 C.F.R. §422.208 for information concerning "substantial financial risk" and "stop-loss protection").

The HMO must make information regarding physician incentive plans available to Members upon request, in accordance with the Uniform Managed Care Manual's requirements. The HMO must provide the following information to the Member:

1. whether the Member's PCP or other Providers are participating in the HMO's physician incentive plan;

2. whether the HMO uses a physician incentive plan that affects the use of referral services;

3. the type of incentive arrangement; and

4. whether stop-loss protection is provided.

No later than five (5) Business Days prior to implementing or modifying a physician incentive plan, the HMO must provide the following information to HHSC:

1. Whether the physician incentive plan covers services that are not furnished by a physician or physician group. The HMO is only required to report on items 2-4 below if the physician incentive plan covers services that are not furnished by a physician or physician group.

2. The type of incentive arrangement (e.g., withhold, bonus, capitation);

3. The percent of withhold or bonus (if applicable);

4. The panel size, and if patients are pooled, the method used (HHSC approval is required for the method used); and

If the physician or physician group is at substantial financial risk, the HMO must report proof that the physician or group has adequate stop-loss coverage, including the amount and type of stop-loss coverage.

8.1.7.9 Collaboration with the EQRO

The HMO will collaborate with HHSC's external quality review organization (EQRO) to develop studies, surveys, or other analytical approaches that will be carried out by the EQRO. The purpose of the studies, surveys, or other analytical approaches is to assess the quality of care and service provided to Members and to identify opportunities for HMO improvement. To facilitate this process, the HMO will supply claims data to the EQRO in a format identified by HHSC in consultation with HMOs, and will supply medical records for focused clinical reviews conducted by the EQRO. The HMO must also work collaboratively with HHSC and the EQRO to annually measure selected HEDIS measures that require chart reviews. During the first year of operations, HHSC anticipates that the selected measures will include, at a minimum, well-child visits and immunizations, appropriate use of asthma medications, measures related to Members with diabetes, and control of high blood pressure.

8.1.8 Utilization Management

The HMO must have a written utilization management (UM) program description, which includes, at a minimum:

1. Procedures to evaluate the need for Medically Necessary Covered Services;

2. The clinical review criteria used, the information sources, the process used to review and approve the provision of Covered Services;

3. The method for periodically reviewing and amending the UM clinical review criteria; and

4. The staff position functionally responsible for the day-to-day management of the UM function.

The HMO must make best efforts to obtain all necessary information, including pertinent clinical information, and consult with the treating physician as appropriate in making UM determinations. When making UM determinations, the HMO must comply with the requirements of 42 C.F.R. §456.111 (Hospitals) and 42 CFR §456.211 (Mental Hospitals), as applicable.

The HMO must issue coverage determinations, including adverse determinations, according to the following timelines:

- Within three (3) business days after receipt of the request for authorization of services;
- Within one (1) business day for concurrent hospitalization decisions; and
- Within one (1) hour for post-stabilization or life-threatening conditions, except that for Emergency Medical Conditions and Emergency Behavioral Health Conditions, the HMO must not require prior authorization.

The HMO's UM Program must include written policies and procedures to ensure:

1. Consistent application of review criteria that are compatible with Members' needs and situations;

2. Determinations to deny or limit services are made by physicians under the direction of the Medical Director;

3. Appropriate personnel are available to respond to utilization review inquiries 8:00 a.m. to 5:00 p.m., Monday through Friday, with a telephone system capable of accepting utilization review inquiries after normal business hours. The HMO must respond to calls within one business day;

4. Confidentiality of clinical information; and

5. Quality is not adversely impacted by financial and reimbursement-related processes and decisions.

For HMOs with preauthorization or concurrent review programs, qualified medical professionals must supervise preauthorization and concurrent review decisions.
The HMO UM Program must include polices and procedures to:

1. Routinely assess the effectiveness and the efficiency of the UM Program;

2. Evaluate the appropriate use of medical technologies, including medical procedures, drugs and devices;

3. target areas of suspected inappropriate service utilization;

4. Detect over- and under-utilization;

5. Routinely generate Provider profiles regarding utilization patterns and compliance with utilization review criteria and policies;

6. Compare Member and Provider utilization with norms for comparable individuals;

7. Routinely monitor inpatient admissions, emergency room use, ancillary, and out-of-area services;

8. Ensure that when Members are receiving Behavioral Health Services from the local mental health authority that the HMO is using the same UM guidelines as those prescribed for use by Local Mental Health Authorities by MHMR which are published at: http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/RDMClinGuide.html; and

9. Refer suspected cases of provider or Member Fraud, Abuse, or Waste to the Office of Inspector General (OIG) as required by **Section 8.1.19**.

8.1.9 Early Childhood Intervention (ECI)

The HMO must ensure that Network Providers are educated regarding their responsibility under federal laws (e.g., 20 U.S.C. §1435 (a)(5); 34 C.F.R. §303.321(d)) to identify and refer any Member birth through 35 months of age suspected of having a developmental disability or delay, or who is at risk of delay, to the designated ECI program for screening and assessment within two (2) working days from the day the Provider identifies the Member. The HMO must use written educational materials developed or approved by the Department of Assistive and Rehabilitative Services – Division for Early Childhood Intervention Services for these "child find" activities. Eligibility for ECI services will be determined by the local ECI program using the criteria contained in 40 T.A.C. §108.25.

The HMO must contract with qualified ECI Providers to provide ECI services to Members birth through 35 months of age who have been determined eligible for ECI services. The HMO must permit Members to self refer to local ECI Service Providers without requiring a referral from the Member's PCP. The HMO's policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self-referral to ECI providers.

The HMO must coordinate and cooperate with local ECI programs in the development and implementation of the Individual Family Service Plan (IFSP), including on-going case management and other non-capitated services required by the Member's IFSP. The IFSP is an agreement developed by the interdisciplinary team that consists of the ECI Case Manager/Service Coordinator, the Member/family, and other professionals who participated in the Member's evaluation or are providing direct services to the Member, and may include the Member's Primary Care Physician (PCP) with parental consent. The IFSP identifies the Member's present level of development based on assessment, describes the services to be provided to the child to meet the needs of the child and the family, and identifies the person or persons responsible for each service required by the plan. The IFSP shall be transmitted by the ECI Provider to the HMO and the PCP with parental consent to enhance coordination of the plan of care. The IFSP may be included in the Member's medical record.

Cooperation with the ECI program includes covering medical diagnostic procedures and providing medical records required to perform developmental assessments and developing the IFSP within the 45-day timeline established in federal rule (34 C.F.R. §303.342(a)). The HMO must require compliance with these requirements through Provider contract provisions. The HMO must not withhold authorization for the provision of such medical diagnostic procedures. The HMO must promptly provide to the ECI program, relevant medical records available to the HMO.

The interdisciplinary team will determine Medical Necessity for health and Behavioral Health Services as approved by the Member's PCP. The HMO must require, through contract provisions, that all Medically Necessary health and Behavioral Health Services contained in the Member's IFSP are provided to the Member in the amount, duration, scope and service setting established by the IFSP. The HMO must allow services to be provided by a non-network provider if a Network Provider is not available to provide the services in the amount, duration, scope and service setting as required by the IFSP. The HMO cannot modify the plan of care or alter the amount, duration, scope, or service setting

required by the Member's IFSP. The HMO cannot create unnecessary barriers for the Member to obtain IFSP services, including requiring prior authorization for the ECI assessment or establishing insufficient authorization periods for prior authorized services.

8.1.10 Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) - Specific Requirements
The HMO must, by contract, require its Providers to coordinate with the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) to provide medical information necessary for WIC eligibility determinations, such as height, weight, hematocrit or hemoglobin. The HMO must make referrals to WIC for Members potentially eligible for WIC. The HMO may use the nutrition education provided by WIC to satisfy certain health education requirements of the Contract.

8.1.11 Coordination with Texas Department of Family and Protective Services
The HMO must cooperate and coordinate with the Texas Department of Family and Protective Services (TDFPS) (formerly the Department of Protective and Regulatory Services) for the care of a child who is receiving services from or has been placed in the conservatorship of TDFPS.

The HMO must comply with all provisions related to Covered Services, including Behavioral Health Services, in the following documents:

- A court order (Order) entered by a Court of Continuing Jurisdiction placing a child under the protective custody of TDFPS.
- A TDFPS Service Plan entered by a Court of Continuing Jurisdiction placing a child under the protective custody of TDFPS.
- A TDFPS Service Plan voluntarily entered into by the parents or person having legal custody of a Member and TDFPS.

The HMO cannot deny, reduce, or controvert the Medical Necessity of any health or Behavioral Health Services included in an Order. The HMO may participate in the preparation of the medical and behavioral care plan prior to TDFPS submitting the health care plan to the Court. Any modification or termination of court-ordered services must be presented and approved by the court having jurisdiction over the matter.
A Member or the parent or guardian whose rights are subject to an Order or Service Plan cannot use the HMO's Complaint or Appeal processes, or the HHSC Fair Hearing process to Appeal the necessity of the Covered Services.
The HMO must include information in its Provider Manuals and training materials regarding:

1. Providing medical records to TDFPS;
2. Scheduling medical and Behavioral Health Services appointments within 14 days unless requested earlier by TDFPS; and
3. Recognition of abuse and neglect, and appropriate referral to TDFPS.

The HMO must continue to provide all Covered Services to a Member receiving services from, or in the protective custody of, TDFPS until the Member has been;(1) disenrolled from the HMO due to loss of Medicaid managed care eligibility; or (2) enrolled in HHSC's managed care program for children in foster care, once the program is implemented.

8.1.12 Services for People with Special Health Care Needs
This section applies to STAR, STAR+PLUS, and CHIP HMOs. It applies to CHIP Perinatal HMOs with respect to their Perinate Newborn Members only.

8.1.12.1 Identification
The HMO must develop and maintain a system and procedures for identifying Members with Special Health Care Needs (MSHCN), including people with disabilities or chronic or complex medical and behavioral health conditions and Children with Special Health Care Needs (CSHCN)1.

The HMO must contact Members pre-screened by the HHSC Administrative Services Contractor as MSHCN to determine whether they meet the HMO's MSHCN assessment criteria, and to determine whether the Member requires special services described in this section. The HMO must implement mechanisms to assess each Member that has been pre-screened by the Administrative Services Contractor, or identified by the HMO as having special health care needs, in order to identify ongoing special conditions requiring a course of treatment or regular care monitoring. The HMO's assessment mechanisms must use appropriate health care professionals.

The HMO must provide information to the HHSC Administrative Services Contractor that identifies Members who the HMO has assessed to be MSHCN, including any Members pre-screened by the HHSC Administrative Services Contractor and confirmed by the HMO as a MSHCN. The information must be provided, in a format and on a timeline to be specified by HHSC in the **Uniform Managed Care Manual**, and updated with newly identified MSHCN by the 10th day of each month. In the event that a MSHCN changes HMOs, the HMO must provide the receiving contractor information concerning the results of the HMO's identification and assessment of that Member's needs, to prevent duplication of those activities.

8.1.12.2 Access to Care and Service Management
Once identified, the HMO must have effective systems to ensure the provision of Covered Services to meet the special preventive, primary Acute Care, and specialty health care needs appropriate for treatment of the individual Member's condition(s). All STAR+PLUS Members are considered to be MSHCN.
The HMO must provide access to identified PCPs and specialty care Providers with experience serving MSHCN. Such Providers must be board-qualified or board-eligible in their specialty. The HMO may request exceptions from HHSC for approval of traditional providers who are not board-qualified or board-eligible but who otherwise meet the HMO's credentialing requirements.
For services to CSHCN, the HMO must have Network PCPs and specialty care Providers that have demonstrated experience with CSHCN in pediatric specialty centers such as children's hospitals, teaching hospitals, and tertiary care centers.
The HMO is responsible for working with MSHCN, their families and legal guardians if applicable, and their health care providers to develop a seamless package of care in which primary, Acute Care, and specialty service needs are met through a Service Plan that is understandable to the Member, or, when applicable, the Member's legal guardian.
The HMO is responsible for providing Service Management to develop a Service Plan and ensure MSHCN, including CSHCN, have access to treatment by a multidisciplinary team when the Member's PCP determines the treatment is Medically Necessary, or to avoid separate and fragmented evaluations and service plans. The team must include both physician and non-

[1] CSHCN is a term often used to refer to a services program for children with special health care needs administered by DSHS, and described in 25 TAC, Part 1, Section 38.1. Although children served through this program may also be served by Medicaid or CHIP, the reference to "CSHCN" in this Contract does not refer to children served through this program.

physician providers determined to be necessary by the Member's PCP for the comprehensive treatment of the Member. The team must:

1. Participate in hospital discharge planning;
2. Participate in pre-admission hospital planning for non-emergency hospitalizations;
3. Develop specialty care and support service recommendations to be incorporated into the Service Plan; and
4. Provide information to the Member, or when applicable, the Member's legal guardian concerning the specialty care recommendations.

MSHCN, their families, or their health providers may request Service Management from the HMO. The HMO must make an assessment of whether Service Management is needed and furnish Service Management when appropriate. The HMO may also recommend to a MSHCN, or to a CSHCN's family, that Service Management be furnished if the HMO determines that Service Management would benefit the Member.
The HMO must provide information and education in its Member Handbook and Provider Manual about the care and treatment available in the HMO's plan for Members with Special Health Care Needs, including the availability of Service Management.
The HMO must have a mechanism in place to allow Members with Special Health Care Needs to have direct access to a specialist as appropriate for the Member's condition and identified needs, such as a standing referral to a specialty physician. The HMO must also provide MSHCN with access to non-primary care physician specialists as PCPs, as required by 28 T.A.C. §11.900 and **Section 8.1**.
The HMO must implement a systematic process to coordinate Non-capitated Services, and enlist the involvement of community organizations that may not be providing Covered Services but are otherwise important to the health and wellbeing of Members. The HMO also must make a best effort to establish relationships with State and local programs and community organizations, such as those listed below, in order to make referrals for MSHCN and other Members who need community services:

- Community Resource Coordination Groups (CRCGs);
- Early Childhood Intervention (ECI) Program;
- Local school districts (Special Education);
- Health and Human Services Commission's Medical Transportation Program (MTP);
- Texas Department of Assistive and Rehabilitative Services (DARS) Blind Children's Vocational Discovery and Development Program;
- Texas Department of State Health (DSHS) services, including community mental health programs, and Title V Maternal and Child Health and Children with Special Health Care Needs (CSHCN) Programs;
- Other state and local agencies and programs such as food stamps, and the Women, Infants, and Children's (WIC) Program;
- Civic and religious organizations and consumer and advocacy groups, such as United Cerebral Palsy, which also work on behalf of the MSHCN population.

8.1.13 Service Management for Certain Populations
The HMO must have service management programs and procedures for the following populations, as applicable to the HMO's Medicaid and/or CHIP Program(s) (See CHIP Perinatal Program Covered Services, **Attachment B-2.2**, for the applicability of these services to the CHIP Perinatal Program):

1. High-cost catastrophic cases;
2. Women with high-risk pregnancies (STAR and STAR+PLUS Programs only);
3. Individuals with mental illness and co-occurring substance abuse; and

4. FWC (STAR and STAR+PLUS Programs only).

8.1.14 Disease Management (DM)
The HMO must provide, or arrange to have provided to Members, comprehensive disease management services consistent with state statutes and regulations. Such DM services must be part of person-based approach to DM and holistically address the needs of persons with multiple chronic conditions. The HMO must develop and implement DM services that relate to chronic conditions that are prevalent in HMO Program Members. HMOs must have DM Programs that address chronic conditions identified in HHSC's**Uniform Managed Care Manual**. HHSC will not identify individual Members with chronic conditions. The HMO must implement policies and procedures to ensure that Members that require DM services are identified and enrolled in a program to provide such DM services. The HMO must develop and maintain screening and evaluation procedures for the early detection, prevention, treatment, or referral of participants at risk for or diagnosed with the chronic conditions identified in the **Uniform Managed Care Manual**. The HMO must ensure that all Members identified for DM are enrolled into a DM Program with the opportunity to opt out of these services within 30 days while still maintaining access to all other Covered Services.
For all new Members not previously enrolled in the HMO and who require DM services, the HMO must evaluate and ensure continuity of care with any previous DM services in accordance with the requirements in the **Uniform Managed Care Manual**.
The DM Program(s) must include:

1. Patient self-management education;

2. Provider education;

3. Evidence-based models and minimum standards of care;

4. Standardized protocols and participation criteria;

5. Physician-directed or physician-supervised care;

6. Implementation of interventions that address the continuum of care;

7. Mechanisms to modify or change interventions that are not proven effective; and

8. Mechanisms to monitor the impact of the DM Program over time, including both the clinical and the financial impact.

The HMO must maintain a system to track and monitor all DM participants for clinical, utilization, and cost measures.

The HMO must provide designated staff to implement and maintain DM Programs and to assist participating Members in accessing DM services. The HMO must educate Members and Providers about the HMO's DM Programs and activities. Additional requirements related to the HMO's Disease Management Programs and activities are found in the **HHSC Uniform Managed Care Manual**.

8.1.14.1 DM Services and Participating Providers
At a minimum, the HMO must:

1. Implement a system for Providers to request specific DM interventions;

2. Give Providers information, including differences between recommended prevention and treatment and actual care received by Members enrolled in a DM Program, and information concerning such Members' adherence to a service plan; and

3. For Members enrolled in a DM Program, provide reports on changes in a Member's health status to their PCP.

8.1.14.2 HMO DM Evaluation
HHSC or its EQRO will evaluate the HMO's DM Program.

8.1.15 Behavioral Health (BH) Network and Services
The requirements in this sub-section pertain to all HMOs except: (1) the STAR HMOs in the Dallas CSA, whose Members receive Behavioral Health Services through the NorthSTAR Program, and (2) the CHIP Perinatal Program HMOs with respect to their Perinate Members.
The HMO must provide, or arrange to have provided, to Members all Medically Necessary Behavioral Health (BH) Services as described in **Attachments B-2, B-2.1, and B-2.2**. All BH Services must be provided in conformance with the access standards included in **Section 8.1.3**. For Medicaid HMOs, BH Services are described in more detail in the **Texas Medicaid Provider Procedures Manual** and the **Texas Medicaid Bulletins**. When assessing Members for BH Services, the HMO and its Network Behavioral Health Service Providers must use the DSM-IV multi-axial classification. HHSC may require use of other assessment instrument/outcome measures in addition to the DSM-IV. Providers must document DSM-IV and assessment/outcome information in the Member's medical record.

8.1.15.1 BH Provider Network
The HMO must maintain a Behavioral Health Services Provider Network that includes psychiatrists, psychologists, and other Behavioral Health Service Providers. The Provider Network must include Behavioral Health Service Providers with experience serving special populations among the HMO Program(s)' enrolled population, including, as applicable, children and adolescents, persons with disabilities, the elderly, and cultural or linguistic minorities, to ensure accessibility and availability of qualified Providers to all Members in the Service Area.

8.1.15.2 Member Education and Self-referral for Behavioral Health Services
The HMO must maintain a Member education process to help Members know where and how to obtain Behavioral Health Services.
The HMO must permit Members to self refer to any in-network Behavioral Health Services Provider without a referral from the Member's PCP. The HMOs' policies and procedures, including its Provider Manual, must include written policies and procedures for allowing such self- referral to BH services.
The HMO must permit Members to participate in the selection of the appropriate behavioral health individual practitioner(s) who will serve them and must provide the Member with information on accessible in-network Providers with relevant experience.

8.1.15.3 Behavioral Health Services Hotline
This Section includes Hotline functions pertaining to Members. Requirements for Provider Hotlines are found in **Section 8.1.4.7**. The HMO must have an emergency and crisis Behavioral Health Services Hotline staffed by trained personnel 24 hours a day, 7 days a week, toll-free throughout the Service Area. Crisis hotline staff must include or have access to qualified Behavioral Health Services professionals to assess behavioral health emergencies. Emergency and crisis Behavioral Health Services may be arranged through mobile crisis teams. It is not acceptable for an emergency intake line to be answered by an answering machine.
The HMO must operate a toll-free hotline as described in **Section 8.1.5.6** to handle Behavioral Health-related calls. The HMO may operate one hotline to handle emergency and crisis calls and routine Member calls. The HMO cannot impose maximum call duration limits and must allow calls to be of sufficient length to ensure adequate information is provided to the Member. Hotline services must meet Cultural Competency requirements and provide linguistic access to all Members, including the interpretive services required for effective communication.
The Behavioral Health Services Hotline may serve multiple HMO Programs if the Hotline staff is knowledgeable about all of the HMO Programs. The Behavioral Health Services Hotline may serve multiple Service Areas if the Hotline staff is knowledgeable about all such Service Areas, including the Behavioral Health Provider Network in each Service Area. The HMO must ensure that the toll-free Behavioral Health Services Hotline meets the following minimum performance requirements for all HMO Programs and Service Areas:

1. 99% of calls are answered by the fourth ring or an automated call pick-up system;

2. no incoming calls receive a busy signal;

3. at least 80% of calls must be answered by toll-free line staff within 30 seconds measured from the time the call is placed in queue after selecting an option;

4. the call abandonment rate is 7% or less; and

5. the average hold time is 2 minutes or less.

The HMO must conduct on-going quality assurance to ensure these standards are met.

The HMO must monitor the HMO's performance against the Behavioral Health Services Hotline standards and submit performance reports summarizing call center performance as indicated in **Section 8.1.20** and the **Uniform Managed Care Manual.**
If HHSC determines that it is necessary to conduct onsite monitoring of the HMO's Behavioral Health Services Hotline functions, the HMO is responsible for all reasonable costs incurred by HHSC or its authorized agent(s) relating to such monitoring.

8.1.15.4 Coordination between the BH Provider and the PCP
The HMO must require, through contract provisions, that PCPs have screening and evaluation procedures for the detection and treatment of, or referral for, any known or suspected behavioral health problems and disorders. PCPs may provide any clinically appropriate Behavioral Health Services within the scope of their practice.
The HMO must provide training to network PCPs on how to screen for and identify behavioral health disorders, the HMO's referral process for Behavioral Health Services and clinical coordination requirements for such services. The HMO must include training on coordination and quality of care such as behavioral health screening techniques for PCPs and new models of behavioral health interventions.
The HMO shall develop and disseminate policies regarding clinical coordination between Behavioral Health Service Providers and PCPs. The HMO must require that Behavioral Health Service Providers refer Members with known or suspected and untreated physical health problems or disorders to their PCP for examination and treatment, with the Member's or the Member's legal guardian's consent. Behavioral Health Providers may only provide physical health care services if they are licensed to do so. This requirement must be specified in all Provider Manuals.
The HMO must require that behavioral health Providers send initial and quarterly (or more frequently if clinically indicated) summary reports of a Members' behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent. This requirement must be specified in all Provider Manuals.

8.1.15.5 Follow-up after Hospitalization for Behavioral Health Services
The HMO must require, through Provider contract provisions, that all Members receiving inpatient psychiatric services are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient treatment must occur within seven (7) days from the date of discharge. The HMO must ensure that Behavioral Health Service Providers contact Members who have missed appointments within 24 hours to reschedule appointments.

8.1.15.6 Chemical Dependency

The HMO must comply with 28 T.A.C. §3.8001 *et seq*., regarding utilization review for Chemical Dependency Treatment. Chemical Dependency Treatment must conform to the standards set forth in 28 T.A.C. Part 1, Chapter 3, Subchapter HH.

8.1.15.7 Court-Ordered Services
"Court-Ordered Commitment" means a commitment of a Member to a psychiatric facility for treatment that is ordered by a court of law pursuant to the Texas Health and Safety Code, Title VII, Subtitle C.
The HMO must provide inpatient psychiatric services to Members under the age of 21, up to the annual limit, who have been ordered to receive the services by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to Court-Ordered Commitments to psychiatric facilities. The HMO is not obligated to cover placements as a condition of probation, authorized by the Texas Family Code.
The HMO cannot deny, reduce or controvert the Medical Necessity of inpatient psychiatric services provided pursuant to a Court-ordered Commitment for Members under age 21. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination.
A Member who has been ordered to receive treatment under the provisions of Chapter 573 or 574 of the Texas Health and Safety Code can only Appeal the commitment through the court system.

8.1.15.8 Local Mental Health Authority (LMHA)
The HMO must coordinate with the Local Mental Health Authority (LMHA) and state psychiatric facility regarding admission and discharge planning, treatment objectives and projected length of stay for Members committed by a court of law to the state psychiatric facility.
Medicaid HMOs are required to comply with additional Behavioral Health Services requirements relating to coordination with the LMHA and care for special populations. These Medicaid HMO requirements are described in **Section 8.2.8**.

8.1.16 Financial Requirements for Covered Services
The HMO must pay for or reimburse Providers for all Medically Necessary Covered Services provided to all Members. The HMO is not liable for cost incurred in connection with health care rendered prior to the date of the Member's Effective Date of Coverage in that HMO. A Member may receive collateral health benefits under a different type of insurance such as workers compensation or personal injury protection under an automobile policy. If a Member is entitled to coverage for specific services payable under another insurance plan and the HMO paid for such Covered Services, the HMO may obtain reimbursement from the responsible insurance entity not to exceed 100% of the value of Covered Services paid.

8.1.17 Accounting and Financial Reporting Requirements
The HMO's accounting records and supporting information related to all aspects of the Contract must be accumulated in accordance with Federal Acquisition Regulations ("FAR"), Generally Accepted Accounting Principles (GAAP), and the cost principles contained in the Cost Principles

Document in the **Uniform Managed Care Manual**. The State will not recognize or pay services that cannot be properly substantiated by the HMO and verified by HHSC.
The HMO must:

1. Maintain accounting records for each applicable HMO Program separate and apart from other corporate accounting records;

2. Maintain records for all claims payments, refunds and adjustment payments to providers, capitation payments, interest income and payments for administrative services or functions and must maintain separate records for medical and administrative fees, charges, and payments;

3. Maintain an accounting system that provides an audit trail containing sufficient financial documentation to allow for the reconciliation of billings, reports, and financial statements with all general ledger accounts; and

4. Within 60 days after Contract execution, submit an accounting policy manual that includes all proposed policies and procedures the HMO will follow during the duration of the Contract. Substantive modifications to the accounting policy manual must be approved by HHSC.

The HMO agrees to pay for all reasonable costs incurred by HHSC to perform an examination, review or audit of the HMO's books pertaining to the Contract.

8.1.17.1 General Access to Accounting Records
The HMO must provide authorized representatives of the Texas and federal government full access to all financial and accounting records related to the performance of the Contract.
The HMO must:

1. Cooperate with the State and federal governments in their evaluation, inspection, audit, and/or review of accounting records and any necessary supporting information;

2. Permit authorized representatives of the State and federal governments full access, during normal business hours, to the accounting records that the State and the Federal government determine are relevant to the Contract. Such access is guaranteed at all times during the performance and retention period of the Contract, and will include both announced and unannounced inspections, on-site audits, and the review, analysis, and reproduction of reports produced by the HMO;

3. Make copies of any accounting records or supporting documentation relevant to the Contract, including Network Provider agreements, available to HHSC or its agents within seven (7) Business Days, or as otherwise specified by HHSC, of receiving a written request from HHSC for specified records or information. If such documentation is not made available as requested, the HMO agrees to reimburse HHSC for all costs, including, but not limited to, transportation, lodging, and subsistence for all State and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, and reproduction functions at the location(s) of such accounting records; and

4. Pay any and all additional costs incurred by the State and federal government that are the result of the HMO's failure to provide the requested accounting records or financial

information within ten (10) business days of receiving a written request from the State or federal government.

8.1.17.2 Financial Reporting Requirements
HHSC will require the HMO to provide financial reports by HMO Program and by Service Area to support Contract monitoring as well as State and Federal reporting requirements. HHSC will consult with HMOs regarding the format and frequency of such reporting. All financial information and reports that are not Member-specific are property of HHSC and will be public record. Any deliverable or report in Section 8.1.17.2 without a specified due date is due quarterly on the last day of the month. Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.
CHIP Perinatal Program data must be reported, and the data will be integrated into existing CHIP Program financial reports. Except for the Financial Statistical Report, no separate CHIP Perinatal Program reports are required. For all other CHIP financial reports, where appropriate, HHSC will designate specific attributes within the CHIP Program financial reports that the CHIP Perinatal HMOs must complete to allow HHSC to extract financial data particular to the CHIP Perinatal Program.
HHSC's **Uniform Managed Care Manual** will govern the timing, format and content for the following reports.

(a) **Audited Financial Statement –**The HMO must provide the annual audited financial statement, for each year covered under the Contract, no later than June 30. The HMO must provide the most recent annual financial statements, as required by the Texas Department of Insurance for each year covered under the Contract, no later than March 1.

(b) **Affiliate Report –** The HMO must submit an Affiliate Report to HHSC if this information has changed since the last report submission. The report must contain the following:

1. A list of all Affiliates, and

2. For HHSC's prior review and approval, a schedule of all transactions with Affiliates that, under the provisions of the Contract, will be allowable as expenses in the FSR Report for services provided to the HMO by the Affiliate. Those should include financial terms, a detailed description of the services to be provided, and an estimated amount that will be incurred by the HMO for such services during the Contract Period.

(c) **BSP Report** - For dates of service from September 1, 2008 to August 31, 2011, the Medicaid HMOs must submit a monthly Bariatric Supplemental Payment (BSP) Report that includes the data elements specified in the Uniform Managed Care Manual. The BSP Report must include only bariatric surgeries that meet all of the following requirements:

• unduplicated reports of bariatric surgeries;

• bariatric surgeries that the HMO has paid under the group of procedure codes defined as allowable for bariatric reimbursement, as designated in the "Texas Medicaid Providers Procedures Manual", including the Texas Medicaid Bulletins; and

• bariatric surgeries that were performed no earlier than 210 days prior to the date HHSC receives the Report, or that were included in the Report within thirty days from the date of discharge from the hospital for the stay related to the bariatric surgery, whichever is later. If a medical service provider does not submit a claim to the HMO by the deadline described herein, the HMO may request and exception to include the claim in the BSP report. HHSC may, at its sole discretion, grant or deny the request.

(d) **Employee Bonus and/or Incentive Payment Plan –** If a HMO intends to include Employee Bonus or Incentive Payments as allowable administrative expenses, the HMO must furnish a written Employee Bonus and/or Incentive Payments Plan to HHSC so it may determine whether such payments are allowable administrative expenses in accordance with Cost Principles Document in the **Uniform Managed Care Manual.** The written plan must include a description of the HMO's criteria for establishing bonus and/or incentive payments, the methodology to calculate bonus and/or incentive payments, and the timing of bonus and/or incentive payments. The Bonus and/or Incentive Payment Plan and description must be submitted to HHSC for approval no later than 30 days after the Effective Date of the Contract and any Contract renewal. If the HMO substantively revises the Employee Bonus and/or Incentive Payment Plan, the HMO must submit the revised plan to HHSC for prior review and approval.

(e) **Claims Lag Report** - The HMO must submit Claims Lag Report as a Contract year-to-date report. The report must be submitted quarterly by the last day of the month following the reporting period. The report must be submitted to HHSC in a format specified by HHSC. The report format is contained in the **Uniform Managed Care Manual** Chapter 5, Section 5.6.2. The report must disclose the amount of incurred claims each month and the amount paid each month.

(f) **DSP Report** - The HMO must submit a monthly Delivery Supplemental Payment (DSP) Report that includes the data elements specified by HHSC in the format specified by HHSC. HHSC will consult with contracted HMOs prior to revising the DSP Report data elements and requirements. The DSP Report must include only unduplicated deliveries and only deliveries for which the HMO has made a payment, to either a hospital or other provider.

(g) **Financial Disclosure Report** - The HMO must file:

1. a Financial Disclosure Report prior to the start of Operations;

2. an updated Financial Disclosure Report no later than 30 days after the end of each Contract Year; and

3. a “change notification” abbreviated version of the report, no later than 30 days after any of the following events:

    a. entering into, renewing, modifying, or terminating a relationship with an affiliated party;

    b. after any change in control, ownership, or affiliations; or,

    c. after any material change in, or need for addition to, the information previously disclosed.

The Financial Disclosure Report will include, at a minimum, a listing of the HMO’s control, ownership, and any affiliations, and information regarding Affiliate transactions. This report will replace, and be in lieu of, the former “Section 1318 Financial Disclosure Report” and the “Form CMS 1513,” and will disclose the same information, plus other information as may be required by HHSC and/or CMS Program Integrity requirements. Minor quarterly adjustments in stock holdings for publicly-traded corporations are excluded from the reporting requirements. The reporting format will be included in the Uniform Managed Care Manual. Until the reporting format is included in the Uniform Managed Care Manual, the HMO will continue to report the information described herein on CMS 1513 form.

(h) **FSR Reports –** The HMO must file quarterly and annual Financial-Statistical Reports (FSR) in the format and timeframe specified by HHSC. HHSC will include FSR format and directions in the **Uniform Managed Care Manual**. The HMO must incorporate financial and statistical data of delegated networks (e.g., IPAs, ANHCs, Limited Provider Networks), if any, in its FSR Reports. Administrative expenses reported in the FSRs must be reported in accordance with the Cost Principles Document in the **Uniform Managed Care Manual**. Quarterly FSR reports are due no later than 30 days after the end of the quarter and must provide information for the current quarter and year-to-date information through the current quarter. The first annual FSR report must reflect expenses incurred through the 90th day after the end of the fiscal year. The first annual report must be filed on or before the 120th day after the end of each fiscal year. Subsequent annual reports must reflect data completed through the 334th day after the end of each fiscal year and must be filed on or before the 365th day following the end of each fiscal year.
HHSC will post all FSRs on the HHSC website.
CHIP Perinatal HMOs are required to submit separate FSRs for the CHIP Perinatal Program following the instructions outlined above and in the **Uniform Managed Care Manual**.

(i) **HUB Reports –** Upon contract award, the HMO must attend a post award meeting in Austin, Texas, at a time specified by HHSC, to discuss the development and submission of a Client Services HUB Subcontracting Plan for inclusion and the HMO’s good faith efforts to notify HUBs of subcontracting opportunities. The HMO must maintain its HUB Subcontracting Plan and submit monthly reports documenting the HMO’s Historically Underutilized Business (HUB) program efforts and accomplishments to the HHSC HUB Office. The report must include a narrative description of the HMO’s program efforts and a financial report reflecting payments made to HUBs. HMOs must use the formats included in HHSC’s **Uniform Managed Care Manual** for the HUB monthly reports. The HMO must comply with HHSC’s standard Client Services HUB Subcontracting Plan requirements for all subcontractors.

(j) **IBNR Plan** - The HMO must furnish a written IBNR Plan to manage incurred-but-not-reported (IBNR) expenses, and a description of the method of insuring against insolvency, including information on all existing or proposed insurance policies. The Plan must include the methodology for estimating IBNR. The plan and description must be submitted to HHSC no later than 60 days after the Effective Date of the Contract. Substantive changes to a HMO’s IBNR plan and description must be submitted to HHSC no later than 30 days before the HMO implements changes to the IBNR plan.

(k) **Medicaid Disproportionate Share Hospital (DSH) Reports** – Medicaid HMOs must file preliminary and final Medicaid DSH reports, required by HHSC to identify and reimburse hospitals that qualify for Medicaid DSH funds. The preliminary and final DSH reports must include the data elements and be submitted in the form and format specified by HHSC in the **Uniform Managed Care Manual**. The preliminary DSH reports are due on or before March 1 of the year following the federal fiscal reporting year. The final DSH reports are due no later than April 1 of the year following the federal fiscal reporting year. This reporting requirement does not apply to CHIP or CHIP Perinatal Program HMOs.

(l) **Out-of-Network Utilization Reports** – The HMO must file quarterly Out-of Network Utilization Reports in the format and timeframe specified by HHSC. HHSC will include the report format and directions in the **Uniform Managed Care Manual**. Quarterly reports are due 30 days after the end of each quarter.

(m)**TDI Examination Report** - The HMO must furnish a copy of any TDI Examination Report, including the financial, market conduct, target exam, quality of care components, and corrective action plans and responses, no later than 10 days after receipt of the final report from TDI.

(n) **TDI Filings –** The HMO must submit annual figures for controlled risk-based capital, as well as its quarterly financial statements, both as required by TDI.

(o) **Registration Statement (also known as the “Form B”) -** If the HMO is a part of an insurance holding company system, the HMO must submit to HHSC a complete registration statement, also known as Form B, and all amendments to this form, and any other information filed by such insurer with the insurance regulatory authority of its domiciliary jurisdiction.

(p) **Third Party Recovery (TPR) Reports** - The HMO must file TPR Reports in accordance with the format developed by HHSC in the **Uniform Managed Care Manual**. HHSC will require the HMO to submit TPR reports no more often than quarterly. TPR reports must include total dollars recovered from third party payers for each HMO Program for services to the HMO’s Members, and the total dollars recovered through coordination of benefits, subrogation, and worker’s compensation.

8.1.18 Management Information System Requirements
The HMO must maintain a Management Information System (MIS) that supports all functions of the HMO’s processes and procedures for the flow and use of HMO data. The HMO must have hardware, software, and a network and communications system with the capability and capacity to handle and operate all MIS subsystems for the following operational and administrative areas:

1. Enrollment/Eligibility Subsystem;
2. Provider Subsystem;
3. Encounter/Claims Processing Subsystem;
4. Financial Subsystem;
5. Utilization/Quality Improvement Subsystem;
6. Reporting Subsystem;
7. Interface Subsystem; and
8. TPR Subsystem, as applicable to each HMO Program.

The MIS must enable the HMO to meet the Contract requirements, including all applicable state and federal laws, rules, and regulations. The MIS must have the capacity and capability to capture and utilize various data elements required for HMO administration.
HHSC will provide the HMO with pharmacy data on the HMO’s Members on a weekly basis through the HHSC Vendor Drug Program, or should these services be outsourced, through the Pharmacy Benefit Manager. HHSC will provide a sample format of pharmacy data to contract awardees.
The HMO must have a system that can be adapted to changes in Business Practices/Policies within the timeframes negotiated by the Parties. The HMO is expected to cover the cost of such systems modifications over the life of the Contract.
The HMO is required to participate in the HHSC Systems Work Group.
The HMO must provide HHSC prior written notice of major systems changes and implementations, no later than 180 days prior to the planned change or implementation, including any changes relating to Material Subcontractors, in accordance with the requirements of this Contract and the **Uniform Managed Care Terms and Conditions.** HHSC retains the right to modify or waive the notification requirement contingent upon the nature of the request from the HMO.
The HMO must provide HHSC any updates to the HMO’s organizational chart relating to MIS and the description of MIS responsibilities at least 30 days prior to the effective date of the change. The HMO must provide HHSC official points of contact for MIS issues on an on-going basis.
HHSC, or its agent, may conduct a Systems Readiness Review to validate the HMO’s ability to meet the MIS requirements as described in **Attachment B-1, Section 7**. The System Readiness Review may include a desk review and/or an onsite review and must be conducted for the following events:

1. A new plan is brought into the HMO Program;
2. An existing plan begins business in a new Service Area;
3. An existing plan changes location;
4. An existing plan changes its processing system, including changes in Material Subcontractors performing MIS or claims processing functions; and
5. An existing plan in one or two HHSC HMO Programs is initiating a Contract to participate in any additional HMO Programs.

If HHSC determines that it is necessary to conduct an onsite review, the HMO is responsible for all reasonable travel costs associated with such onsite reviews. For purposes of this section, “reasonable travel costs” include airfare, lodging, meals, car rental and fuel, taxi, mileage, parking, and other incidental travel expenses incurred by HHSC or its authorized agent in connection with the onsite reviews. This provision does not limit HHSC’s ability to collect other costs as damages in accordance with Attachment A, Section 12.02(e), “Damages.”
If for any reason, a HMO does not fully meet the MIS requirements, then the HMO must, upon request by HHSC, either correct such deficiency or submit to HHSC a Corrective Action Plan and Risk Mitigation Plan to address such deficiency as requested by HHSC. Immediately upon identifying a deficiency, HHSC may impose remedies and either actual or liquidated damages according to the severity of the deficiency. HHSC may also freeze enrollment into the HMO’s plan for any of its HMO Programs until such deficiency is corrected. Refer to **Attachment A, Article 12** and **Attachment B-5** for additional information regarding remedies and damages. **Refer to Attachment B-1, Section 7** and **Attachment B-1, Section 8.1.1.2 f**or additional information regarding HMO Readiness Reviews. Refer to **Attachment A, Section 4.08(c)** for information regarding Readiness Reviews of the HMO’s Material Subcontractors.

8.1.18.1 Encounter Data
The HMO must provide complete Encounter Data for all Covered Services, including Value-added Services. Encounter Data must follow the format, and data elements as described in the HIPAA-compliant 837 format. HHSC will specify the method of transmission, the submission schedule, and any other requirements in the **Uniform Managed Care Manual**. The HMO must submit Encounter Data transmissions monthly, and include all Encounter Data and Encounter Data adjustments processed by the HMO. Encounter Data quality validation must incorporate assessment standards developed jointly by the HMO and HHSC. The HMO must submit complete and accurate encounter data not later than the 30th calendar day after the last day of the month in which the claim was adjudicated. The HMO must make original records available for inspection by HHSC for validation purposes. Encounter Data that do not meet quality standards must be corrected and returned within a time period specified by HHSC.
In addition to providing Encounter Data in the 837 format described above, HMOs may be requested to submit an Encounter Data file to HHSC's EQRO, in the format provided in the **Uniform Managed Care Manual**. This additional submission requirement is time-limited and may not be required for the entire term of the Contract.
For reporting Encounters and fee-for-service claims to HHSC, the HMO must use the procedure codes, diagnosis codes, and other codes as directed by HHSC. Any exceptions will be considered on a code-by-code basis after HHSC receives written notice from the HMO requesting an exception. The HMO must also use the provider numbers as directed by HHSC for both Encounter and fee-for-service claims submissions, as applicable.

8.1.18.2 HMO Deliverables related to MIS Requirements
At the beginning of each state fiscal year, the HMO must submit the following documents and corresponding checklists for HHSC's review and approval:

1. Disaster Recovery Plan;*
2. Business Continuity Plan;* and
3. Security Plan

* The Business Continuity Plan and the Disaster Recovery Plan may be combined into one document.
Additionally, at the beginning of each state fiscal year, if the HMO modifies the following documents, it must submit the revised documents and corresponding checklists for HHSC's review and approval:

1. Joint Interface Plan;
2. Risk Management Plan; and
3. Systems Quality Assurance Plan.

The HMO must submit plans and checklists to HHSC according to the format and schedule identified in the HHSC **Uniform Managed Care Manual**. Additionally, if a Systems Readiness Review is triggered by one of the events described in Section 8.1.18, the HMO must submit all of the plans identified in this Section 8.1.18.2 in accordance with an HHSC-approved timeline
The HMO must follow all applicable Joint Interface Plans (JIPs) and all required file submissions for HHSC's Administrative Services Contractor, External Quality Review Organization (EQRO) and HHSC Medicaid Claims Administrator. The JIPs can be accessed through the **Uniform Managed Care Manual**.

8.1.18.3 System-wide Functions
The HMO's MIS system must include key business processing functions and/or features, which must apply across all subsystems as follows:

1. Process electronic data transmission or media to add, delete or modify membership records with accurate begin and end dates;
2. Track Covered Services received by Members through the system, and accurately and fully maintain those Covered Services as HIPAA-compliant Encounter transactions;
3. Transmit or transfer Encounter Data transactions on electronic media in the HIPAA format to the contractor designated by HHSC to receive the Encounter Data;
4. Maintain a history of changes and adjustments and audit trails for current and retroactive data;
5. Maintain procedures and processes for accumulating, archiving, and restoring data in the event of a system or subsystem failure;
6. Employ industry standard medical billing taxonomies (procedure codes, diagnosis codes) to describe services delivered and Encounter transactions produced;
7. Accommodate the coordination of benefits;
8. Produce standard Explanation of Benefits (EOBs);
9. Pay financial transactions to Providers in compliance with federal and state laws, rules and regulations;
10. Ensure that all financial transactions are auditable according to GAAP guidelines.
11. Relate and extract data elements to produce report formats (provided within the **Uniform Managed Care Manual)** or otherwise required by HHSC;
12. Ensure that written process and procedures manuals document and describe all manual and automated system procedures and processes for the MIS;
13. Maintain and cross-reference all Member-related information with the most current Medicaid, CHIP or CHIP Perinatal Program Provider number; and
14. Ensure that the MIS is able to integrate pharmacy data from HHSC's Drug Vendor file (available through the Virtual Private Network (VPN)) into the HMO's Member data.

8.1.18.4 Health Insurance Portability and Accountability Act (HIPAA) Compliance
The HMO's MIS system must comply with applicable certificate of coverage and data specification and reporting requirements promulgated pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996, P.L. 104-191 (August 21, 1996), as amended or modified. The HMO must comply with HIPAA EDI requirements. HMO's enrollment files must be in the 834 HIPAA-compliant format. Eligibility inquiries must be in the 270/271 format and all claims and remittance transactions in the 837/835 format.
The HMO must provide its Members with a privacy notice as required by HIPAA. The HMO must provide HHSC with a copy of its privacy notice for filing.

8.1.18.5 Claims Processing Requirements
The HMO must process and adjudicate all provider claims for Medically Necessary Covered Services that are filed within the time frames specified in the **Uniform Managed Care Manual**. The HMO is subject to remedies, including liquidated damages and interest, if the HMO does not process and adjudicate claims within the timeframes listed in the **Uniform Managed Care Manual.**

The HMO must administer an effective, accurate, and efficient claims payment process in compliance with federal laws and regulations, applicable state laws and rules, the Contract, and the **Uniform Managed Care Manual**. In addition, a Medicaid HMO must be able to accept and process provider claims in compliance with the Texas Medicaid Provider Procedures Manual and The Texas Medicaid Bulletin.

The HMO must maintain an automated claims processing system that registers the date a claim is received by the MCO, the detail of each claim transaction (or action) at the time the transaction occurs, and has the capability to report each claim transaction by date and type to include interest payments. The claims system must maintain information at the claim and line detail level. The claims system must maintain adequate audit trails and report accurate claims performance measures to HHSC.

The HMO's claims system must maintain online and archived files. The HMO must keep online automated claims payment history for the most current 18 months. The HMO must retain other financial information and records, including all original claims forms, for the time period established in **Attachment A, Section 9.01**. All claims data must be easily sorted and produced in formats as requested by HHSC.

The HMO must offer its Providers/Subcontractors the option of submitting and receiving claims information through electronic data interchange (EDI) that allows for automated processing and adjudication of claims. EDI processing must be offered as an alternative to the filing of paper claims. Electronic claims must use HIPAA-compliant electronic formats.

The HMO must make an electronic funds transfer (EFT) payment process (for direct deposit) available to in-network providers when processing claims for Medically Necessary covered STAR+PLUS services.

The HMO may deny a claim submitted by a provider for failure to file in a timely manner as provided for in the **Uniform Managed Care Manual**. The HMO must not pay any claim submitted by a provider based on an order or referral that excludes the National Provider Identifier (NPI) for the ordering or referring physician. The HMO must not pay any claim submitted by a provider excluded or suspended from the Medicare, Medicaid, CHIP or CHIP Perinatal programs for Fraud, Abuse, or Waste. The HMO must not pay any claim submitted by a Provider that is on payment hold under the authority of HHSC or its authorized agent(s), or who has pending accounts receivable with HHSC.

The HMO is subject to the requirements related to coordination of benefits for secondary payors in the Texas Insurance Code Section 843.349 (e) and (f).

The HMO must notify HHSC of major claim system changes in writing no later than 180 days prior to implementation. The HMO must provide an implementation plan and schedule of proposed changes. HHSC reserves the right to require a desk or on-site readiness review of the changes.

The HMO must inform all Network Providers about the information required to submit a claim at least 30 days prior to the Operational Start Date and as a provision within the HMO/Provider contract. The HMO must make available to Providers claims coding and processing guidelines for the applicable provider type. Providers must receive 90 days notice prior to the HMO's implementation of changes to claims guidelines.

8.1.18.6 National Correct Coding Initiative
Effective for claims filed on or after October 1, 2010, the HMO must comply with the requirements of Section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), regarding "Mandatory State Use of National Correct Coding Initiatives," including all applicable rules, regulations, and methodologies implemented as a result of this initiative.

8.1.19 Fraud and Abuse
A HMO is subject to all state and federal laws and regulations relating to Fraud, Abuse, and Waste in health care and the Medicaid and CHIP programs. The HMO must cooperate and assist HHSC and any state or federal agency charged with the duty of identifying, investigating, sanctioning or prosecuting suspected Fraud, Abuse or Waste. The HMO must provide originals and/or copies of all records and information requested and allow access to premises and provide records to the Inspector General for the Texas Health and Human Services System, HHSC or its authorized agent(s), the Centers for Medicare and Medicaid Services (CMS), the U.S. Department of Health and Human Services (DHHS), Federal Bureau of Investigation, TDI, or other units of state government. The HMO must provide all copies of records free of charge.

Each HMO must designate one primary and one secondary contact person for all HHSC OIG records requests. HHSC OIG records requests will be sent to the designated HMO contact person(s) in writing via email, fax or regular mail, and will provide the specifics of the information being requested (see below). The HMO will respond to the appropriate HHSC OIG staff member within the timeframe designated in the request. If the HMO is unable to provide all of the requested information with in the designated timeframe, an extension may be granted and must be request in writing (email) by the HMO no less than two (2) Business Days prior to the due date. When a request for data is provided to the HMO, the HMO's response must include data for all data fields, as available. If any data field is left blank, an explanation must accompany the response. The data must be provided in the order and format requested. The HMO must not include any additional data fields in its response. All requested information must be accompanied by a notarized Business Records Affidavit unless indicated otherwise in HHSC OIG's record request.

The most common requests will include:

- 1099 data and other financial information - five (5) Business Days.
- Claims data for sampling - 20 Business Days.
- Urgent claims data requests - 15 Business Days (with OIG manager's approval).
- Provider education information - 10 Business Days.
- Files associated with an HMO conducted investigation - 15 Business Day.
- Other time-sensitive requests - as needed.

The HMO must submit a written Fraud and Abuse compliance plan to the Office of Inspector General at HHSC for approval each year. The plan must be submitted 60 days prior to the start of the State fiscal year. (See **Attachment B-1, Section 7** for requirements regarding timeframes for submitting the original plan.) If an HMO has not made any changes to its plan from the previous year, it may notify the HHSC OIG that: (1) no changes have been made to the privously-approved plan, (2) the plan will remain in place for the upcoming State Fiscal Year. The notification must be signed and certified by an officer or director of the HMO that is responsible for carrying out the Fraud and Abuse compliance plan. Upon receipt of a written request from the HHSC OIG, the HMO must submit the complete Fraud and Abuse compliance plan.

The HMO is subject to and must meet all requirements in Section 531.113 of the Texas Government Code, Section 533.012 of the Texas Government Code, Title 1 Texas Administrative Code (TAC), Part 15, Chapter 353, Subchapter F, Rule 353.501-353.505, and Title 1 Texas Administrative Code (TAC), Part 15, Chapter 370, Subchapter F, Rule 370.501-370.505.

Additional Requirements for STAR and STAR+PLUS HMOs:
In accordance with Section 1902(a)(68) of the Social Security Act, STAR and STAR+PLUS HMOs that receive or make annual Medicaid payments of at least $5 million must:

1. Establish written policies for all employees, managers, officers, contractors, subcontractors, and agents of the HMO, which provide detailed information about the False Claims Act, administrative remedies for false claims and statements, any state laws pertaining to civil or criminal penalties for false claims, and whistleblower protections under such laws, as described in Section 1902(a)(68)(A).

2. Include as part of such written policies, detailed provisions regarding the HMO's policies and procedures for detecting and preventing fraud, waste, and abuse.

3. Include in any employee handbook a specific discussion of the laws described in Section 1902(a)(68)(A), the rights of employees to be protected as whistleblowers, and the HMO's policies and procedures for detecting and preventing fraud, waste, and abuse.

8.1.20 Reporting Requirements
The HMO must provide and must require its subcontractors to provide:

1. All information required under the Contract, including but not limited to, the reporting requirements or other information related to the performance of its responsibilities hereunder as reasonably requested by the HHSC; and

2. Any information in its possession sufficient to permit HHSC to comply with the Federal Balanced Budget Act of 1997 or other Federal or state laws, rules, and regulations. All information must be provided in accordance with the timelines, definitions, formats and instructions as specified by HHSC. Where practicable, HHSC may consult with HMOs to establish time frames and formats reasonably acceptable to both parties.

Any deliverable or report in Section 8.1.20 without a specified due date is due quarterly on the last day of the month following the end of the reporting period. Where the due date states 30 days, the HMO is to provide the deliverable by the last day of the month following the end of the reporting period. Where the due date states 45 days, the HMO is to provide the deliverable by the 15th day of the second month following the end of the reporting period.

The HMO's Chief Executive and Chief Financial Officers, or persons in equivalent positions, must certify that financial data, Encounter Data and other measurement data has been reviewed by the HMO and is true and accurate to the best of their knowledge after reasonable inquiry.

8.1.20.1 HEDIS and Other Statistical Performance Measures
The HMO must provide to HHSC or its designee all information necessary to analyze the HMO's provision of quality care to Members using measures to be determined by HHSC in consultation with the HMO. Such measures must be consistent with HEDIS or other externally based measures or measurement sets, and involve collection of information beyond that present in Encounter Data. The **Performance Indicator Dashboard**, found in the **Uniform Managed Care Manual** provides additional information on the role of the HMO and the EQRO in the collection and calculation of HEDIS, CAHPS, and other performance measures.

8.1.20.2 Reports
The HMO must provide the following reports, in addition to the Financial Reports described in **Section 8.1.17** and those reporting requirements listed elsewhere in the Contract. The **HHSC Uniform Managed Care Manual** will include a list of all required reports, and a description of the format, content, file layout and submission deadlines for each report.
For the following reports, CHIP Perinatal Program data will be integrated into existing CHIP Program reports. Generally, no separate CHIP Perinatal Program reports are required. Where appropriate, HHSC will designate specific attributes within the CHIP Program reports that the CHIP Perinatal HMOs must complete to allow HHSC to extract data particular to the CHIP Perinatal Program.

(a) **Claims Summary Report -** The HMO must submit quarterly Claims Summary Reports to HHSC by HMO Program, Service Area and claim type by the 30th day following the end of the reporting period unless otherwise specified. Claim Types include facility and/or professional services for Acute Care, Behavioral Health, Vision, and Long Term Services and Supports. Within each claim type, claims data must be reported separately on the UB and CMS 1500 claim forms. The format for the Claims Summary Report is contained in Chapter 5, Section 5.6.1 of the **Uniform Managed Care Manual**.

(b) **QAPI Program Annual Summary Report -** The HMO must submit a QAPI Program Annual Summary in a format and timeframe as specified in the Uniform Managed Care Manual.

(c) **Fraudulent Practices Report -** Utilizing the HHSC-Office of Inspector General (OIG) fraud referral form, the HMO's assigned officer or director must report and refer all possible acts of waste, abuse or fraud to the HHSC-OIG within 30 working days of receiving the reports of possible acts of waste, abuse or fraud from the HMO's Special Investigative Unit (SIU). The report and referral must include: an investigative report identifying the allegation, statutes/regulations violated or considered, and the results of the investigation; copies of program rules and regulations violated for the time period in question; the estimated overpayment identified; a summary of the interviews conducted; the encounter data submitted by the provider for the time period in question; and all supporting documentation obtained as

the result of the investigation. This requirement applies to all reports of possible acts of waste, abuse and fraud.
Additional reports required by the Office of the Inspector General relating to waste, abuse or fraud are listed in the **HHSC Uniform Managed Care Manual**.

(d) **Provider Termination Report: (CHIP (including integrated CHIP Perinatal Program data), STAR, and STAR+PLUS) -** MCO must submit a quarterly report that identifies any providers who cease to participate in MCO's provider network, either voluntarily or involuntarily. The report must be submitted to HHSC in the format specified by HHSC, no later than 30 days after the end of the reporting period.

(e) **PCP Network & Capacity Report: (CHIP only (including integrated CHIP Perinatal Program data)) -** For the CHIP Program, MCO must submit a quarterly report listing all unduplicated PCPs in the MCO's Provider Network. For the CHIP Perinatal Program, the Perinatal Newborns are assigned PCPs that are part of the CHIP PCP Network. The report must be submitted to HHSC in the format specified by HHSC, no later than 30 days after the end of the reporting quarter.

(f) **Summary Report of Member Complaints and Appeals -** The HMO must submit quarterly Member Complaints and Appeals reports. The HMO must include in its reports Complaints and Appeals submitted to its subcontracted risk groups (e.g., IPAs) and any other subcontractor that provides Member services. The HMO must submit the Complaint and Appeals reports electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **HHSC Uniform Managed Care Manual,** Chapter 5.4.2.
HHSC may direct the CHIP Perinatal HMOs to provide segregated Member Complaints and Appeals reports on an as-needed basis.

(g) **Summary Report of Provider Complaints -** The HMO must submit Provider complaints reports on a quarterly basis. The HMO must include in its reports complaints submitted by providers to its subcontracted risk groups (e.g., IPAs) and any other subcontractor that provides Provider services. The complaint reports must be submitted electronically on or before 45 days following the end of the state fiscal quarter, using the format specified by HHSC in the **HHSC Uniform Managed Care Manual,** Chapter 5.4.2.
HHSC may direct the CHIP Perinatal HMOs to provide segregated Provider Complaints and Appeals reports on an as-needed basis.

(h) **Hotline Reports -** The HMO must submit, on a quarterly basis, a status report for the Member Hotline, the Behavioral Health Services Hotline, and the Provider Hotline in comparison with the performance standards set out in **Sections 8.1.5.6, 8.1.15.3, and 8.1.4.7**. The HMO shall submit such reports using a format to be prescribed by HHSC in consultation with the HMOs.
If the HMO is not meeting a hotline performance standard, HHSC may require the HMO to submit monthly hotline performance reports and implement corrective actions until the hotline performance standards are met. If a HMO has a single hotline serving multiple

Service Areas, multiple HMO Programs, or multiple hotline functions, (i.e. Member, Provider, Behavioral Health Services hotlines), HHSC may request on an annual basis that the HMO submit certain hotline response information by HMO Program, by Service Area, and by hotline function, as applicable to the HMO. HHSC may also request this type of hotline information if a HMO is not meeting a hotline performance standard.

(i) **Audit Reports –** The HMO must comply with the Uniform Managed Care Manual's requirements regarding notification and/or submission of audit reports.

(j) **Medicaid Managed Care Texas Health Steps Medical Checkups Reports** – Medicaid HMOs must submit reports identifying the number of New Members and Existing Members receiving Texas Health Steps medical checkups. Medicaid HMOs must also document and report those Members refusing to obtain the medical checkups. The documentation must include the reason the Member refused the checkup or the reason the checkup was not received.
The definitions, timeframe, format, and details of the reports are contained and described in the **Uniform Managed Care Manual**, Chapters 12.4, 12.5, 12.6, and 12.13.

(k) **Children of Migrant Farm Workers Annual Report (FWC Annual Report)** Beginning in SFY 2008, Medicaid HMOs must submit an annual report, in the timeframe and format described in the Uniform Managed Care Manual, about the identification of and delivery of services to children of migrant farm workers (FWC). The report will include a description and results of the each of the following:

(1) the HMO's efforts to identify as many community and statewide groups that work with FWC as possible within each of its Service Areas;

(2) the HMO's efforts to coordinate and cooperate with as many of such groups as possible; and

(3) the HMO's efforts to encourage the community groups to assist in the identification of FWC.

The HMO will maintain accurate, current lists of all identified FWC Members.

(l) **Frew Quarterly Monitoring Report**

Each calendar year quarter, HHSC prepares a report for the court that addresses the status of the Consent Decree paragraphs of the *Frew vs. Suehs* lawsuit. Medicaid HMOs must prepare responses to questions posed by HHSC on the Frew Quarterly Monitoring Report template.
The timeframe, format, and details of the report are set forth in the **Uniform Managed Care Manual**.

(m) **Frew Health Care Provider Training Report**
Per the *Frew vs. Suehs'* "Corrective Action Order: Health Care Provider Training," HHSC must compile a summary of the training health care providers receive throughout the year for

the October Quarterly Monitoring Report for the court. Medicaid HMOs must report to HHSC health care provider training conducted throughout the year to be included in this report.
The timeframe, format, and details of the report are contained and described in the **Uniform Managed Care Manual**.

(n) **Frew Provider Recognition Report**
Per the *Frew vs. Suehs'* "Corrective Action Order: Health Care Provider Training," HHSC must recognize Medicaid enrolled healthcare providers who complete Frew and/or Texas Health Steps (THSteps) training. Medicaid HMOs must collect and track provider training recognition information for all Frew and/or THSteps trainings conducted and report the names of those Medicaid enrolled healthcare providers who consent to being recognized to HHSC quarterly.
The timeframe, format, and details of the report are contained and described in the **Uniform Managed Care Manual**.

8.2.21 Immunizations
The HMO must educate Providers on the Immunization Standard Requirements set forth in Chapter 161, Health and Safety Code; the standards in the Advisory Committee on Immunization Practices (ACIP) Immunization Schedule; the AAP Periodicity Schedule for CHIP Members; and the Texas Health Steps Periodicity Schedule for Medicaid Members. The HMO must educate Providers that Medicaid Members birth through age 20 must be immunized during the Texas Health Steps checkup according to the ACIP routine immunizaiton schedule. The HMO must also educate Providers that the screening provider is responsible for administration of the immunization and should not refer children to Local Health Departments to receive immunizations.

The HMO must educate Providers about, and require Providers to comply with, the requirements of Chapter 161, Health and Safety Code, relating to the Texas Immunization Registry (ImmTrac) to include parental consent on the Vaccine Information Statement.

8.2 Additional Medicaid HMO Scope of Work

The following provisions apply to any HMO participating in the STAR or STAR+PLUS HMO Program.

8.2.1 Continuity of Care and Out-of-Network Providers
The HMO must ensure that the care of newly enrolled Members is not disrupted or interrupted. The HMO must take special care to provide continuity in the care of newly enrolled Members whose health or behavioral health condition has been treated by specialty care providers or whose health could be placed in jeopardy if Medically Necessary Covered Services are disrupted or interrupted. See Section 8.1.14 Disease Management for specific requirements for new Members transferring to the HMO's DM Program.

The HMO is required to ensure that Expansion County clients receiving acute care services through a prior authorization as of the STAR and STAR+PLUS Operational Start Date receive continued authorization of those services for the shorter of: (1) 90 calendar days after Operational Start Date, or (2) until the expiration date of the prior authorization The HMO is also required to ensure that Expansion County clients receiving Community-based Long Term Care Services as of the STAR+PLUS Operational Start Date receive continued authorization of those services for up to six (6) months after the Operational Start Date, unless a new assessment has been completed and new authorizations issued as described in **Section 8.3.2.4**. During transition, an HHSC's Administrative Services Contractor or an HHS Agency will provide the HMO with files identifying clients with prior authorizations for acute care services and clients receiving Community-based Long Term Care Services. The HMO is required to work with HHSC, its Administrative Services Contractor, and DADS to ensure that all necessary authorizations are in place within the HMO's system(s) for the continuation of Community-based Long Term Care Services and prior authorized acute care services. The HMO must describe the process it will use to ensure continuation of these services in its Transition/Implementation Plan for the Expansion Counties as noted in **Section 7.3.1.1 "**Contract Start-Up and Planning". The HMO is also required to ensure that Community-based Long Term Care Services Providers in the Expansion Counties are educated about and trained regarding the process for continuing such services prior to the Operational Start Date (see **Section 8.3.6.1**).

The HMO must allow pregnant Members past the 24th week of pregnancy to remain under the care of the Member's current OB/GYN through the Member's postpartum checkup, even if the provider is Out-of-Network. If a Member wants to change her OB/GYN to one who is in the Network, she must be allowed to do so if the Provider to whom she wishes to transfer agrees to accept her in the last trimester of pregnancy.

The HMO must pay a Member's existing Out-of-Network providers for Medically Necessary Covered Services until the Member's records, clinical information and care can be transferred to a Network Provider, or until such time as the Member is no longer enrolled in that HMO, whichever is shorter. Payment to Out-of-Network providers must be made within the time period required for Network Providers. The HMO must comply with out-of-network provider reimbursement rules as adopted by HHSC.

This Article does not extend the obligation of the HMO to reimburse the Member's existing Out-of-Network providers for on-going care for:

1. More than 90 days after a Member enrolls in the HMO's Program, or

2. For more than nine (9) months in the case of a Member who, at the time of enrollment in the HMO, has been diagnosed with and receiving treatment for a terminal illness and remains enrolled in the HMO.

The HMO's obligation to reimburse the Member's existing Out-of-Network provider for services provided to a pregnant Member with 12 weeks or less remaining before the expected delivery date extends through delivery of the child, immediate postpartum care, and the follow-up checkup within the first six weeks of delivery.
The HMO must provide or pay Out-of-Network providers who provide Medically Necessary Covered Services to Members who move out of the Service Area through the end of the period for which capitation has been paid for the Member.
The HMO must provide Members with timely and adequate access to Out-of-Network services for as long as those services are necessary and covered benefits not available within the network, in accordance with 42 C.F.R. §438.206(b)(4).
The HMO will not be obligated to provide a Member with access to Out-of-Network services if such services become available from a Network Provider.
The HMO must ensure that each Member has access to a second opinion regarding the use of any Medically Necessary Covered Service. A Member must be allowed access to a second opinion from a Network Provider or Out-of-Network provider if a Network Provider is not available, at no cost to the Member, in accordance with 42 C.F.R. §438.206(b)(3).

8.2.2 Provisions Related to Covered Services for Medicaid Members

8.2.2.1 Emergency Services
HMO policy and procedures, Covered Services, claims adjudication methodology, and reimbursement performance for Emergency Services must comply with all applicable state and federal laws, rules, and regulations including 42 C.F.R. §438.114, whether the provider is in-network or Out-of-Network. HMO policies and procedures must be consistent with the prudent layperson definition of an Emergency Medical Condition and the claims adjudication processes required under the Contract and 42 C.F.R. §438.114.
The HMO must pay for the professional, facility, and ancillary services that are Medically Necessary to perform the medical screening examination and stabilization of a Member presenting with an Emergency Medical Condition or an Emergency Behavioral Health Condition to the hospital emergency department, 24 hours a day, 7 days a week, rendered by either the HMO's Network or Out-of-Network providers.
The HMO cannot require prior authorization as a condition for payment for an Emergency Medical Condition, an Emergency Behavioral Health Condition, or labor and delivery. The HMO
cannot limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms. The HMO cannot refuse to cover Emergency Services based on the emergency room provider, hospital, or fiscal agent not notifying the Member's PCP or the HMO of the Member's screening and treatment within 10 calendar days of presentation for Emergency Services. The HMO may not hold the Member who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose the specific condition or stabilize the patient. The HMO must accept the emergency physician or provider's determination of when the Member is sufficiently stabilized for transfer or discharge.
A medical screening examination needed to diagnose an Emergency Medical Condition must be provided in a hospital based emergency department that meets the requirements of the Emergency Medical Treatment and Active Labor Act (EMTALA) (42 C.F.R. §§489.20, 489.24 and 438.114(b)&(c)). The HMO must pay for the emergency medical screening examination, as required by 42 U.S.C. §1395dd. The HMO must reimburse for both the physician's services and the hospital's Emergency Services, including the emergency room and its ancillary services.
When the medical screening examination determines that an Emergency Medical Condition exists, the HMO must pay for Emergency Services performed to stabilize the Member. The emergency physician must document these services in the Member's medical record. The HMO must reimburse for both the physician's and hospital's emergency stabilization services including the emergency room and its ancillary services.
The HMO must cover and pay for Post-Stabilization Care Services in the amount, duration, and scope necessary to comply with 42 C.F.R. §438.114(b)&(e) and 42 C.F.R. §422.113(c)(iii). The HMO is financially responsible for post-stabilization care services obtained within or outside the Network that are not pre-approved by a Provider or other HMO representative, but administered to maintain, improve, or resolve the Member's stabilized condition if:

1. The HMO does not respond to a request for pre-approval within 1 hour;

2. The HMO cannot be contacted; or

3. The HMO representative and the treating physician cannot reach an agreement concerning the Member's care and a Network physician is not available for consultation. In this situation, the HMO must give the treating physician the opportunity to consult with a Network physician and the treating physician may continue with care of the patient until an HMO physician is reached. The HMO's financial responsibility ends as follows: the HMO physician with privileges at the treating hospital assumes responsibility for the Member's care; the HMO physician assumes responsibility for the Member's care through transfer; the HMO representative and the treating physician reach an agreement concerning the Member's care; or the Member is discharged.

8.2.2.2 Family Planning - Specific Requirements
The HMO must require, through Provider contract provisions, that Members requesting contraceptive services or family planning services are also provided counseling and education about the family planning and family planning services available to Members. The HMO must develop outreach programs to increase community support for family planning and encourage Members to use available family planning services.

The HMO must ensure that Members have the right to choose any Medicaid participating family planning provider, whether the provider chosen by the Member is in or outside the Provider Network. The HMO must provide Members access to information about available providers of family planning services and the Member's right to choose any Medicaid family planning provider. The HMO must provide access to confidential family planning services.
The HMO must provide, at minimum, the full scope of services available under the Texas Medicaid program for family planning services. The HMO will reimburse family planning agencies the Medicaid fee-for service amounts for family planning services, including Medically Necessary medications, contraceptives, and supplies not covered by the Vendor Drug Program and will reimburse Out-of-Network family planning providers in accordance with HHSC's administrative rules. The HMO cannot require prior authorization for family planning services whether rendered by a Network or Out-of-Network provider.
The HMO must provide medically approved methods of contraception to Members, provided that the methods of contraception are Covered Services. Contraceptive methods must be accompanied by verbal and written instructions on their correct use. The HMO must establish mechanisms to ensure all medically approved methods of contraception are made available to the Member, either directly or by referral to a subcontractor.
The HMO must develop, implement, monitor, and maintain standards, policies and procedures for providing information regarding family planning to Providers and Members, specifically regarding State and federal laws governing Member confidentiality (including minors). Providers and family planning agencies cannot require parental consent for minors to receive family planning services. The HMO must require, through contractual provisions, that subcontractors have mechanisms in place to ensure Member's (including minor's) confidentiality for family planning services.

8.2.2.3 Texas Health Steps (EPSDT)

8.2.2.3.1 Medical Checkups

The HMO must develop effective methods to ensure that children birth through age 20 receive Texas Health Steps services when due and according to the recommendations established by the Texas Health Steps periodicity schedule for children. The HMO must arrange for Texas Health Steps services for all eligible Members except when a Member knowingly and voluntarily declines or refuses services after receiving sufficient information to make an informed decision. For New Members birth through age 20, overdue or upcoming Texas Health Steps medical checkups should be offered as soon as practicable, but in no case later than 14 days of enrollment for newborns, and no later than 90 days of enrollment for all other eligible child Members. Effective September 1, 2010, the Texas Health Steps annual medical checkup for an Existing Member age 36 months and older is due on the child's birthday. The annual medical checkup is considered timely if it occurs no later than 364 calendar days after the child's birthday. For purposes of this requirement, the terms "New Member" and "Existing Member" are defined in Chapter 12.4 of the Uniform Managed Care Manual.

The HMO must have mechanisms in place to ensure that all newborn Members have an initial newborn checkup before discharge from the hospital and in accorndance with the Texas Health Steps periodicity schedule.

8.2.2.3.2 Oral Evaluation and Fluoride Varnish
The HMO must educate Providers on the availability of the Oral Evaluation and Fluoride Varnish (OEVS) Medicaid benefit that can be rendered and billed by certified Texas Health Steps providers when performed on the same day as the Texas Health Steps medical checkup. The Provider education must include information about how to assist a Member with referral to a dentist to establish a dental home.

8.2.2.3.3 Lab
The HMO must require Providers to send all Texas Health Steps newborn screens to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code. Providers must include detailed identifying information for all screened newborn Members and the Member's mother to allow DSHS to link the screens performed at the hospital with screens performed at the newborn follow up Texas Health Steps medical checkup.
All laboratory specimens collected as a required component of a Texas Health Steps checkup (see Texas Medicaid Provider Procedures Manual for age-specific requirements) must be submitted to the DSHS Laboratory Services Section or to a laboratory approved by the department under Section 33.016 of the Health and Safety Code for analysis. The HMO must educate Providers about Texas Health Steps Program requirements for submitting laboratory tests to the DSHS Laboratory Services Section.

8.2.2.3.4 Education/Outreach
The HMO must ensure that Members are provided information and educational materials about the services available through the Texas Health Steps Program, and how and when they may obtain the services. The information should tell the Member how they can obtain dental benefits, transportation services through the Medical Transportation Program, and advocacy assistance from the HMO. The HMO will encourage Medicaid-enrolled pharmacies to also become Medicaid-enrolled durable medical equipment (DME) providers.

The HMO must provide outreach to Members to ensure they receive prompt services and are effectively informed about available Texas Health Steps services. Each month, the HMO must retrieve from the HHSC Administrative Services Contractor Bulletin Board System a list of Members who are due and overdue Texas Health Steps services. Using these lists and its own internally generated list, the HMO will contact such Members to obtain the service as soon as possible. The HMO outreach staff must coordinate with Texas Health Steps outreach unit to ensure that Members have access to the Medical Transportation Program, and that any coordination with other agencies is maintained.

The HMO must cooperate and coordinate with the State, outreach programs and Texas Health Steps regional program staff and agents to ensure prompt delivery of services to children of migrant farm workers and other migrant populations who may transition into and out of the HMO's Program more rapidly and/or unpredictably than the general population.

The HMO must make an effort to coordinate and cooperate with existing community and school-based health and education programs that offer services to school-aged children in a location that is both familiar and convenient to the Members. The HMO must make a good faith effort to comply with Head Start's requirement that Members participating in Head Start receive their Texas Health Steps checkup no later than 45 days after enrolling into either program.

8.2.2.3.5 Training
The HMO must provide appropriate training to all Network Providers and Provider staff in the Providers' area of practice regarding the scope of benefits available and the Texas Health Steps Program. Training must include:

1. Texas Health Steps benefits;
2. the periodicity schedule for Texas Health Steps medical checkups and immunizations;
3. the required elements of Texas Health Steps medical checkups;
4. providing or arranging for all required lab screening tests (including lead screening), and Comprehensive Care Program (CCP) services available under the Texas Health Steps program to Members birth through age 20;
5. Medical Transportation services avilable to Members such as rides to healthcare service by bus, taxi, van, airfare, etc., gas money, mileage reimbursement, meals and lodging when away from home;
6. importance of updating contact information to ensure accurate provider directories and the Medicaid Online Povider Lookup;
7. information about HMO's process for acceleration of THSteps services for Children of Migrant Farm Workers;
8. missed appointment referrals and assistance provided by the THSteps Outreach and Informing Unit; and
9. administrative issues such as claims filing and services available to Members.

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HMO must also educate and train Providers regarding the requirements imposed on HHSC and contracting HMOs under the Consent Decree and Corrective Action Orders entered in Frew v. Suehs, et. al., Civil Action No. 3:93CV65, in the United States District Court for the Eastern District of Texas, Paris Division. Providers should be educated and trained to treat each Texas Health Steps visit as an opportunity for a comprehensive assessment of the Member**.**

8.2.2.3.6 Data Validation
The HMO must require all Texas Health Steps Providers to submit claims for services paid (either on a capitated or fee-for service basis) on the CMS 1500 claim form and use the HIPAA compliant code set required by HHSC. Encounter Data will be validated by chart review of a random sample of Texas Health Steps eligible enrollees against monthly Encounter Data reported by the HMO. HHSC or its designee will conduct chart reviews to validate that all screens are performed when due and as reported, and that reported data is accurate and timely. Substantial deviation between reported and charted Encounter Data could result in the HMO and/or Network Providers being investigated for potential Fraud, Abuse, or Waste without notice to the HMO or the Provider.

8.2.2.4 Perinatal Services
The HMO's perinatal health care services must ensure appropriate care is provided to women and infant Members of the HMO from the preconception period through the infant's first year of life. The HMO's perinatal health care system must comply with the requirements of the Texas Health and Safety Code, Chapter 32 (the Maternal and Infant Health Improvement Act) and administrative rules codified at 25 T.A.C. Chapter 37, Subchapter M.
The HMO must have a perinatal health care system in place that, at a minimum, provides the following services:

1. Pregnancy planning and perinatal health promotion and education for reproductive- age women;
2. Perinatal risk assessment of non-pregnant women, pregnant and postpartum women, and infants up to one year of age;
3. Access to appropriate levels of care based on risk assessment, including emergency care;
4. Transfer and care of pregnant women, newborns, and infants to tertiary care facilities when necessary;
5. Availability and accessibility of OB/GYNs, anesthesiologists, and neonatologists capable of dealing with complicated perinatal problems; and
6. Availability and accessibility of appropriate outpatient and inpatient facilities capable of dealing with complicated perinatal problems.

The HMO must have a process to expedite scheduling a prenatal appointment for an obstetrical exam for a TP40 Member no later than two weeks after receiving the daily Enrollment File verifying the Member's enrollment into the HMO.
The HMO must have procedures in place to contact and assist a pregnant/delivering Member in selecting a PCP for her baby either before the birth or as soon as the baby is born.
The HMO must provide inpatient care and professional services relating to labor and delivery for its pregnant/delivering Members, and neonatal care for its newborn Members at the time of delivery and for up to 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated Caesarian delivery.
The HMO must Adjudicate provider claims for services provided to a newborn Member in accordance with HHSC's claims processing requirements using the proxy ID number or State-issued Medicaid ID number. The HMO cannot deny claims based on a provider's non-use of State-issued Medicaid ID number for a newborn Member. The HMO must accept provider claims for newborn services based on mother's name and/or Medicaid ID number with accommodations for multiple births, as specified by the HMO.
The HMO must notify providers involved in the care of pregnant/delivering women and newborns (including Out-of-Network providers and hospitals) of the HMO's prior authorization requirements. The HMO cannot require a prior authorization for services provided to a pregnant/delivering Member or newborn Member for a medical condition that requires Emergency Services, regardless of when the emergency condition arises.

8.2.2.5 Sexually Transmitted Diseases (STDs) and Human Immunodeficiency Virus (HIV)
The HMO must provide STD services that include STD/HIV prevention, screening, counseling, diagnosis, and treatment. The HMO is responsible for implementing procedures to ensure that Members have prompt access to appropriate services for STDs, including HIV. The HMO must allow Members access to STD services and HIV diagnosis services without prior authorization or referral by a PCP.
The HMO must comply with Texas Family Code Section 32.003, relating to consent to treatment by a child. The HMO must provide all Covered Services required to form the basis for a diagnosis by the Provider as well as the STD/HIV treatment plan.
The HMO must make education available to Providers and Members on the prevention, detection and effective treatment of STDs, including HIV.
The HMO must require Providers to report all confirmed cases of STDs, including HIV, to the local or regional health authority according to 25 T.A.C. §§97.131 - 97.134, using the required forms and procedures for reporting STDs. The HMO must require the Providers to coordinate with the HHSC regional health authority to ensure that Members with confirmed cases of syphilis, chancroid, gonorrhea, chlamydia and HIV receive risk reduction and partner elicitation/notification counseling.
The HMO must have established procedures to make Member records available to public health agencies with authority to conduct disease investigation, receive confidential Member information, and provide follow up activities.
The HMO must require that Providers have procedures in place to protect the confidentiality of Members provided STD/HIV services. These procedures must include, but are not limited to, the manner in which medical records are to be safeguarded, how employees are to protect medical information, and under what conditions information can be shared. The HMO must inform and require its Providers who provide STD/HIV services to comply with all state laws relating to communicable disease reporting requirements. The HMO must implement policies and procedures to monitor Provider compliance with confidentiality requirements.
The HMO must have policies and procedures in place regarding obtaining informed consent and counseling Members provided STD/HIV services.

8.2.2.6 Tuberculosis (TB)
The HMO must provide Members and Providers with education on the prevention, detection and effective treatment of tuberculosis (TB). The HMO must establish mechanisms to ensure all procedures required to screen at-risk Members and to form the basis for a diagnosis and proper prophylaxis and management of TB are available to all Members, except services referenced in **Section 8.2.2.8** as Non-Capitated Services. The HMO must develop policies and procedures to ensure that Members who may be or are at risk for exposure to TB are screened for TB. An at-risk Member means a person who is susceptible to TB because of the association with certain risk factors, behaviors, drug resistance, or environmental conditions. The HMO must consult with the local TB control program to ensure that all services and treatments are in compliance with the guidelines recommended by the American Thoracic Society (ATS), the Centers for Disease Control and Prevention (CDC), and DSHS policies and standards.

The HMO must implement policies and procedures requiring Providers to report all confirmed or suspected cases of TB to the local TB control program within one working day of identification, using the most recent DSHS forms and procedures for reporting TB. The HMO must provide access to Member medical records to DSHS and the local TB control program for all confirmed and suspected TB cases upon request.
The HMO must coordinate with the local TB control program to ensure that all Members with confirmed or suspected TB have a contact investigation and receive Directly Observed Therapy (DOT). The HMO must require, through contract provisions, that Providers report to DSHS or the local TB control program any Member who is non-compliant, drug resistant, or who is or may be posing a public health threat. The HMO must cooperate with the local TB control program in enforcing the control measures and quarantine procedures contained in Chapter 81 of the Texas Health and Safety Code.
The HMO must have a mechanism for coordinating a post-discharge plan for follow-up DOT with the local TB program. The HMO must coordinate with the DSHS South Texas Hospital and Texas Center for Infectious Disease for voluntary and court-ordered admission, discharge plans, treatment objectives and projected length of stay for Members with multi-drug resistant TB.

8.2.2.7 Objection to Provide Certain Services
In accordance with 42 C.F.R. §438.102, the HMO may file an objection to providing, reimbursing for, or providing coverage of, a counseling or referral service for a Covered Service based on moral or religious grounds. The HMO must work with HHSC to develop a work plan to complete the necessary tasks and determine an appropriate date for implementation of the requested changes to the requirements related to Covered Services. The work plan will include timeframes for completing the necessary Contract and waiver amendments, adjustments to Capitation Rates, identification of the HMO and enrollment materials needing revision, and notifications to Members.
In order to meet the requirements of this section, the HMO must notify HHSC of grounds for and provide detail concerning its moral or religious objections and the specific services covered under the objection, no less than 120 days prior to the proposed effective date of the policy change.

8.2.2.8 Medicaid Non-capitated Services
The following Texas Medicaid programs and services have been excluded from HMO Covered Services. Medicaid Members are eligible to receive these Non-capitated Services on a Fee-for-Service basis from Texas Medicaid providers. HMOs should refer to relevant chapters in the **Provider Procedures Manual** and the **Texas Medicaid Bulletins** for more information.

1. Texas Health Steps dental (including orthodontia);

2. Texas Health Steps environmental lead investigation (ELI)

3. Early Childhood Intervention (ECI) case management/service coordination;

4. DSHS targeted case management;

5. DSHS mental health rehabilitation;

6. DSHS case management for Children and Pregnant Women;

7. Texas School Health and Related Services (SHARS);

8. Department of Assistive and Rehabilitative Services Blind Children's Vocational Discovery and Development Program;

9. Tuberculosis services provided by DSHS-approved providers (directly observed therapy and contact investigation);

10. Vendor Drug Program (out-of-office drugs);

11. Health and Human Services Commission's Medical Transportation;

12. DADS hospice services (all Members are disenrolled from their health plan upon enrollment into hospice except STAR+PLUS members);

13. Audiology services and hearing aids for children (birth through age 20) (hearing screening services are provided through the Texas Health Steps Program and are capitated).

14. For STAR+PLUS, Inpatient Stays are Non-capitated (with the exception of inpatient mental health services, which are capitated).

15. For STAR, Personal Care Services for persons under age 21 are Non-capitated Services.

16. For STAR+PLUS, nursing facility services are Non-capitated Services; and

17. For Members who are enrolled in STAR or STAR+PLUS during and Inpatient Stay under one of the exceptions identified in Attachment A, Section 5.05(a)(2), Hospital facility charges associated with the Inpatient Stay are Non-Capitated Services under the circumstances described in Attachment A, Section 5.05(a)(2)..

8.2.2.9 Referrals for Non-capitated Services
Although Medicaid HMOs are not responsible for paying or reimbursing for Non-capitated Services, HMOs are responsible for educating Members about the availability of Non-capitated Services, and for providing appropriate referrals for Members to obtain or access these services. The HMO is responsible for informing Providers that bills for all Non-capitated Services must be submitted to HHSC's Claims Administrator for reimbursement.

8.2.2.10 Cooperation with Immunization Registry
The HMO must work with HHSC and health care providers to improve the immunization rate of Medicaid clients and the reporting of immunization information for inclusion in the Texas Immunization Registry, called "ImmTrac."

8.2.2.11 Case Management for Children and Pregnant Women
The HMO must educate Members and Providers on the services available through Case Management for Children and Pregnant Women (CPW) as described on the program's website at http://www.dshs.state.tx.us/caseman/default.shtm. An HMO may provide information about CPW's website and basic information about CPW services in order to meet this requirement. CPW information and materials must be included in the HMO's Provider Manual, Member Handbook and Provider orientations. The information and materials must also inform Providers that the disclosure of medical records or information between Providers, HMO's and CPW case managers does not require a medical release form from the Member.

The HMO must coordinate services with CPW regarding a Member's health care needs that are identified by CPW and referred to the HMO. Upon receipt of a referral or assessment from a CPW case manager, the HMO's designated staff are required to review the assessment and determine, based on the HMO's policies, the appropriate level of health care and services. The HMO's staff must also coordinate with the Member's family, Member's Primary Care Provider (PCP), in and Out-of-Network Providers, agencies, and the HMO's utilization management staff to ensure that the health care and services identified are properly referred, authorized, scheduled and provided within a timely manner.
The HMO must ensure that access to medically necessary health care needed by the Member is available within the standards established by HHSC for respective care. HMOs are not required to arrange or provide for any covered or non-covered services identified in the CPW assessment. The decision whether to authorize these services is made by the HMO. Within five (5) business days of identifying any non-covered health care services or other services that the Member may need, the HMO's staff must report to the CPW case manager which items/services will not be performed by the HMO. Additionally, within ten (10) business days after all of the authorized services have been provided, the HMO's staff must follow-up with CPW case manager to report the provision of services. The HMO's staff must ensure that all services provided to a Member by an HMO Provider are reported to the Member's PCP.
The CPW program requires its contracted case managers to coordinate with the HMO and the HMO's PCPs. The HMO should report problems regarding CPW referrals, assessments or coordination activities to HHSC for follow-up with CPW program staff.

8.2.2.12 Children of Migrant Farmworkers (FWC)
The HMO must cooperate and coordinate with the State, outreach programs, and Texas Health Steps regional program staff and agents to ensure prompt delivery of services, in accordance with the timeframes in this Contract, to FWC Members and other migrant populations who may transition into and out of the HMO more rapidly and/or unpredictably than the general population.
The HMO must provide accelerated services to FWC Members. For purposes of this section, "accelerated services" are services that are provided to a child of a migrant farm worker prior to their leaving Texas to work in other states. Accelerated services include the provision of preventive Health Care Services that will be due during the time the FWC Member is out of Texas. The need for accelerated services must be determined on a case-by-case and according to the FWC Member's age, periodicity schedule and health care needs.
The HMO must develop a plan annually for the process it will use to identify FWC and for the methods that will be used to provide accelerated services and submit an annual certification that the HMO will comply with the plan. The plan for FY2008 must be submitted for HHSC approval no later than December 1, 2007 and implemented by February 1, 2008. The plan must include at a minimum:

- Identification of community and statewide groups that work with FWC Members within the HMO's Service Areas;

- Participation of the community groups in assisting with the identification of FWC Members;

- Appropriate aggressive efforts to reach each identified FWC to provide timely medical checkups and follow up care if needed;

- Methods to maintain accurate, current lists of all identified FWC Members;

- Methods that the HMO and its Subcontractors will implement to maintain the confidentiality of information about the identity of FWC; and

- Methods to provide accelerated services to FWC.

8.2.3 Medicaid Significant Traditional Providers
In the first three (3) years of a Medicaid HMO Program operating in a Service Area, the HMO must seek participation in its Network from all Medicaid Significant Traditional Providers (STPs) defined by HHSC in the applicable Service Area for the applicable HMO Program. For STAR HMOs, the Medicaid STP requirements only apply in the Nueces Service Area. For STAR+PLUS HMOs, the Medicaid STP requirements apply to all Service Areas, except Harris County within the Harris Service Area.
Medicaid STPs are defined as PCPs and, for STAR+PLUS, Community-based Long Term Care providers in a county, that, when listed by provider type by county in descending order by unduplicated number of clients, served the top 80% of unduplicated clients. Hospitals receiving Disproportionate Share Hospital (DSH) funds are also considered STPs in the Service Area in which they are located. Note that STAR+PLUS HMOs are not required to contract with Hospitals for Inpatient Stays, but are required to contract with Hospitals for Outpatient Hospital Services. The HHSC website includes a list of Medicaid STPs by Service Area.
Because the STP lists were produced in FY2005, HHSC has developed an updated list for Long Term Care Providers. The list will be provided to HMOs and posted on HHSC's website.
The STP requirement will be in place for three years after the program has been implemented. During that time, providers who believe they meet the STP requirements may contact HHSC request HHSC's consideration for STP status. STAR+PLUS HMOs will be notified when Providers are added to the list of STPs for a Service Area.
The HMO must give STPs the opportunity to participate in its Network for at least three (3) years commencing on the implementation date of Medicaid managed care in the Service Area. However, the STP provider must:

1. Agree to accept the HMO's Provider reimbursement rate for the provider type; and

2. Meet the standard credentialing requirements of the HMO, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is not the sole grounds for exclusion from the Provider Network.

8.2.4 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
The HMO must make reasonable efforts to include FQHCs and RHCs (freestanding and hospital-based) in its Provider Network. The HMO must reimburse FQHCs, RHCs, and Municipal Health Department's public clinics for Health Care Services provided outside of regular business hours, as defined by HHSC in rules, including weekend days or holidays, at a rate that is equal to the allowable rate for those services as determined under Section 32.028, Human Resources Code, if the Member does not have a referral from their PCP. Depending on the date of the claim, FQHCs or RHCs may receive a cost settlement from HHSC and must agree to accept initial payments from the HMO in an amount that is equal to or greater than the HMO's payment terms for other Providers providing the same or similar services.

1. **Prior to September 1, 2007**: For claims accruing prior to September 1, 2007, cost settlements apply to all Service Areas except the Nueces Service Area and the STAR+PLUS Service Areas. The HMOs serving the Nueces Service Area and the STAR+PLUS Service Areas must pay the full encounter rates to the FQHCs and RHCs for claims accruing before September 1, 2007.

2. **September 1, 2007 to September 1, 2008:** For claims accruing on or after September 1, 2007 but prior to September 1, 2008, HMOs are not required to pay full encounter rates to the FQHCs and RHCs. Therefore, HHSC cost settlements for FQHC's will continue to apply to all STAR and STAR+PLUS Service Areas for this period of time.

3. **On or after September 1, 2008:** HMOs are required to pay the full encounter rates to RHCs for claims accruing on or after September 1, 2008; therefore, HHSC cost settlements will not apply to RHCs for this period of time. However, HMOs are not required to pay the full encounter rates to FQHCs for claims accruing on or after September 1, 2008; therefore, HHSC cost settlements will apply to FQHCs for this period of time.

3. **On or after September 1, 2011:** HMOs are required to pay the full encounter rates to FQHCs for claims accruing on or after September 1, 2011. HHSC cost settlements will not apply to FQHCs after that date.

The HMO must submit monthly FQHC and RHC encounter and payment reports to all contracted FQHCs and RHCs, and FQHCs and RHCs with which there have been encounters, not later than 21 days from the end of the month for which the report is submitted. The format will be developed by HHSC and provided in the **Uniform Managed Care Manual**. The FQHC and RHC must validate the encounter and payment information contained in the report(s). The HMO and the FQHC/RHC must both sign the report(s) after each party agrees that it accurately reflects encounters and payments for the month reported. The HMO must submit the signed FQHC and RHC encounter and payment reports to HHSC not later than 45 days from the end of the reported month. Encounter and payment reports will not be necessary for

1. the Nueces Service Area and the STAR+PLUS Service Areas for claims accruing before September 1, 2007, since the HMOs in those Areas will pay the full encounter rates to the FQHCs and RHCs for this period of time; and

2. for claims paid to RHCs on or after September 1, 2008, because the HMOs will pay full encounter rates to RHCs for this period of time.

3. for claims paid to FQHCs on or after September 1, 2011, because the HMOs will pay full encounter rates to FQHCs for this period of time.

8.2.5 Provider Complaints and Appeals

8.2.5.1 Provider Complaints
Medicaid HMOs must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider complaints. Within this process, the HMO must respond fully and completely to each complaint and establish a tracking mechanism to document the status and final disposition of each Provider complaint. The HMO must resolve Provider Complaints within 30 days from the date the Complaint is received. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Provider Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions and Attachment B-5, Deliverables/Liquidated Damages Matrix.**
HMOs must also resolve Provider Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will generally provide HMOs ten (10) Business Days to resolve such Complaints. If an HMO cannot resolve a Complaint by the due date indicated on the notification form, it may submit a request to extend the deadline. HHSC may, in its reasonable discretion, grant a written extension if the HMO demonstrates good cause. Unless HHSC has granted a written extension as described above, the HMO is subject to remedies, including liquidated damages if Provider Complaints are not resolved by the timeframes indicated herein.

8.2.5.2 Appeal of Provider Claims
Medicaid HMOs must develop, implement, and maintain a system for tracking and resolving all Medicaid Provider appeals related to claims payment. Within this process, the HMO must respond fully and completely to each Medicaid Provider's claims payment appeal and establish a tracking mechanism to document the status and final disposition of each Medicaid Provider's claims payment appeal.
Medicaid HMOs must contract with physicians who are not Network Providers to resolve claims disputes related to denial on the basis of medical necessity that remain unresolved subsequent to a Provider appeal. The determination of the physician resolving the dispute must be binding on the HMO and the Provider. The physician resolving the dispute must hold the same specialty or a related specialty as the appealing Provider. HHSC reserves the right to amend this process to include an independent review process established by HHSC for final determination on these disputes.

8.2.6 Member Rights and Responsibilities
In accordance with 42 C.F.R. §438.100, all Medicaid HMOs must maintain written policies and procedures for informing Members of their rights and responsibilities, and must notify their Members of their right to request a copy of these rights and responsibilities. The Member Handbook must include notification of Member rights and responsibilities.

8.2.7 Medicaid Member Complaint and Appeal System
The HMO must develop, implement, and maintain a Member Complaint and Appeal system that complies with the requirements in applicable federal and state laws and regulations, including 42 C.F.R. §431.200, 42 C.F.R. Part 438, Subpart F, "Grievance System," and the provisions of 1 T.A.C. Chapter 357 relating to Medicaid managed care organizations.
The Complaint and Appeal system must include a Complaint process, an Appeal process, and access to HHSC's Fair Hearing System. The procedures must be the same for all Members and must be reviewed and approved in writing by HHSC or its designee. Modifications and amendments to the Member Complaint and Appeal system must be submitted for HHSC's approval at least 30 days prior to the implementation.

8.2.7.1 Member Complaint Process
The HMO must have written policies and procedures for receiving, tracking, responding to, reviewing, reporting and resolving Complaints by Members or their authorized representatives. For purposes of this **Section 8.2.7**, an "authorized representative" is any person or entity acting on behalf of the Member and with the Member's written consent. A Provider may be an authorized representative.

HMOs also must resolve Member Complaints received by HHSC no later than the due date indicated on HHSC's notification form. HHSC will provide HMOs up to ten (10) Business Days to resolve such Complaints, depending on the severity and/or urgency of the Complaint. HHSC may, in its reasonable discretion, grant a written extension if the HMO demonstrates good cause.

Unless the HHSC has granted a written extension as described above, the HMO is subject to remedies, including liquidated damages if Member Complaints are not resolved by the timeframes indicated herein.

The HMO must resolve Complaints within 30 days from the date the Complaint is received. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.** The Complaint procedure must be the same for all Members under the Contract. The Member or Member's authorized representative may file a Complaint either orally or in writing. The HMO must also inform Members how to file a Complaint directly with HHSC, once the Member has exhausted the HMO's complaint process.

The HMO must designate an officer of the HMO who has primary responsibility for ensuring that Complaints are resolved in compliance with written policy and within the required timeframe. For purposes of **Section 8.2.7.2**, an "officer" of the HMO means a president, vice president, secretary, treasurer, or chairperson of the board for a corporation, the sole proprietor, the managing general partner of a partnership, or a person having similar executive authority in the organization.

The HMO must have a routine process to detect patterns of Complaints. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Complaints.

The HMO's Complaint procedures must be provided to Members in writing and through oral interpretive services. A written description of the HMO's Complaint procedures must be available in prevalent non-English languages for Major Population Groups identified by HHSC, at no more than a 6th grade reading level. The HMO must include a written description of the Complaint process in the Member Handbook. The HMO must maintain and publish in the Member Handbook, at least one toll-free telephone number with TeleTypewriter/Telecommunications Device for the Deaf (TTY/TDD) and interpreter capabilities for making Complaints. The HMO must provide such oral interpretive service to callers free of charge.

The HMO's process must require that every Complaint received in person, by telephone, or in writing must be acknowledged and recorded in a written record and logged with the following details:

1. Date;

2. Identification of the individual filing the Complaint;

3. Identification of the individual recording the Complaint;

4. Nature of the Complaint;

5. Disposition of the Complaint (i.e., how the HMO resolved the Complaint);

6. Corrective action required; and

7. Date resolved.

For Complaints that are received in person or by telephone, the HMO must provide Members or their representatives with written notice of resolution if the Complaint cannot be resolved within one working day of receipt.

The HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making a Complaint.

If the Member makes a request for disenrollment, the HMO must give the Member information on the disenrollment process and direct the Member to the HHSC Administrative Services Contractor. If the request for disenrollment includes a Complaint by the Member, the Complaint will be processed separately from the disenrollment request, through the Complaint process.

The HMO will cooperate with the HHSC's Administrative Services Contractor and HHSC or its designee to resolve all Member Complaints. Such cooperation may include, but is not limited to, providing information or assistance to internal Complaint committees.

The HMO must provide designated Member Advocates to assist Members in understanding and using the HMO's Complaint system as described in **Section 8.2.7.9**. The HMO's Member Advocates must assist Members in writing or filing a Complaint and monitoring the Complaint through the HMO's Complaint process until the issue is resolved.

8.2.7.2 Medicaid Standard Member Appeal Process
The HMO must develop, implement and maintain an Appeal procedure that complies with state and federal laws and regulations, including 42 C.F.R.§ 431.200 and 42 C.F.R. Part 438, Subpart F, "Grievance System." An Appeal is a disagreement with an HMO Action as defined in **HHSC's Uniform Contract Terms and Conditions**. The Appeal procedure must be the same for all Members. When a Member or his or her authorized representative expresses orally or in writing any dissatisfaction or disagreement with an Action, the HMO must regard the expression of dissatisfaction as a request to Appeal an Action.

A Member must file a request for an Appeal with the HMO within 30 days from receipt of the notice of the Action. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Appeals are not resolved within 30 days of receipt of the Appeal by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions and Attachment B-5, Deliverables/Liquidated Damages Matrix.** To ensure continuation of currently authorized services, however, the Member must file the Appeal on or before the later of 10 days following the HMO's mailing of the notice of the Action, or the intended effective date of the proposed Action. The HMO must designate an officer who has primary responsibility for ensuring that Appeals are resolved in compliance with written policy and within the 30-day time limit.

The provisions of Chapter 4201, Texas Insurance Code, relating to a Member's right to Appeal an Adverse Determination made by the HMO or a utilization review agent to an independent review organization, do not apply to a Medicaid recipient. Chapter 4201 is pre-empted by federal Fair Hearings requirements.

The HMO must have policies and procedures in place outlining the Medical Director's role in an Appeal of an Action. The Medical Director must have a significant role in monitoring, investigating and hearing Appeals. In accordance with 42 C.F.R.§ 438.406, the HMO's policies and procedures must require that individuals who make decisions on Appeals are not involved in any previous level of review or decision-making, and are health care professionals who have the appropriate clinical expertise in treating the Member's condition or disease.

The HMO must provide designated Member Advocates, as described in **Section 8.2.7.9**, to assist Members in understanding and using the Appeal process. The HMO's Member Advocates must assist Members in writing or filing an Appeal and monitoring the Appeal through the HMO's Appeal process until the issue is resolved.

The HMO must have a routine process to detect patterns of Appeals. Management, supervisory, and quality improvement staff must be involved in developing policy and procedure improvements to address the Appeals.

The HMO's Appeal procedures must be provided to Members in writing and through oral interpretive services. A written description of the Appeal procedures must be available in prevalent non-English languages identified by HHSC, at no more than a 6th grade reading level. The HMO must include a written description of the Appeals process in the Member Handbook. The HMO must maintain and publish in the Member Handbook at least one toll-free telephone number with TTY/TDD and interpreter capabilities for requesting an Appeal of an Action. The HMO must provide such oral interpretive service to callers free of charge.

The HMO's process must require that every oral Appeal received must be confirmed by a written, signed Appeal by the Member or his or her representative, unless the Member or his or her representative requests an expedited resolution. All Appeals must be recorded in a written record and logged with the following details:

1) Date notice is sent;

2) Effective date of the Action;

3) Date the Member or his or her representative requested the Appeal;

4) Date the Appeal was followed up in writing;

5) Identification of the individual filing;

6) Nature of the Appeal; and

7) Disposition of the Appeal, and notice of disposition to Member.

The HMO must send a letter to the Member within five (5) business days acknowledging receipt of the Appeal request. Except for the resolution of an Expedited Appeal as provided in **Section 8.2.7.3**, the HMO must complete the entire standard Appeal process within 30 calendar days after receipt of the initial written or oral request for Appeal. The timeframe for a standard Appeal may be extended up to 14 calendar days if the Member or his or her representative requests an extension; or the HMO shows that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the HMO must give the Member written notice of the reason for delay if the Member had not requested the delay. The HMO must designate an officer who has primary responsibility for ensuring that Appeals are resolved within these timeframes and in accordance with the HMO's written policies.

During the Appeal process, the HMO must provide the Member a reasonable opportunity to present evidence and any allegations of fact or law in person as well as in writing. The HMO must inform the Member of the time available for providing this information and that, in the case of an expedited resolution, limited time will be available.

The HMO must provide the Member and his or her representative opportunity, before and during the Appeal process, to examine the Member's case file, including medical records and any other documents considered during the Appeal process. The HMO must include, as parties to the Appeal, the Member and his or her representative or the legal representative of a deceased Member's estate.

In accordance with 42 C.F.R.§ 438.420, the HMO must continue the Member's benefits currently being received by the Member, including the benefit that is the subject of the Appeal, if all of the following criteria are met:

1. The Member or his or her representative files the Appeal timely as defined in this Contract:

2. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

3. The services were ordered by an authorized provider;

4. The original period covered by the original authorization has not expired; and

5. The Member requests an extension of the benefits.

If, at the Member's request, the HMO continues or reinstates the Member's benefits while the Appeal is pending, the benefits must be continued until one of the following occurs:

1. The Member withdraws the Appeal;

2. Ten (10) days pass after the HMO mails the notice resolving the Appeal against the Member, unless the Member, within the 10-day timeframe, has requested a Fair Hearing with continuation of benefits until a Fair Hearing decision can be reached; or

3. A state Fair Hearing officer issues a hearing decision adverse to the Member or the time period or service limits of a previously authorized service has been met.

In accordance with 42 C.F.R.§ 438.420(d), if the final resolution of the Appeal is adverse to the Member and upholds the HMO's Action, then to the extent that the services were furnished to comply with the Contract, the HMO may recover such costs from the Member.

If the HMO or State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, the HMO must authorize or provide the disputed services promptly and as expeditiously as the Member's health condition requires.

If the HMO or State Fair Hearing Officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, the HMO is responsible for the payment of services.

The HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for making an Appeal.

8.2.7.3 Expedited Medicaid HMO Appeals
In accordance with 42 C.F.R. §438.410, the HMO must establish and maintain an expedited review process for Appeals, when the HMO determines (for a request from a Member) or the provider indicates (in making the request on the Member's behalf or supporting the Member's request) that taking the time for a standard resolution could seriously jeopardize the Member's life or health. The HMO must follow all Appeal requirements for standard Member Appeals as set forth in **Section 8.2.7.2**), except where differences are specifically noted. The HMO must accept oral or written requests for Expedited Appeals.
Members must exhaust the HMO's Expedited Appeal process before making a request for an expedited Fair Hearing. After the HMO receives the request for an Expedited Appeal, it must hear an approved request for a Member to have an Expedited Appeal and notify the Member of the outcome of the Expedited Appeal within 3 business days, except that the HMO must complete investigation and resolution of an Appeal relating to an ongoing emergency or denial of continued hospitalization: (1) in accordance with the medical or dental immediacy of the case; and (2) not later than one (1) business day after receiving the Member's request for Expedited Appeal is received.
Except for an Appeal relating to an ongoing emergency or denial of continued hospitalization, the timeframe for notifying the Member of the outcome of the Expedited Appeal may be extended up to 14 calendar days if the Member requests an extension or the HMO shows (to the satisfaction of HHSC, upon HHSC's request) that there is a need for additional information and how the delay is in the Member's interest. If the timeframe is extended, the HMO must give the Member written notice of the reason for delay if the Member had not requested the delay.
If the decision is adverse to the Member, the HMO must follow the procedures relating to the notice in **Section 8.2.7.5**. The HMO is responsible for notifying the Member of his or her right to access an expedited Fair Hearing from HHSC. The HMO will be responsible for providing documentation to the State and the Member, indicating how the decision was made, prior to HHSC's expedited Fair Hearing.
The HMO is prohibited from discriminating or taking punitive action against a Member or his or her representative for requesting an Expedited Appeal. The HMO must ensure that punitive action is neither taken against a provider who requests an expedited resolution or supports a Member's request.
If the HMO denies a request for expedited resolution of an Appeal, it must:

(1) Transfer the Appeal to the timeframe for standard resolution, and

(2) Make a reasonable effort to give the Member prompt oral notice of the denial, and follow up within two (2) calendar days with a written notice.

8.2.7.4 Access to Fair Hearing for Medicaid Members
The HMO must inform Members that they have the right to access the Fair Hearing process at any time during the Appeal system provided by the HMO. In the case of an expedited Fair Hearing process, the HMO must inform the Member that he or she must first exhaust the HMO's internal Expedited Appeal process prior to filing an Expedited Fair Hearing. The HMO must notify Members that they may be represented by an authorized representative in the Fair Hearing process.
If a Member requests a Fair Hearing, the HMO will complete the request for Fair Hearing, and submit the form via facsimile to the appropriate Fair Hearings office, within five (5) calendar days of the Member's request for a Fair Hearing. Within five (5) calendar days of notification that the Fair Hearing is set, the HMO will prepare an evidence packet for submission to the HHSC Fair Hearings staff and send a copy of the packet to the Member. The evidence packet must comply with HHSC's Fair Hearings requirements.

8.2.7.5 Notices of Action and Disposition of Appeals for Medicaid Members
The HMO must notify the Member, in accordance with 1 T.A.C. Chapter 357, whenever the HMO takes an Action. The notice must, at a minimum, include any information required by 1 T.A.C. Chapter 357 that relates to a managed care organization's notice of Action and any information required by 42 C.F.R. §438.404 as directed by HHSC, including but not limited to:
1. The dates, types and amount of service requested;

2. The Action the HMO has taken or intends to take;

3. The reasons for the Action (If the Action taken is based upon a determination that the requested service is not medically necessary, the HMO must provide an explanation of the medical basis for the decision, application of policy or accepted standards of medical practice to the individuals medical circumstances, in it's notice to the member.);

4. The Member's right to access the HMO's Appeal process.

5. The procedures by which the Member may Appeal the HMO's Action;

6. The circumstances under which expedited resolution is available and how to request it;

7. The circumstances under which a Member may continue to receive benefits pending resolution of the Appeal, how to request that benefits be continued, and the circumstances under which the Member may be required to pay the costs of these services;

8. The date the Action will be taken;

9. A reference to the HMO policies and procedures supporting the HMO's Action;

10. An address where written requests may be sent and a toll-free number that the Member can call to request the assistance of a Member representative, file an Appeal, or request a Fair Hearing;

11. An explanation that Members may represent themselves, or be represented by a provider, a friend, a relative, legal counsel or another spokesperson;

12. A statement that if the Member wants a Fair Hearing on the Action, the Member must make the request for a Fair Hearing within 90 days of the date on the notice or the right to request a hearing is waived;

13. A statement explaining that the HMO must make its decision within 30 days from the date the Appeal is received by the HMO, or 3 business days in the case of an Expedited Appeal; and

14. A statement explaining that the hearing officer must make a final decision within 90 days from the date a Fair Hearing is requested.

8.2.7.6 Timeframe for Notice of Action
In accordance with 42 C.F.R.§ 438.404(c), the HMO must mail a notice of Action within the following timeframes:

1. For termination, suspension, or reduction of previously authorized Medicaid-covered services, within the timeframes specified in 42 C.F.R.§§ 431.211, 431.213, and 431.214;

2. For denial of payment, at the time of any Action affecting the claim;

3. For standard service authorization decisions that deny or limit services, within the timeframe specified in 42 C.F.R.§ 438.210(d)(1);

4. If the HMO extends the timeframe in accordance with 42 C.F.R. §438.210(d)(1), it must:

5. give the Member written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file an Appeal if he or she disagrees with that decision; and

6. issue and carry out its determination as expeditiously as the Member's health condition requires and no later than the date the extension expires;

7. For service authorization decisions not reached within the timeframes specified in 42 C.F.R.§ 438.210(d) (which constitutes a denial and is thus an adverse Action), on the date that the timeframes expire; and

8. For expedited service authorization decisions, within the timeframes specified in 42 C.F.R. 438.210(d).

8.2.7.7 Notice of Disposition of Appeal
In accordance with 42 C.F.R.§ 438.408(e), the HMO must provide written notice of disposition of all Appeals including Expedited Appeals. The written resolution notice must include the results and date of the Appeal resolution. For decisions not wholly in the Member's favor, the notice must contain:

1. The right to request a Fair Hearing;

2. How to request a Fair Hearing;

3. The circumstances under which the Member may continue to receive benefits pending a Fair Hearing;

4. How to request the continuation of benefits;

5. If the HMO's Action is upheld in a Fair Hearing, the Member may be liable for the cost of any services furnished to the Member while the Appeal is pending; and

6. Any other information required by 1 T.A.C. Chapter 357 that relates to a managed care organization's notice of disposition of an Appeal.

8.2.7.8 Timeframe for Notice of Resolution of Appeals
In accordance with 42 C.F.R.§ 438.408, the HMO must provide written notice of resolution of Appeals, including Expedited Appeals, as expeditiously as the Member's health condition requires, but the notice must not exceed the timelines as provided in this Section for Standard or Expedited Appeals. For expedited resolution of Appeals, the HMO must make reasonable efforts to give the Member prompt oral notice of resolution of the Appeal, and follow up with a written notice within the timeframes set forth in this Section for Expedited Appeals. If the HMO denies a request for expedited resolution of an Appeal, the HMO must transfer the Appeal to the timeframe for standard resolution as provided in this Section, and make reasonable efforts to give the Member prompt oral notice of the denial, and follow up within two calendar days with a written notice.

8.2.7.9 Medicaid Member Advocates
The HMO must provide Member Advocates to assist Members. Member Advocates must be physically located within the Service Area unless an exception is approved by HHSC. Member Advocates must inform Members of the following:

1. Their rights and responsibilities,

2. The Complaint process,

3. The Appeal process,

4. Covered Services available to them, including preventive services, and

5. Non-capitated Services available to them.

Member Advocates must assist Members in writing Complaints and are responsible for monitoring the Complaint through the HMO's Complaint process.
Member Advocates are responsible for making recommendations to management on any changes needed to improve either the care provided or the way care is delivered. Member Advocates are also responsible for helping or referring Members to community resources available to meet Member needs that are not available from the HMO as Medicaid Covered Services.

8.2.8 Additional Medicaid Behavioral Health Provisions

8.2.8.1 Local Mental Health Authority (LMHA)
Assessment to determine eligibility for rehabilitative and targeted DSHS case management services is a function of the LMHA. Covered Services must be provided to Members with severe and persistent mental illness (SPMI) and severe emotional disturbance (SED), when Medically Necessary, whether or not they are also receiving targeted case management or rehabilitation services through the LMHA.
The HMO must enter into written agreements with all LMHAs in the Service Area that describe the process(es) that the HMO and LMHAs will use to coordinate services for Medicaid Members with SPMI or SED. The agreements will:

1. Describe the Behavioral Health Services indicated in detail in the **Provider Procedures Manual** and in the **Texas Medicaid Bulletin**, include the amount, duration, and scope of basic and Value-added Services, and the HMO's responsibility to provide these services;

2. Describe criteria, protocols, procedures and instrumentation for referral of Medicaid Members from and to the HMO and the LMHA;

3. Describe processes and procedures for referring Members with SPMI or SED to the LMHA for assessment and determination of eligibility for rehabilitation or targeted case management services;

4. Describe how the LMHA and the HMO will coordinate providing Behavioral Health Services to Members with SPMI or SED;

5. Establish clinical consultation procedures between the HMO and LMHA including consultation to effect referrals and on-going consultation regarding the Member's progress;

6. Establish procedures to authorize release and exchange of clinical treatment records;

7. Establish procedures for coordination of assessment, intake/triage, utilization review/utilization management and care for persons with SPMI or SED;

8. Establish procedures for coordination of inpatient psychiatric services (including Court- ordered Commitment of Members under 21) in state psychiatric facilities within the LMHA's catchment area;

9. Establish procedures for coordination of emergency and urgent services to Members;

10. Establish procedures for coordination of care and transition of care for new Members who are receiving treatment through the LMHA; and

11. Establish that when Members are receiving Behavioral Health Services from the Local Mental Health Authority that the HMO is using the same UM guidelines as those prescribed for use by local mental health authorities by DSHS which are published at: http://www.mhmr.state.tx.us/centraloffice/behavioralhealthservices/RDMClinGuide.html.

The HMO must offer licensed practitioners of the healing arts (defined in 25 T.A.C., Part 2, Chapter 419, Subchapter L), who are part of the Member's treatment team for rehabilitation services, the opportunity to participate in the HMO's Network. The practitioner must agree to accept the HMO's Provider reimbursement rate, meet the credentialing requirements, and comply with all the terms and conditions of the HMO's standard Provider contract.
HMOs must allow Members receiving rehabilitation services to choose the licensed practitioners of the healing arts who are currently a part of the Member's treatment team for rehabilitation services to provide Covered Services. If the Member chooses to receive these services from licensed practitioners of the healing arts who are part of the Member's rehabilitation services treatment team but are not part of the HMO's Network, the HMO must reimburse the Local Mental Health Authority through Out-of-Network reimbursement arrangements.
Nothing in this section diminishes the potential for the Local Mental Health Authority to seek best value for rehabilitative services by providing these services under arrangement, where possible, as specified is 25 T.A.C. §419.455.

8.2.8.2 Substance Abuse Benefit
Substance Abuse and Dependency Treatment Services

The requirements in this subsection apply to STAR+PLUS HMOs in all Service Areas and to STAR HMOs in all Service Areas except the Dallas Service Area. Members in the Dallas Service Area receive Behavioral Health Services through the NorthSTAR Program.
Benefits related to the treatment of substance use disorder must be available to Medicaid Members by the later of September 1, 2010, or the effective date(s) noted in the Medicaid State Plan, 1915(b) STAR+PLUS waiver and 1915(b) STAR waiver for "Mental Health and Substance Use Disorder Treatment Services." Substance use disorder includes substance abuse and dependence as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM).

Providers
Providers for this benefit include: hospitals, chemical dependency treatment facilities licensed by the Department of State Health Services, and practitioners of the healing arts.
Medicaid HMOs must include Significant Traditional Providers (STPs) of these benefits in its Network, and provide STPs with expedited credentialing. Medicaid HMOs must enter into provider agreements with any willing Significant Traditional Provider (STP) of these benefits that meets the Medicaid enrollment requirements, HMO credentialing requirements and agrees to the HMO's contract terms and rates. For purposes of this section, STPs are providers who meet the Medicaid enrollment requirements and have a contract with the Department of State Health Services (DSHS) to receive funding for treatment under the Federal Substance Abuse Prevention and Treatment block grant.
Medicaid HMOs must maintain a provider education process to inform substance abuse treatment Providers in the HMO's Network on how to refer Members for treatment.

Service Coordination
Medicaid HMOs shall ensure service coordination is provided to Members with a substance use disorder. Medicaid HMOs must work with providers, facilities, and Members to coordinate care for Members with a substance use disorder and to ensure Members have access to the full continuum of Covered Services (including without limitation assessment, detoxification, residential treatment, outpatient services, and medication therapy) as medically necessary and appropriate. Medicaid HMOs must also coordinate services with the DSHS, DFPS, and their designees for Members requiring Non-Capitated Services. Non-Capitated Services includes, without limitation, services that are not available for coverage under the Contract, State Plan or Waiver that are available under the Federal Substance Abuse and Prevention and Treatment block grant when provided by a DSHS-funded provider or covered by the DFPS under direct contract with a treatment provider. Medicaid HMOs must work with DSHS, DFPS, and providers to ensure payment for Covered Services is available to Out-of-Network Providers who also provide related Non-capitated Services when the Covered Services are not available through Network Providers.

Member Education and Self-Referral for Substance Abuse Treatment Services
Medicaid HMOs must maintain a Member education process (including hotlines, manuals, policies and other Member Materials) to inform Members of the availability of and access to substance abuse treatment services, including information on self-referral.

8.2.9 Third Party Liability and Recovery
Medicaid HMOs are responsible for establishing a plan and process for recovering costs for services that should have been paid through a third party in accordance with State and Federal law and regulations. To recognize this requirement, capitation payments to the HMOs are reduced by the projected amount of TPR that the HMO is expected to recover.
The HMOs must provide required reports as stated in **Section 8.1.17.2,** Financial Reporting Requirements.
After 120-days from the date of adjudication on any claim, encounter, or other Medicaid related payment by the HMO subject to Third Party Recovery, HHSC may attempt recovery independent of any HMO action. HHSC will retain, in full, all funds received as a result of the state initiated recovery or subrogation action.
HMOs shall provide a Member quarterly file, which contains the following information if available to the HMO: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file shall be used for the purpose of matching the Texas Medicaid eligibility file against the HMO Member file to identify Medicaid clients enrolled in the HMO, which may not be known the Medicaid Program.

8.2.10 Coordination With Public Health Entities

8.2.10.1 Reimbursed Arrangements with Public Health Entities
The HMO must make a good faith effort to enter into a subcontract for Covered Services with Public Health Entities. Possible Covered Services that could be provided by Public Health Entities include, but are not limited to, the following services:

1. Sexually Transmitted Diseases (STDs) services;

2. Confidential HIV testing;

3. Immunizations;

4. Tuberculosis (TB) care;

5. Family Planning services;

6. Texas Health Steps medical checkups, and

7. Prenatal services.

These subcontracts must be available for review by HHSC or its designated agent(s) on the same basis as all other subcontracts. If the HMO is unable to enter into a contract with Public Health Entities, the HMO must document efforts to contract with Public Health Entities, and make such documentation available to HHSC upon request.

HMO Contracts with Public Health Entities must specify the scope of responsibilities of both parties, the methodology and agreements regarding billing and reimbursements, reporting responsibilities, Member and Provider educational responsibilities, and the methodology and agreements regarding sharing of confidential medical record information between the Public Health Entity and the HMO or PCP.
The HMO must:

1. Identify care managers who will be available to assist public health providers and PCPs in efficiently referring Members to the public health providers, specialists, and health-related service providers either within or outside the HMO's Network; and

2. Inform Members that confidential healthcare information will be provided to the PCP, and educate Members on how to better utilize their PCPs, public health providers, emergency departments, specialists, and health-related service providers.

8.2.10.2 Non-Reimbursed Arrangements with Local Public Health Entities
The HMO must coordinate with Public Health Entities in each Service Area regarding the provision of essential public health care services. In addition to the requirements listed above in Section 8.2.2, or otherwise required under state law or this contract, the HMO must meet the following requirements:

1. Report to public health entities regarding communicable diseases and/or diseases that are preventable by immunization as defined by state law;

2. Notify the local Public Health Entity, as defined by state law, of communicable disease outbreaks involving Members;

3. Educate Members and Providers regarding WIC services available to Members; and

4. Coordinate with local public health entities that have a child lead program, or with DSHS regional staff when the local public health entity does not have a child lead program, for follow-up of suspected or confirmed cases of childhood lead exposure.

8.2.11 Coordination with Other State Health and Human Services (HHS) Programs
The HMO must coordinate with other state HHS Programs in each Service Area regarding the provision of essential public health care services. In addition to the requirements listed above in Section 8.2.2. or otherwise required under state law or this contract, the HMO must meet the following requirements:

1. Require Providers to use the DSHS Bureau of Laboratories for specimens obtained as part of a Texas Health Steps medical checkup, including Texas Health Steps newborn screens, lead testing, and hemoglobin/hematocrit tests;

2. Notify Providers of the availability of vaccines through the Texas Vaccines for Children Program;

3. Work with HHSC and Providers to improve the reporting of immunizations to the statewide ImmTrac Registry;

4. Educate Providers and Members about the Department of State Health Services (DSHS) Case Management for Children and Pregnant Women (CPW) services available;

5. Coordinate services with CPW specifically in regard to an HMO Member's health care needs that are identified by CPW and referred to the HMO;

6. Participate, to the extent practicable, in the community-based coalitions with the Medicaid-funded case management programs in the Department of Assistive and Rehabilitative Services (DARS), the Department of Aging and Disability Services (DADS), and DSHS;

7. Cooperate with activities required of state and local public health authorities necessary to conduct the annual population and community based needs assessment;

8. Report all blood lead results, coordinate and follow-up of suspected or confirmed cases of childhood lead exposure with the Childhood Lead Poisoning Prevention Program in DSHS; and

9. Coordinate with Texas Health Steps.

8.2.12 Advance Directives
Federal and state law require HMOs and providers to maintain written policies and procedures for informing all adult Members 18 years of age and older about their rights to refuse, withhold or withdraw medical treatment and mental health treatment through advance directives (see Social Security Act §1902(a)(57) and §1903(m)(1)(A)). The HMO's policies and procedures must include written notification to Members and comply with provisions contained in 42 C.F.R. § 489, Subpart I, relating to advance directives for all hospitals, critical access hospitals, skilled nursing facilities, home health agencies, providers of home health care, providers of personal care services and hospices, as well as the following state laws and rules:

1. A Member's right to self-determination in making health care decisions;

2. The Advance Directives Act, Chapter 166, Texas Health and Safety Code, which includes:

a. A Member's right to execute an advance written directive to physicians and family or surrogates, or to make a non-written directive to administer, withhold or withdraw life-sustaining treatment in the event of a terminal or irreversible condition;

b. A Member's right to make written and non-written out-of-hospital do-not-resuscitate (DNR) orders;

c. A Member's right to execute a Medical Power of Attorney to appoint an agent to make health care decisions on the Member's behalf if the Member becomes incompetent; and

3. The Declaration for Mental Health Treatment, Chapter 137, Texas Civil Practice and Remedies Code, which includes: a Member's right to execute a Declaration for Mental Health Treatment in a document making a declaration of preferences or instructions regarding mental health treatment.

The HMO must maintain written policies for implementing a Member's advance directive. Those policies must include a clear and precise statement of limitation if the HMO or a Provider cannot or will not implement a Member's advance directive.
The HMO cannot require a Member to execute or issue an advance directive as a condition of receiving health care services. The HMO cannot discriminate against a Member based on whether or not the Member has executed or issued an advance directive.

The HMO's policies and procedures must require the HMO and subcontractors to comply with the requirements of state and federal law relating to advance directives. The HMO must provide education and training to employees and Members on issues concerning advance directives.
All materials provided to Members regarding advance directives must be written at a 7th - 8th grade reading comprehension level, except where a provision is required by state or federal law and the provision cannot be reduced or modified to a 7th - 8th grade reading level because it is a reference to the law or is required to be included "as written" in the state or federal law.
The HMO must notify Members of any changes in state or federal laws relating to advance directives within 90 days from the effective date of the change, unless the law or regulation contains a specific time requirement for notification.

8.3 Additional STAR+PLUS Scope of Work

8.3.1 Covered Community-Based Long-Term Care Services
The HMO must ensure that STAR+PLUS Members needing Community Long-term Care Services are identified and that services are referred and authorized in a timely manner. The HMO must ensure that Providers of Community Long-term Care Services are licensed to deliver the service they provide. The inclusion of Community Long-term Care Services in a managed care model presents challenges, opportunities and responsibilities.
Community Long-term Care Services may be necessary as a preventative service to avoid more expensive hospitalizations, emergency room visits, or institutionalization. Community Long-term Care Services should also be made available to Members to assure maintenance of the highest level of functioning possible in the least restrictive setting. A Member's need for Community Long-term Care Services to assist with the activities of daily living must be considered as important as needs related to a medical condition. HMOs must provide Functionally Necessary Covered Services to Community Long-term Care Service Members.

8.3.1.1 Community Based Long-Term Care Services Available to All Members
The HMO shall enter into written contracts with Providers of Personal Assistance Services and Day Activity and Health Services (DAHS) to make them available to all STAR+PLUS Members. These Providers must at a minimum, meet all of the following state licensure and certification requirements for providing the services in **Attachment B-2.1, Covered Services**.

Community Long-Term Care Services Available to All Members	
Service	**Licensure and Certification Requirements**
Personal Attendant Services/Primary Home Care	The Provider must be licensed by DADS as a Home and Community Support Services Agency (HCSSA). The level of licensure required depends on the type of service delivered. NOTE: For primary home care and client managed attendant care, the agency may have only the Personal Assistance Services level of licensure.

Community Long-Term Care Services Available to All Members Service	Licensure and Certification Requirements
Day Activity and Health Services (DAHS)	The Provider must be licensed by DADS Regulatory Division, as an adult day care provider. To provide DAHS, the Provider must provide the range of services required for DAHS.

8.3.1.2 1915(c) STAR+PLUS Waiver Services Available to Members Who Qualify for 1915 (c) STAR+PLUS Waiver Services
The 1915(c) STAR+PLUS Waiver (SPW) provides Community Long-term Care Services to Medicaid Eligibles who are elderly and to adults with disabilities as a cost-effective alternative to living in a nursing facility. These Members must be age 21 or older, be a Medicaid recipient or be otherwise financially eligible for waiver services. To be eligible for 1915(c) SPW Services, a Member must meet income and resource requirements for Medicaid nursing facility care, and receive a determination from HHSC on the medical necessity/level of care of the nursing facility care. The HMO must make available to STAR+PLUS Members who meet the eligibility requirements the array of services allowable through HHSC's CMS-approved SPW (see **Appendix B-2.1, STAR+PLUS Covered Services**).

Community Long-Term Care Services Under the 1915(c) STAR+PLUS Waiver	
Service	**Licensure and Certification Requirements**
Personal Attendant Services	The Provider must be licensed by DADs as a Home and Community Support Services Agency (HCSSA). The level of licensure required depends on the type of service delivered. For Primary Home Care and Client Managed Attendant Care, the agency may have only the Personal Assistance Services level of licensure.
Assisted Living	The Provider must be licensed by the Texas Department of Aging and Disability Services, Long Term Care Regulatory Division in accordance with 40 T.A.C, Part 1, Chapter 92. The type of licensure determines what services may be provided.
Emergency Response Service Provider	Licensed by the Texas Deparement of State Health Services as a Personal Emergency Response Services Agency under T.A.C, Title 25, Part 1, Chapter 140, Subchapter B.
Nursing Services	Licensed Registered Nurse by the Texas Board of Nursing under 22 T.A.C, Part 11, Chapter 217.
Adult Foster Home	Adult foster care homes serving three (3) or fewer participants must comply with requirements outlined in 40 TAC, Part 1, Chapter 48, Subchapter K. Adult foster care homes serving four (4) participants must be licensed by DADS as an assisted living facility under 40 TAC Part 1, Chapter 92.
Respite Care	Licensed by DADS as a Home and Community Support Services Agency (HCSSA) under T.A.C., Title 40, Part 1, Chapter 97.
Home Delivered Meals	Providers must comply with requirments for providing home delivered meal services, which include requirements such as dietary requirements, food temperature, delivery times, and training of volunteers and others who deliver meals. In accordance with T.A.C., Title 40, Part 1, Chapter 55.
Physical Therapy (PT) Services	Licensed Physical Therapist through the Texas Board of Physical Therapy Examiners, Chapter 453.
Occupational Therapy (OT) Services	Licensed Occupational Therapist through the Texas Board of Occupational Therapy Examiners, Chapter 454.
Speech, Hearing, and Language Therapy Services	Licensed Speech Therapist Through the Department of State Health Services under TAC, Part 32, Chapter 741.
Consumer Directed Services (CDS)	No licensure or certification requirements. Must have completed required training by DADS. CDSAs contracted by DADS are assumed to have completed the training.
Transition Assistance Services	The Provider must comply with the requirements for delivery of TAS, which includes requirements such as allowable purchases, cost limits, and time frames for delivery. TAS providers must

	demonstrate knowledge of, and experience in, successfully serving individuals who require home and community-based services.
Minor Home Modification	No licensure or certification requirements.
Adaptive Aids and Medicaid Equipment	No licensure or certification requirements.
Medical supplies	No licensure or certification requirements.

8.3.2 Service Coordination

The HMO must furnish a Service Coordinator to all STAR+PLUS Members who request one. The HMO should also furnish a Service Coordinator to a STAR+PLUS Member when the HMO determines one is required through an assessment of the Member's health and support needs. The HMO must ensure that each STAR+PLUS Member has a qualified PCP who is responsible for overall clinical direction and, in conjunction with the Service Coordinator, serves as a central point of integration and coordination of Covered Services, including primary, Acute Care, long-term care and Behavioral Health Services.

The Service Coordinator must work as a team with the PCP, and coordinate all STAR+PLUS Covered Services and any applicable Non-capitated Services with the PCP. This requirement applies whether or not the PCP is in the HMO's Network, as some STAR+PLUS Members dually eligible for Medicare may have a PCP that is not in the HMO's Provider Network. In order to integrate the Member's Acute Care and primary care, and stay abreast of the Member's needs and condition, the Service Coordinator must also actively involve and coordinate with the Member's primary and specialty care providers, including Behavioral Health Service providers, and providers of Non-capitated Services.

STAR+PLUS Members dually eligible for Medicare will receive most prescription drug services through Medicare rather than Medicaid. The Texas Vendor Drug Program will pay for a limited number of medications not covered by Medicare.

The HMO must identify and train Members or their families to coordinate their own care, to the extent of the Member's or the family's capability and willingness to coordinate care.

8.3.2.1 Service Coordinators

The HMO must employ as Service Coordinators persons experienced in meeting the needs of vulnerable populations who have Chronic or Complex Conditions. Such Service Coordinators are Key HMO Personnel as described in **Attachment A**, **HHSC's Uniform Managed Care Contract Terms and Conditions, Section 4.02,** and must meet the requirements set forth in **Section 4.04.1** of **HHSC's Uniform Managed Care Contract Terms and Conditions**.

8.3.2.2 Referral to Community Organizations

The HMO must provide information about and referral to community organizations that may not be providing STAR+PLUS Covered Services, but are otherwise important to the health and well being of Members. These organizations include, but are not limited to:

1. State/federal agencies (e.g., those agencies with jurisdiction over aging, public health, substance abuse, mental health/retardation, rehabilitation, developmental disabilities, income support, nutritional assistance, family support agencies, etc.);

2. social service agencies (e.g., Area Agencies on Aging, residential support agencies, independent living centers, supported employment agencies, etc.);

3. city and county agencies (e.g., welfare departments, housing programs, etc.);

4. civic and religious organizations; and

5. consumer groups, advocates, and councils (e.g., legal aid offices, consumer/family support groups, permanency planning, etc.).

8.3.2.3 Discharge Planning

The HMO must have a protocol for quickly assessing the needs of Members discharged from a Hospital or other care or treatment facility.

The HMO's Service Coordinator must work with the Member's PCP, the hospital discharge planner(s), the attending physician, the Member, and the Member's family to assess and plan for the Member's discharge. When long-term care is needed, the HMO must ensure that the Member's discharge plan includes arrangements for receiving community-based care whenever possible. The HMO must ensure that the Member, the Member's family, and the Member's PCP are all well informed of all service options available to meet the Member's needs in the community.

8.3.2.4 Transition Plan for New STAR+PLUS Members

The HMO must provide a transition plan for Members enrolled in the STAR+PLUS Program. HHSC, and/or the previous STAR+PLUS HMO contractor, will provide the HMO with detailed Care Plans, names of current providers, etc., for newly enrolled Members already receiving long-term care services at the time of enrollment. The HMO must ensure that current providers are paid for Medically Necessary Covered Services that are delivered in accordance with the Member's existing treatment/long-term care services plan after the Member has become enrolled in the HMO and until the transition plan is developed.

The transition planning process must include, but is not limited to, the following:

1. review of existing DADS long-term care services plans;

2. preparation of a transition plan that ensures continuous care under the Member's existing Care Plan during the transfer into the HMO's Network while the HMO conducts an appropriate assessment and development of a new plan, if needed;

3. if durable medical equipment or supplies had been ordered prior to enrollment but have not been received by the time of enrollment, coordination and follow-through to ensure that the Member receives the necessary supportive equipment and supplies without undue delay; and

4. payment to the existing provider of service under the existing authorization until the HMO has completed the assessment and service plans and issued new authorizations.

Except as provided below, the HMO must review any existing care plan and develop a transition plan within 30 days of receiving the Member's enrollment. For all existing care plans received prior to the Operational Start Date, the HMO will have additional time to complete this process, not-to-exceed 120 days after the Member's enrollment. The transition plan will remain in place until the HMO contacts the Member and coordinates modifications to the Member's current treatment/long-term care services plan. The HMO must ensure that the existing services continue and that there are no breaks in services. For initial implementation of the STAR+PLUS program in a Service Area, the HMO must complete this process within 90-days of the Member's enrollment.

The HMO must review any existing care plan and develop a transition plan within 30 days of receiving the Member's enrollment. The transition plan will remain in place until the HMO contacts the Member and coordinates modifications to the Member's current treatment/long-term care services plan. The HMO must ensure that the existing services continue and that there are no breaks in services. For initial implementation of the STAR+PLUS program in a Service Area, the HMO must complete this process within 90-days of the Member's enrollment.

The HMO must ensure that the Member is involved in the assessment process and fully informed about options, is included in the development of the care plan, and is in agreement with the plan when completed.

8.3.2.5 Centralized Medical Record and Confidentiality

The Service Coordinator shall be responsible for maintaining a centralized record related to Member contacts, assessments and service authorizations. The HMO shall ensure that the organization of and documentation included in the centralized Member record meets all applicable professional standards ensuring confidentiality of Member records, referrals, and documentation of information.

The HMO must have a systematic process for generating or receiving referrals and sharing confidential medical, treatment, and planning information across providers.

8.3.2.6 Nursing Facilities

Nursing facility care, although a part of the care continuum, presents a challenge for managed care. Because of the process for becoming eligible for Medicaid assistance in a nursing facility, there is frequently a significant time gap between entry into the nursing home and determination of Medicaid eligibility. During this gap from entry to Medicaid eligibility, the resident has "nested" in the facility and many of the community supports are no longer available. To require participation of all nursing facility residents would result in the HMO maintaining a Member in the nursing facility without many options for managing their health. For this reason, persons who qualify for Medicaid as a result of nursing facility residency are not enrolled in STAR+PLUS.

The STAR+PLUS HMO must participate in the Promoting Independence initiative for such individuals. Promoting Independence (PI) is a philosophy that aged and disabled individuals remain in the most integrated setting to receive long-term care services. PI is Texas' response to the U.S. Supreme Court ruling in *Olmstead v. L.C.* that requires states to provide community-based services for persons with disabilities who would otherwise be entitled to institutional services, when:

- the state's treatment professionals determine that such placement is appropriate;

- the affected persons do not oppose such treatment; and

- the placement can be reasonably accommodated, taking into account the resources available to the state and the needs of others who are receiving state supported disability services.

In accordance with legislative direction, the HMO must designate a point of contact to receive referrals for nursing facility residents who may potentially be able to return to the community through the use of 1915(c) Nursing Facility Waiver services. To be eligible for this option, an individual must reside in a nursing facility until a written plan of care for safely moving the resident back into a community setting has been developed and approved.

A STAR+PLUS Member who enters a nursing facility will remain a STAR+PLUS Member for a total of four months. The nursing facility will bill the state directly for covered nursing facility services delivered while the Member is in the nursing facility. See **Section 8.3.2.7** for further information.

The HMO is responsible for the Member at the time of nursing facility entry and must utilize the Service Coordinator staff to complete an assessment of the Member within 30 days of entry in the nursing facility, and develop a plan of care to transition the Member back into the community if possible. If at this initial review, return to the community is possible, the Service Coordinator will work with the resident and family to return the Member to the community using 1915(c) Waiver Services.

If the initial review does not support a return to the community, the Service Coordinator will conduct a second assessment 90 days after the initial assessment to determine any changes in the individual's condition or circumstances that would allow a return to the community. The Service Coordinator will develop and implement the transition plan.

The HMO will provide these services as part of the Promoting Independence initiative. The HMO must maintain the documentation of the assessments completed and make them available for state review at any time.

It is possible that the STAR+PLUS HMO will be unaware of the Member's entry into a nursing facility. It is the responsibility of the nursing facility to review the Member's Medicaid card upon entry into the facility and notify the HMO. The nursing facility is also required to notify HHSC of the entry of a new resident.

8.3.2.7 HMO Four-Month Liability for Nursing Facility Care

A STAR+PLUS Member who enters a nursing facility will remain a STAR+PLUS Member for a total of four months. The four months do not have to be consecutive. Upon completion of four months of nursing facility care, the individual will be disenrolled from the STAR+PLUS Program and the Medicaid Fee-for-Service program will provide Medicaid benefits. A STAR+PLUS Member may not change HMOs while in a nursing facility.

Tracking the four months of liability is done through a counter system. The four-month counter starts with the earlier of: (1) the date of the Medicaid admission to the nursing facility, or (2) on the 21st day of a Medicare stay, if applicable. A partial month counts as a full month. In other words, the month in which the Medicaid admission occurs or the month on which the 21st day of the Medicare stay occurs, is counted as one of the four months.

The HMO will not be liable for the cost of care provided in a nursing facility. For Medicaid-only Members, the cost of all other Covered Services will be included in the capitation payment analysis. The HMO will not maintain nursing facilities in its Provider Network, and will not reimburse the nursing facilities for Covered Services provided in such facilities. Nursing facilities will use the traditional Fee-for-Service (FFS) system of billing HHSC rather than billing the HMO.

8.3.2.8 Prioritization Plan
Prior to the 9/1/2011 Operational Start Date of the STAR+PLUS program in the Expansion Counties, HHSC and DADS will provide the HMO a plan that outlines a priority of populations and special handling procedures that the HMO must implement to help ensure timely assessments for potential enrollees and incoming Members as well as continuity of care for incoming Members. The populations that will be part of the priority list will include but are not limited to Money Follows the Person (MFP); Medically Dependent Children Program (MDCP), Comprehensive Care Program -Personal Care Services (CCP-PCS) and Comprehensive Care Program-Private Duty Nursing (CCP-PDN) aging out consumers; Medical Assistance Only (MAO) Interest List consumers; and Supplemental Security Income (SSI) consumer. HHSC and/or DADS will also provide the HMO with information concerning Members who will be enrolled through manual processes and will need expedited access to services.

8.3.3 STAR+PLUS Assessment Instruments
The HMO must have and use functional assessment instruments to identify Members with significant health problems, Members requiring immediate attention, and Members who need or are at risk of needing long-term care services. The HMO, a subcontractor, or a Provider may complete assessment instruments, but the HMO remains responsible for the data recorded.
HMOs must use the DADS Form 2060, as amended or modified, to assess a Member's need for Functionally Necessary Personal Attendant Services. The HMO may adapt the form to reflect the HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment.
The DADS Form 2060 must be completed if a need for or a change in Personal Attendant Services is warranted at the initial contact, at the annual reassessment, and anytime a Member requests the services or requests a change in services. The DADS Form 2060 must also be completed at any time the HMO determines the Member requires the services or requires a change in the Personal Attendant Services that are authorized.
HMOs must use the Texas Medicaid Personal Care Assessment Form (PCAF Form) in lieu of the DADS Form 2060 for children under the age of 21 when assessing the Member's need for Functional Necessary Personal Attendant Services. HMOs may adapt the PCAF Form to reflect the HMO's name or distribution instructions, but the elements must be the same and instructions for completion must be followed without amendment. Reassessments using the PCAF Form must be completed every twelve months and as requested by the Member's parent or other legal guardian. The PCAF Form must also be completed at any time the HMO determines the Member may require a change in the number of authorized Personal Attendant Service hours.
For Members and applicants seeking or needing the 1915(c) Nursing Facility Waiver services, the HMOs must use the Community Medical Necessity and Level of Care Assessment Instrument, as amended or modified, to assess Members and to supply current medical information for Medical Necessity determinations. The HMO must also complete the Individual Service Plan (ISP), Form 3671 for each Member receiving 1915(c) Nursing Facility Waiver Services. The ISP is established for a one-year period. After the initial ISP is established, the ISP must be completed on an annual basis and the end date or expiration date does not change. Both of these forms (Community Medical Necessity and Level of Care Assessment Instrument and Form 3671) must be completed annually at reassessment. The HMO is responsible for tracking the end dates of the ISP to ensure all Member reassessment activities have been completed and posted on the LTC online portal prior to the expiration date of the ISP. Note that the HMO cannot submit its initial Community Medical Necessity and Level of Care Assessment Instrument cannot be submitted earlier than 120 days prior to the expiration date of the ISP. An Initial Community Medical Necessity and Level of Care determination will expire 120 days after it is approved by the HHSC Claims Administrator. The HMO cannot submit a renewal of the Community Medical Necessity and Level of Care Assessment Instrument earlier than 90 days prior to the expiration date of the ISP. Such renewal will expire 90 days after it is approved by the HHSC Claims Administrator.

8.3.4 1915(c) Nursing Facility Waiver Service Eligibility
Recipients of 1915(c) Nursing Facility Waiver services must meet nursing facility criteria for participation in the waiver and must have a plan of care at initial determination of eligibility in which the plan's annualized cost is equal to or less than 200% of the annualized cost of care if the individual were to enter a nursing facility. If the HMO determines that the recipient's cost of care will exceed the 200% limit, the HMO will submit to Health Plan Operations a request to consider the use of State General Revenue Funds to cover costs over the 200% allowance, as per HHSC's policy and procedures related to use of general revenue for 1915(c) Nursing Facility Waiver participants. If HHSC approves the use of general revenue funds, the HMO will be allowed to provide waiver services as per the Individual Service Plan, and non-waiver services (services in excess of the 200% allowance) utilizing State General Revenue Funds. Non-waiver services are not Medicaid Allowable Expenses, and may not be reported as such on the FSRs. The HMO will submit reports documenting expenses for non-waiver services in accordance with the requirements of the **Uniform Managed Care Manual**. HHSC will reimburse the HMO for such expenses in accordance with the procedures set forth in the **Uniform Managed Care Manual**.

8.3.4.1 For Members
Members can request to be tested for eligibility into the 1915(c) STAR+PLUS Waiver (SPW). The HMO can also initiate SPW eligibility testing on a STAR+PLUS Member, if the HMO determines that the Member would benefit from the SPW services.

To be eligible for the SPW, the Member must meet risk criteria, Medical Necessity/Level of Care, the cost of the Individual Service Plan (ISP) cannot exceed 202% of cost of providing the same services in a nursing facility, and the HMO must be able to demonstrate that that Member has a minimum of one (1) unmet need for at least one (1) SPW service. The HMO must apply risk criteria as illustrated in Section 3242.3 of the STAR+PLUS Handbook, "Risk Assessment."

If the HMO determines that a Member does not meet the risk criteria for SPW eligibility, the HMO must notify HHSC's Administrative Services Contractor. The Administrative Services Contractor will notify the Member that he or she did not meet the eligibility criteria for the SPW, and the right to Appeal the Adverse Determination.

If the HMO determined that the Member meets risk criteria for SPW eligibility, the HMO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination, and submit the form to HHSC's Administrative Services Contractor. The HMO is also responsible for completing the assessment documentation, and preparing a 1915(c) STAR+PLUS Waiver ISP for identifying SPW services. The ISP is submitted to the State to ensure that the total cost does not exceed the 202% cost limit. The HMO must complete these activities within 45 days of receiving the State's authorization form for eligibility testing.

HHSC will notify the Member and the HMO of the eligibility determination, which will be based on results of the assessments and the information provided by the HMO. If the STAR+PLUS Member is eligible for SPW services, HHSC will notify the Member of the effective date of eligibility. If the Member is not eligible for SPW services, HHSC will provide the Member information on right to Appeal the Adverse Determination. Regardless of the SPW eligibility determination, HHSC will send a copy of the Member notice to the HMO.

8.3.4.2 For Medical Assistance Only (MAO) Non-Member Applicants
Non-Member persons who are not eligible for Medicaid in the community may apply for participation in the 1915(c) STAR+PLUS Waiver (SPW) program under the financial and functional eligibility requirements for MAO. HHSC will inform the non-member applicant that services are provided through an HMO and allow the applicant to select the HMO. HHSC will provide the selected HMO an authorization form to initiate pre-enrollment assessment services required under the SPW for the applicant. The HMO's initial home visit with the applicant must occur within 14 days of the receipt of the referral. To be eligible for SPW, the applicant must meet financial eligibility, risk criteria, Medical Necessity/Level of Care, the cost of the Individual Service Plan (ISP) cannot exceed 202% of cost of providing the same services in a nursing facility, and the HMO must be able to demonstrate that the applicant has a minimum of one (1) unmet need for at least one (1) SPW service. The HMO must apply risk criteria as illustrated in Section 3242.3 of the STAR+PLUS Handbook, "Risk Assessment."

If the HMO determines that the applicant does not meet the risk criteria for SPW eligibility, the HMO must notify HHSC's Administrative Services Contractor. The Administrative Services Contractor will notify the applicant that he or she did not meet the eligibility criteria for the SPW, and the right to Appeal the Adverse Determination.

If the HMO determined that the applicant meets risk criteria for SPW eligibility, the HMO must complete the Community Medical Necessity and Level of Care Assessment Instrument for Medical Necessity/Level of Care determination, and submit the form to HHSC's Administrative Services Contractor. The HMO is also responsible for completing the assessment documentation, and preparing a 1915(c) STAR+PLUS ISP for identifying the needed SPW services. The ISP is submitted to the State to ensure that the total cost does not exceed the 202% cost ceiling. The HMO must complete these activities within 45 days of receiving the State's authorization form for eligibility testing.

HHSC will notify the applicant and the HMO of the results of its eligibility determination. If the applicant is eligible, HHSC will notify the applicant and the HMO will be notified of the effective date of eligibility, which will be the first day of the month following the determination of eligibility. The HMO must initiate the Individual Service Plan (ISP) on the date of enrollment.

If the applicant is not eligible, the HHSC notice will provide information on the applicant's right to Appeal the Adverse Determination. HHSC will also send notice to the HMO if the applicant is not eligible for 1915(c) Nursing Facility Waiver services.

8.3.4.3 Annual Reassessment
Prior to the end date of the annual ISP, the HMO must initiate an annual reassessment to determine and validate continued eligibility for 1915(c) Nursing Facility Waiver services for each Member receiving such services. The HMO will be expected to complete the same activities for each annual reassessment as required for the initial eligibility determination.

8.3.5 Consumer Directed Services Options
There are three (3) options available to STAR+PLUS Members desiring to self-direct the delivery of Primary Home Care (PHC) for Members in the 1915(b) waiver; and personal attendant services (PAS) in-home or out-of-home respite, nursing, physical therapy (PT), occupational therapy (OT), and/or speech/language therapy (SLT) for Members in the 1915(c) STAR+PLUS Waivers (SPW). These three (3) options are: 1) Consumer-Directed; 2) Service-Related; and 3) Agency. The HMO must provide information concerning the three (3) options to all Members: (1) who meet the functional requirements for PHC Services in the 1915(b) Waiver, and the requirements for PAS in the SPW (the functional criteria for these services are described in the Form 2060), (2) who are eligible for in-home or out-of-home respite services in the SPW; and (3) who are eligible for nursing, PT, OT and/or SLT in the SPW. In addition to providing information concerning the three (3) options, the HMO must provide Member orientation in the option selected by the Member. The HMO must provide the information to any STAR+PLUS Member receiving PHC/PAS and/or in-home or out-of-home respite:

- at initial assessment;
- at annual reassessment or annual contact with the STAR+PLUS Member;
- at any time when a STAR+PLUS Member receiving PHC/PAS/Respite/Nursing/PT/OT/SLT requests the information; and
- in the Member Handbook.

The HMO must contract with Providers who are able to offer PHC/PAS, in-home or out-of-home respite, nursing, PT, OT, and/or SLT and must also educate/train the HMO Network Providers regarding the three (3) PAS options. Network Providers must meet licensure/certification requirements as indicated in Attachment B-1, Sections 8.3.1.1 and 8.3.1.2 of the Uniform Managed Care Contract.

In all three (3) options, the Service Coordinator and the Member work together in developing the Individual Service Plan.

A more comprehensive description of Consumer Directed Services is found in the STAR+PLUS Handbook: http://www.dads.state.tx.us/handbooks/sph/8000/8000.htm#sec8120.

8.3.5.1 Consumer Directed Service Options
In the Consumer-Directed Model, the Member or the Member's legal guardian is the employer of record and retains control over the hiring, management, and termination of an individual providing PHC/PAS ; in-home or out-of-home respite; nursing, PT, OT, and/or SLT. The Member is responsible for assuring that the employee meets the requirements for PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT, including the criminal history check. The Member uses a Consumer Directed Services agency (CDSA) to handle the employer-related administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS; in-home or out-of-home respite; nursing, PT, OT, and/or SLT.

8.3.5.2 Service Related Option Model
In the Service Related Option Model, the Member or the Member's legal guardian is actively involved in choosing their personal attendant, respite provider, nurse, physical therapist, occupational therapist and/or speech/language therapist but is not the employer of record. The Home and Community Support Services agency (HCSSA) in the HMO Provider Network is the employer of record for the personal attendant employee and respite provider. In this model, the Member selects the personal attendant and/or respite provider from the HCSSA's personal attendant employees. The personal attendant's/respite provider's schedule is set up based on the Member input, and the Member manages the PHC/PAS, and/or in-home or out-of-home respite. The Member retains the right to supervise and train the personal attendant. The Member may request a different personal attendant and the HCSSA would be expected to honor the request as long as the new attendant is a Network Provider. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS and/or in-home or out-of-home respite. The HMO is the employer or contractor of record for the nurse, physical therapist, occupational therapist, and/or speech/language therapist. In this model, the Member selects the nurse, physical therapist, occupational therapist, and/or speech/language therapist from the HMO's Provider Network. The nurse, physical therapist, occupational therapist, and/or speech/language therapist's schedule is set up based on the Member's input, and the Member manages the nursing, PT, OT, and/or SLT services. The Member retains the right to supervise and train the nurse, physical therapist, occupational therapist, and/or speech/language therapist. The Member may request a different nurse,

physical therapist, occupational therapist, and/or speech/language therapist and the HMO must honor the request as long as the nurse, physical therapist, occupational therapist, and/or speech/language therapist is a Network Provider. The HMO establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of nursing, PT, OT, and/or SLT services.

8.3.5.3 Agency Model
In the Agency Model, the HMO contracts with a Home and Community Support Services agency (HCSSA) for the delivery of waiver services. The HCSSA is the employer of record for the personal attendant, respite provider, nurse, physical therapist, occupational therapist, and speech language therapist. The HCSSA establishes the payment rate, benefits, and provides all administrative functions such as payroll, substitute (back-up), and filing tax-related reports of PHC/PAS and/or in-home or out-of home respite.

8.3.6 Community Based Long-term Care Service Providers

8.3.6.1 Training
The HMO must comply with Section 8.1.4.6 regarding Provider Manual and Provider training specific to the STAR+PLUS Program. The HMO must train all Community Long-term Care Service Providers regarding the requirements of the Contract and special needs of STAR+PLUS Members. The HMO must establish ongoing STAR+PLUS Provider training addressing the following issues at a minimum:

1. Covered Services and the Provider's responsibilities for providing such services to STAR+PLUS Members and billing the HMO for such services. The HMO must place special emphasis on Community Long-term Care Services and STAR+PLUS requirements, policies, and procedures that vary from Medicaid Fee-for-Service and commercial coverage rules, including payment policies and procedures.

2. Inpatient Stay hospital services and the authorization and billing of such services for STAR+PLUS Members.

3. Relevant requirements of the STAR+PLUS Contract, including the role of the Service Coordinator;

4. Processes for making referrals and coordinating Non-capitated Services;

5. The HMO's quality assurance and performance improvement program and the Provider's role in such programs; and

6. The HMO's STAR+PLUS policies and procedures, including those relating to Network and Out-of-Network referrals.

7. For Expansion Counties with an Operational Start Date of 9/1/2011, the process for continuing up to six (6) months of Community-based Long Term Care Services for Members receiving those services as of the Operational Start Date, including provider billing practices for these services and whom to contact at the HMO for assistance with this process.

8.3.6.2 LTC Provider Billing
Long-term care providers are not required to utilize the billing systems that most medical facilities use on a regular basis. For this reason, the HMO must make accommodations to the claims processing system for such providers to allow for a smooth transition from traditional Medicaid to Managed Care Medicaid.
HHSC will meet with HMOs to develop a standardized method long-term care billing. All STAR+PLUS HMOs will be required to utilize the standardized method, which will be incorporated into the **HHSC Uniform Managed Care Manual**.

8.3.6.3 Rate Enhancement Payments for Agencies Providing Attendant Care
All HMOs participating in the STAR+PLUS program must allow their Long-term Support Services (LTSS) Providers to participate in the STAR+PLUS Attendant Care Enhancement Program.
Attachment B-7, STAR+PLUS Attendant Care Enhanced Payment Methodology explains the methodology that the STAR+PLUS HMO will use to implement and pay the enhanced payments, including a description of the timing of the payments, in accordance with the requirements in the **Uniform Managed Care Manual** and the intent of the 2000-01 General Appropriations Act (Rider 27, House Bill 1, 76th Legislature, Regular Session, 1999) and T.A.C. Title 1, Part 15, Chapter 355.

8.3.6.4 This Section Intentionally Left Blank

8.3.6.5 STAR+PLUS Handbook
The STAR+PLUS Handbook will contain HHSC-approved policies and procedures related to the STAR+PLUS Program, including policies and procedures relating to the 1915(b) and 1915(c) STAR+PLUS Waivers. The STAR+PLUS Handbook will include additional requirements regarding the STAR+PLUS Program and guidance for the HMOs, the STAR+PLUS Support Units at DADS, and HHSC staff for administrating and managing STAR+PLUS Program operations. The STAR+PLUS Handbook, once approved by HHSC, is incorporated by reference into this Contract.

8.3.6.6 Required Contract with STAR+PLUS Members
The HMO is required to contact each STAR+PLUS Member a minimum of two (2) times per calendar year. This contact can be done telephonically, written, or as an onsite visit to the Member's residence, contingent upon the Member's level of need. The HMO must document the mechanisms, number and method of contacts, and outcomes within the HMO's Service Coordination system.

8.4 Additional CHIP Scope of Work

The following provisions only apply to HMOs participating in CHIP.

8.4.1 CHIP Provider Network
In each Service Area, the HMO must seek to obtain the participation in its Provider Network of CHIP Significant Traditional Providers (STPs), defined by HHSC as PCP Providers currently serving the CHIP population and DSH hospitals. The Procurement Library includes CHIP STPs by Service Area.
The HMO must give STPs the opportunity to participate in its Network if the STPs:

1. Agree to accept the HMO's Provider reimbursement rate for the provider type; and

2. Meet the standard credentialing requirements of the HMO, provided that lack of board certification or accreditation by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) is not the sole grounds for exclusion from the Provider Network.

8.4.2 CHIP Provider Complaint and Appeals
CHIP Provider Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The HMO must resolve Provider Complaints within 30 days from the date the Complaint is received. The HMO is subject to rememdies, including liquidated damages, if at least 98 percent of Porvider Complaints are not resolved within 30 days of receipt of the Complaint by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.**

8.4.3 CHIP Member Complaint and Appeal Process
CHIP Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the HMO to resolve Complaints and Appeals (that are not elevated to TDI) within 30 days from the date the Complaint or Appeal is received. The HMO is subject to remedies, including liquidated damages, if at least 98 percent of Member Complaints or Member Appeals are not resolved within 30 days of receipt of the Complaint or Appeal by the HMO. Please see the **Uniform Managed Care Contract Terms & Conditions** and **Attachment B-5, Deliverables/Liquidated Damages Matrix.** Any person, including those dissatisfied with a HMO's resolution of a Complaint or Appeal, may report an alleged violation to TDI.

8.4.4 Dental Coverage for CHIP Members
The HMO is not responsible for reimbursing dental providers for preventive and therapeutic dental services obtained by CHIP Members. However, medical and/or hospital charges, such as anesthesia, that are necessary in order for CHIP Members to access standard therapeutic dental services, are Covered Services for CHIP Members. The HMO must provide access to facilities and physician services that are necessary to support the dentist who is providing dental services to a CHIP Member under general anesthesia or intravenous (IV) sedation.
The HMO must inform Network facilities, anesthesiologists, and PCPs what authorization procedures are required, and how Providers are to be reimbursed for the preoperative evaluations by the PCP and/or anesthesiologist and for the facility services. For dental-related medical Emergency Services, the HMO must reimburse in-network and Out-of-Network providers in accordance with federal and state laws, rules, and regulations.

8.4.5 Third Party Liability and Recovery
CHIP HMOs are authorized to engage in Third Party Recovery (TPR) actions for claims resulting from the care and/or treatment of CHIP Members. CHIP HMOs are responsible for establishing a plan and process for recovering costs for services that should have been paid through a third party in accordance with applicable State and Federal laws and regulations, including State insurance laws and regulations. HHSC may reduce capitation payments to CHIP HMOs by the projected amount of TPR that the HMOs are expected to recover.
CHIP HMOs must provide required reports as stated in **Section 8.1.17.2,** Financial Reporting Requirements.
After 120-days from the date of service on any claim, encounter, or other CHIP related payment by the HMO subject to TPR, HHSC may attempt recovery independent of any HMO action.

HHSC will retain, in full, all funds received as a result of the state initiated recovery or subrogation action.
CHIP HMOs shall provide a Member quarterly file, which contains the following information if available to the HMO: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file shall be used for the purpose of matching the Texas CHIP eligibility file against the HMO Member file to identify CHIP Members enrolled in the HMO who may have TPR information not known to the CHIP Program.

8.4.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)
On or after October 1, 2009: CHIP HMOs are required to pay the full encounter rates as determined by HHSC to FQHCs and RHCs for dates of services occurring on or after October 1, 2009.

8.5 Additional CHIP Perinatal Scope of Work

The following provisions only apply to HMOs participating in CHIP Perinatal Program.

8.5.1 CHIP Perinatal Provider Network
In each Service Area, the CHIP Perinatal HMO must seek to obtain the participation of Providers for CHIP Perinate Members. CHIP Perinatal HMOs are encouraged to obtain the participation of Obstetricians/Gynecologists (OB/GYNs), Family Practice Physicians with experience in prenatal care, or other qualified health care Providers as CHIP Perinate Providers.
See Sections 8.1.3.2, Access to Network Providers, and 8.1.4.2, Primary Care Providers, regarding distinctions in the provider networks for CHIP Perinates and CHIP Perinate Newborns.

8.5.2 CHIP Perinatal Program Provider Complaint and Appeals
CHIP Perinatal Program Provider Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. The HMO must resolve Provider Complaints within 30 days from the date the Complaint is received.

8.5.3 CHIP Perinatal Program Member Complaint and Appeal Process
CHIP Perinatal Program Member Complaints and Appeals are subject to disposition consistent with the Texas Insurance Code and any applicable TDI regulations. HHSC will require the HMO to resolve Complaints and Appeals (that are not elevated to TDI) within 30 days from the date the Complaint or Appeal is received. Any person, including those dissatisfied with a HMO's resolution of a Complaint or Appeal, may report an alleged violation to TDI.

8.5.4 Dental Coverage for CHIP Perinate Newborn Members

The HMO is not responsible for reimbursing dental providers for preventive and therapeutic dental services obtained by CHIP Perinate Newborn Members. However, medical and/or hospital charges, such as anesthesia, that are necessary in order for CHIP Perinate Newborn Members to access standard therapeutic dental services, are Covered Services for CHIP Perinate Newborn Members. The HMO must provide access to facilities and physician services that are necessary to support the dentist who is providing dental services to a CHIP Perinate Newborn Member under general anesthesia or intravenous (IV) sedation.

The HMO must inform Network facilities, anesthesiologists, and PCPs what authorization procedures are required, and how Providers are to be reimbursed for the preoperative evaluations by the PCP and/or anesthesiologist and for the facility services. For dental-related medical Emergency Services, the HMO must reimburse Network and Out-of-Network Providers in accordance with federal and state laws, rules, and regulations.

8.5.5 Third Party Liability and Recovery

CHIP Perinatal HMOs are authorized to engage in Third Party Recovery (TPR) actions for claims resulting from the care and/or treatment of CHIP Perinatal Program Members. CHIP Perinatal HMOs are responsible for establishing a plan and process for recovering costs for services that should have been paid through a third party in accordance with applicable State and Federal laws and regulations, including State insurance laws and regulations. HHSC may reduce capitation payments to the CHIP Perinatal HMOs by the projected amount of TPR that the HMOs are expected to recover.

CHIP Perinatal HMOs must provide required reports as stated in **Section 8.1.17.2,** Financial Reporting Requirements.

After 120-days from the date of service on any claim, encounter, or other CHIP Perinatal Program-related payment by the HMO subject to TPR, HHSC may attempt recovery independent of any HMO action. HHSC will retain, in full, all funds received as a result of the state initiated recovery or subrogation action.

CHIP Perinatal HMOs shall provide a Member quarterly file, which contains the following information if available to the HMO: the Member name, address, claim submission address, group number, employer's mailing address, social security number, and date of birth for each subscriber or policyholder and each dependent of the subscriber or policyholder covered by the insurer. The file shall be used for the purpose of matching the Texas CHIP Perinatal Program eligibility file against the HMO Member file to identify CHIP Perinatal Program Members enrolled in the HMO who may have TPL information not known to the CHIP Perinatal Program.

8.5.6 Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

On or after October 1, 2009: CHIP Perinatal HMOs are required to pay the full encounter rates as determined by HHSC to FQHCs and RHCs for dates of services occurring on or after October 1, 2009.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version Attachment B-1, Section 7
Revision	1.1	June 30, 2006	Contract amendment to include STAR+PLUS program. No change to this Section.
Revision	1.2	September 1, 2006	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.3	September 1, 2006	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.4	September 1, 2006	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.8	September 1, 2007	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.11	September 1, 2008	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.13	September 1, 2009	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.16	September 1, 2010	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-1 Section 9 – Turnover Requirements
Revision	1.18	March 1, 2011	Contract amendment did not revise Attachment B-1 Section 9 - Turnover Requirements.
Revision	1.19	September 1, 2011	Contract amendment did not revise Attachment B-1 Section 9 - Turnover Requirements.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment B-1 Section 9 - Turnover Requirements.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

9. Turnover Requirements

9.1 Introduction

This section presents the Turnover Requirements to which the HMO must agree. Turnover is defined as those activities that are required for the HMO to perform upon termination of the Contract in situations in which the HMO must transition Contract operations to HHSC or a subsequent Contractor.

9.2 Transfer of Data

The HMO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new HMO, at the sole discretion of HHSC and as directed by HHSC. All transferred data must be compliant with HIPAA.

All relevant data must be received and verified by HHSC or the subsequent Contractor. If HHSC determines that not all of the data regarding the provision of Covered Services to Members was transferred to HHSC or the subsequent Contractor, as required, or the data is not HIPAA compliant, HHSC reserves the right to hire an independent contractor to assist HHSC in obtaining and transferring all the required data and to ensure that all the data are HIPAA compliant. The reasonable cost of providing these services will be the responsibility of the HMO.

9.3 Turnover Services

Six months prior to the end of the Contract Period, including any extensions to such Period, the HMO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State or a successor HMO. The Turnover Plan must be a comprehensive document detailing the proposed schedule, activities, and resource requirements associated with the turnover tasks. The Turnover Plan must be approved by HHSC.

As part of the Turnover Plan, the HMO must provide HHSC with copies of all relevant Member and service data, documentation, or other pertinent information necessary, as determined by the HHSC, for HHSC or a subsequent Contractor to assume the operational activities successfully. This includes correspondence, documentation of ongoing outstanding issues, and other operations support documentation. The plan will describe the HMO’s approach and schedule for transfer of all data and operational support information, as applicable. The information must be supplied in media and format specified by the State and according to the schedule approved by the State.

HHSC is not limited or restricted in the ability to require additional information from the HMO or modify the turnover schedule as necessary.

9.4 Post-Turnover Services

Thirty (30) days following turnover of operations, the HMO must provide HHSC with a Turnover Results report documenting the completion and results of each step of the Turnover Plan. Turnover will not be considered complete until this document is approved by HHSC.

If the HMO does not provide the required relevant data and reference tables, documentation, or other pertinent information necessary for HHSC or the subsequent Contractor to assume the operational activities successfully, the HMO agrees to reimburse the State for all reasonable costs, including, but not
limited to, transportation, lodging, and subsistence for all state and federal representatives, or their agents, to carry out their inspection, audit, review, analysis, reproduction and transfer functions at the location(s) of such records.

The HMO also agrees to pay any and all additional costs incurred by the State that are the result of the HMO’s failure to provide the requested records, data or documentation within the time frames agreed to in the Turnover Plan.

The HMO must maintain all files and records related to Members and Providers for five years after the date of final payment under the Contract or until the resolution of all litigation, claims, financial management review or audit pertaining to the Contract, whichever is longer. The HMO agrees to repay any valid, undisputed audit exceptions taken by HHSC in any audit of the Contract.

Subject: Attachment B-2 - Covered Services

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version Attachment B-2, Covered Services
Revision	1.1	June 30, 2006	Revised Attachment B-2, Covered Services, by adding Attachment B-2.1, STAR+PLUS Covered Services.
Revision	1.2	September 1. 2006	Revised Attachment B-2 to include provisions applicable to MCOs participating in the STAR and CHIP Programs. STAR Covered Services, Services Included under the HMO Capitation Payment, is modified to clarify the STAR covered services related to "optometry" and "vision." CHIP Covered Services is modified to correct services related to artificial aids including surgical implants.
Revision	1.3	September 1, 2006	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.4	September 1, 2006	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.8	September 1, 2007	CHIP Covered Services are modified to comply with legislative changes required by HB 109 to eliminate the 6 month enrollment period effective 9/1/07.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.11	September 1, 2008	Attachment B-2, Covered Services is modified to include additional covered services resulting from the Frew Settlement.
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-2, Covered Services.
Revision	1.13	September 1, 2009	All references to "check-ups" are changed to "checkups" Annual adult well check is removed from the list of enhanced benefits and added to "Services included under the HMO capitation payment". STAR Covered Services "Services included under the HMO capitation payment" is modified to remove "birthing center services" and add "Birthing services provided by a certified nurse midwife in a birthing center". CHIP Covered Services "Inpatient General Acute and Inpatient Rehabilitation Hospital Services" is modified clarify the requirements regarding miscarriage and non-viable pregnancy, as well as orthodontic services for treatment of craniofacial anomalies. CHIP Covered Services "Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center" is modified to clarify the requirements regarding miscarriage and non-viable pregnancy, as well as orthodontic services for treatment of craniofacial anomalies. CHIP Covered Services "Physician/Physician Extender Professional Services" is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. CHIP Covered Services "Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies" is modified to clarify the requirements regarding dental devices. CHIP Covered Services "Outpatient Mental Health Services" is revised to provide additional clarity as it relates to Qualified Mental Health Providers – Community Services (QMHP-CS). CHIP Exclusions From Covered Services is modified to clarify requirements regarding dental devices. CHIP DME/Supplies is modified to clarify the requirements regarding dental devices.
Revision	1.14	December 1, 2009	"Services included under the HMO capitation payment" is modified to remove references to PACT. CHIP Covered Services "Inpatient General Acute and Inpatient Rehabilitation Hospital Services" is modified to clarify the requirements regarding orthodontic services for treatment of craniofacial anomalies. It is also modified to clarify the requirements of Section 2103(f)(2) of the Social Security Act, as amended by CHIPRA. This provision requires CHIP health plans to comply

			with the Title 42 U.S.C., Chapter 6A, Subchapter XXV, Part A, Subpart 2, 300gg-6. CHIP Covered Services "Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center" is modified to clarify the requirements regarding orthodontic services for treatment of craniofacial anomalies. It is also modified to clarify the requirements of Section 2103(f)(2) of the Social Security Act, as amended by CHIPRA. This provision requires CHIP health plans to comply with Title 42 U.S.C., Chapter 6A, Subchapter XXV, Part A, Subpart 2, 300gg-6. CHIP Covered Services "Physician/Provider Extender Professional Services" is modified to clarify the requirements regarding orthodontic services for treatment of craniofacial anomalies. It is also modified to clarify the requirements of 2103(f)(2) of the Social Security Act, as amended by CHIPRA. This provision requires CHIP health plans to comply with Title 42 U.S.C., Chapter 6A, Subchapter XXV, Part A, Subpart 2, 300gg-6. CHIP Covered Services "Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical supplies" is modified to ad external breast prostheses. CHIP Covered Services "Outpatient Mental Health Services" is revised to update the TAC citation.
Revision	1.15	March 1, 2010	"Services included under the HMO capitation payment" is modified to add substance abuse services. This amendment will be effective the later of: September 1, 2010 or upon final approval of the Medicaid State Plan, 1915(b) STAR+PLUS waiver and/or the 1915(b) STAR waiver, as applicable to the HMO Program
Revision	1.16	September 1, 2010	STAR Covered Services is modified to waive the 30 visit limit for outpatient mental health services (as required by Mental Health Parity requirements). "Services included under the HMO capitation payment" is modified to clarify the substance abuse services; correct the error of adding the general category of "inpatient mental health services for Adults"; and to replace "certified nurse midwife" with "physician or Advanced Practice Nurse" and add the word "licensed" to Birthing Services. In addition, "mastectomy, breast reconstruction, and related follow-up procedures" and "Birthing services provided by a licensed birthing center" are added. CHIP Covered Services "Inpatient General Acute and Inpatient Rehabilitation Hospital Services" is modified to add "external breast prostheses". CHIP Covered Services "Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center" is modified to add "external breast prostheses". CHIP Covered Services "Physician/Physician Extender Professional Services" is modified to add "external breast prostheses".
Revision	1.17	December 1, 2010	CHIP Hospice Care Services modified to require concurrent CHIP and hospice care services to comply with the federal requirements from Section 2302 of the Patient Protection and Affordable Care Acts of 2010 (P.L. 111-148). By law, CHIP health plans were required to provide concurrent hospice care services effective August 1, 2010.
Revision	1.18	March 1, 2011	Services included under the HMO capitation payment is modified to remove the services effective prior to the effective dates of the State Plan and 1915(b) STAR Waiver. Services included under the HMO capitation payment is modified to add a reference to "Cancer screening, diagnostic, and treatment services". These services are already 1905(a) covered services, therefore adding this reference does not impact the HMOs' rates. CHIP Inpatient Mental Health Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Also modified to clarify the court-ordered service requirement. CHIP Inpatient Substance Abuse Treatment Services is modified to comply with the federal requirements of the Mental Health Parity and Additction Equity Act of 2008 (MHPAEA), as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). CHIP Outpatient Substance Abuse Treatment Services is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).
Revision	1.19	September 1, 2011	Attachment B-2 is modified effective September 1, 2011 and subject to CMS approval, to remove

			the waiverof the three prescription limit for adults.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment B-2, Covered Services.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

STAR Covered Services

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the STAR Medicaid managed care program.
Medicaid HMO Contractors are responsible for providing a benefit package to Members that includes all medically necessary services covered under the traditional, fee-for-service Medicaid programs except for Non-capitated Services provided to STAR Members outside of the HMO capitation and listed in Attachment B-1, **Section 8.2.2.8**. Medicaid HMO Contractors must coordinate care for Members for these Non-capitated Services so that Members have access to a full range of medically necessary Medicaid services, both capitated and non-capitated. A Contractor may elect to offer additional acute care Value-added Services.
Adult STAR Members are provided with two enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1) waiver of the three-prescription per month limit;

2) waiver of the 30-day spell-of-illness limitation under fee-for-services; and

Subject to CMS approval, the waiver of the three-prescription per month limit will no longer be an enhanced benefit for adult STAR members. HHSC will provide Medicaid HMOs with advance written notice of the effective date of this change, which it anticipates will be on or after September 1, 2011. Members enrolled in a 1915(c) waiver program will still have access to unlimited prescriptions as a benefit of that program.

Medicaid HMO Contractors are responsible for providing a benefit package to Members that includes the waiver of the 30-day spell-of-illness limitation under traditional, fee-for-service Medicaid coverage. Prescription drug benefits to Medicaid HMO Members are provided outside of the HMO capitation.

Contractors should refer to the current ***Texas Medicaid Provider Procedures Manual*** and the bi-monthly ***Texas Medicaid Bulletin*** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. (These documents can be accessed online at: http://www.tmhp.com.)

The services listed in this Attachment are subject to modification based on Federal and State laws and regulations and Programs policy updates.

Services included under the HMO capitation payment

- Ambulance services
- Audiology services, including hearing aids, for adults (audiology services and hearing aids for children are a non-capitated service)
- (These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the HMO's non-quantitative treatmetn limiations, provided such limitations comply with the requirements of the Mental Health Parity and Addiction Equity Act of 2008.) Behavioral Health Services, including:
    - Inpatient mental health services for Children (under age 21)
    - Outpatient mental health services
    - Psychiatry services
    - Counseling services for adults (21 years of age and over)
    - Outpatient substance use disorder treatment services including:
        - o Assessment
        - o Detoxification services
        - o Counseling treatment
        - o Medication assisted therapy
    - Residential substance use disorder treatment services including:
        - o Detoxification services
    - Substance use disorder treatment (including room and board)
- Birthing services provided by a physician or Advanced Practice Nurse in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, including inpatient and outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
    - inpatient services; outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
        - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
        - surgery and reconstruction on the other breast to produce symmetrical appearance;
        - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
        - prophylactic mastectomy to prevent the development of breast cancer.
    - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Podiatry
- Prenatal care
- Primary care services

· Preventive services including an annual adult well check for patients 21 years of age and over

· Radiology, imaging, and X-rays

· Specialty physician services

· Therapies – physical, occupational and speech

· Transplantation of organs and tissues

· Vision (Includes optometry and glasses. Contact lenses are only covered if they are medically necessary for vision correction, which can not be accomplished by glasses.)

CHIP Covered Services

Covered CHIP services must meet the CHIP definition of Medically Necessary Covered Services as defined in this **Contract**. There is no lifetime maximum on benefits; however, 12-month period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays apply until a family reaches its specific cost-sharing maximum.

Covered Benefit	Description
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: Hospital-provided Physician or Provider services Semi-private room and board (or private if medically necessary as certified by attending) General nursing care Special duty nursing when medically necessary ICU and services Patient meals and special diets Operating, recovery and other treatment rooms Anesthesia and administration (facility technical component) Surgical dressings, trays, casts, splints Drugs, medications and biologicals Blood or blood products that are not provided free-of-charge to the patient and their administration X-rays, imaging and other radiological tests (facility technical component) Laboratory and pathology services (facility technical component) Machine diagnostic tests (EEGs, EKGs, etc.) Oxygen services and inhalation therapy Radiation and chemotherapy Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalent levels of care In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. Hospital, physician and related medical services, such as anesthesia, associated with dental care Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. Surgical implants Other artificial aids including surgical implants Inpatient services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined plan to treat: - cleft lip or palate; - severe skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: Semi-private room and board Regular nursing services Rehabilitation services Medical supplies and use of appliances and equipment furnished by the facility
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: X-ray, imaging, and radiological tests (technical component) Laboratory and pathology services (technical component) Machine diagnostic tests Ambulatory surgical facility services Drugs, medications and biologicals Casts, splints, dressings Preventive health services Physical, occupational and speech therapy Renal dialysis

	Respiratory services Radiation and chemotherapy Blood or blood products that are not provided free-of-charge to the patient and the administration of these products Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. Surgical implants Other artificial aids including surgical implants Outpatient services provided at an oupatient hospital and ambultory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from mastectomy and treatment of lymphedemas. Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined plan to treat: - cleft lip or palate; - severe skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Physician/Physician Extender Professional Services	Services include, but are not limited to, the following: American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) Physician office visits, in-patient and out-patient services Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation Medications, biologicals and materials administered in Physician's office Allergy testing, serum and injections Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations Hospital-based Physician services (including Physician-performed technical and interpretive components) Physician and professional services for a mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed - surgery and reconstruction on the other breast to produce symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. Physician services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero). Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: - dilation and curettage (D&C) procedures; - appropriate provider-administered medications; - ultrasounds, and - histological examination of tissue samples. Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined plan to treat: - cleft lip or palate; - severe skeletal and/or congenital craniofacial deviations; or - severe facial asymmetry secondary skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this ccap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: Orthotic braces and orthotics Dental devices Prosthetic devices such as artificial eyes, limbs, braces, and external breast prostheses Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease Hearing aids Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: Home infusion Respiratory therapy Visits for private duty nursing (R.N., L.V.N.) Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). Home health aide when included as part of a plan of care during a period that skilled visits have been approved. Speech, physical and occupational therapies. Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker

	Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services Services are not intended to replace 24-hour inpatient or skilled nursing facility services
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: Neuropsychological and psychological testing. When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with juridiction over the matter for determination. Does not require PCP referral
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility Neuropsychological and psychological testing Medication management Rehabilitative day treatments Residential treatment services Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) Skills training (psycho-educational skill development) When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding detemination of medical necessity. Any modification or termination of services must be presented to the court with jursidiction over the matter for determination A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and family education, and crisis services Does not require PCP referral
Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs Does not require PCP referral
Outpatient Substance Abuse Treatment Services	Outpatient substance abuse treatment services include, but are not limited to, the following: Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. Intensive outpatient services Partial hospitalization Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, education services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day Outpatient treatement service is defined as consisting of at least one or two hours per week providing structured group and individual therapy, educational services, and life skills training Does not require PCP referral
Rehabilitation Services	Services include, but are not limited to, the following: Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: Physical, occupational and speech therapy Developmental assessment
Hospice Care Services	Services include, but are not limited to, the following: Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death Treatment services , including treatment related to the terminal illness Up to a maximum of 120 days with a 6 month life expectancy Patients electing hospice services may cancel this election at anytime Services apply to the hospice diagnosis
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions or labor and delivery. Covered services include, but are not limited to, the following: Emergency services based on prudent lay person definition of emergency health condition Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers Medical screening examination Stabilization services Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services Emergency ground, air and water transportation Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.
Transplants	Services include, but are not limited to, the following: Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include: One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization One pair of non-prosthetic eyewear per 12-month period

Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan- approved program Health Plan defines plan-approved program. May be subject to formulary requirements.

CHIP EXCLUSIONS FROM COVERED SERVICES

[Value-added services]	*See Attachment B-3*

Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system

Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury

Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community

Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court

Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.

Mechanical organ replacement devices including, but not limited to artificial heart

Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan

Prostate and mammography screening

Elective surgery to correct vision

Gastric procedures for weight loss

Cosmetic surgery/services solely for cosmetic purposes

Dental devices soley for cosmetic purposes

Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section

Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan

Acupuncture services, naturopathy and hypnotherapy

Immunizations solely for foreign travel

Routine foot care such as hygienic care

Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)

Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor

Corrective orthopedic shoes

Convenience items

Orthotics primarily used for athletic or recreational purposes

Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.

Housekeeping

Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities

Services or supplies received from a nurse, which do not require the skill and training of a nurse

Vision training and vision therapy

Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP

Donor non-medical expenses

Charges incurred as a donor of an organ when the recipient is not covered under this health plan

CHIP DME/SUPPLIES

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula:

			• For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		
Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version of Attachment B-2, Covered Services.
Revision	1.1	June 30, 2006	Revised Attachment B-2, Covered Services, by adding Attachment B-2.1, STAR+PLUS Covered Services. This is the initial version of Attachment B-2.1, STAR+PLUS Covered Services, which lists the Acute Care Services and the Community Based Long Term Care Services.
Revision	1.2	September 1, 2006	Contract Amendment did not revise Attachment B-2.1- STAR+PLUS Covered Services.
Revision	1.3	September 1, 2006	Contract Amendment did not revise Attachment B-2.1- STAR+PLUS Covered Services.
Revision	1.4	September 1, 2006	Contract Amendment did not revise Attachment B-2.1- STAR+PLUS Covered Services.
Revision	1.5	January 1, 2007	Revised Attachment B-2.1, STAR+PLUS Covered Services, to include inpatient and outpatient mental health services for adults.
Revision	1.6	February 1, 2007	Revised Attachment B-2.1, STAR+PLUS Covered Services, to exclude inpatient mental health services for adults and children, and to establish monetary limits on Transition Assistance Services. Personal Attendant Services is clarified to include the three service delivery options described in Attachment B-1, Section 8.3.5. Consumer Directed Personal Attendant Services is deleted from the list since it is one of the three service delivery options under Personal Attendant Services.
Revision	1.7	June 1, 2007	Revised Attachment B-2.1, STAR+PLUS Covered Services, to include inpatient mental health services for adults and children and to include effective dates by service area.
Revision	1.8	September 1, 2007	Contract Amendment did not revise Attachment B-2.1- STAR+PLUS Covered Services.
Revision	1.9	December 1, 2007	Contract Amendment did not revise Attachment B-2.1- STAR+PLUS Covered Services.
Revision	1.10	March 1, 2008	Contract Amendment did not revise Attachment B-2.1- STAR+PLUS Covered Services.
Revision	1.11	September 1, 2008	Attachment B-2.1 - STAR+PLUS Covered Services is modified to include additional covered services resulting from the Frew Settlement.
Revision	1.12	March 1, 2009	Attachment B-2.1- STAR+PLUS Covered Services is modified to exclude nursing home services.
Revision	1.13	September 1, 2009	All references to “check-ups” are changed to “checkups” Annual adult well check is removed from the list of enhanced benefits and added to “Services included under the HMO capitation payment”. “Services included under the HMO capitation payment” is modified to remove “birthing center services” and add “Birthing services provided by a certified nurse midwife in a birthing center”. “1915(c) NF Waiver Services” is modified to add “In-Home or Out-of-Home Respite Services”, to clarify that all covered services are medically necessary, and to clarify that that Medical Supplies not available under the Medicaid State Plan are covered.
Revision	1.14	December 1, 2009	"Acute Care Services" is modified to clarify that the 30-day spell-of-illness limit is waived for inpatient behavioral health services. Services included under the HMO capitation payment" is modified to remove references to PACT.
Revision	1.15	March 1, 2010	“Services included under the HMO capitation payment” is modified to add substance abuse services. This amendment will be effective the later of: September 1, 2010 or upon final approval of the Medicaid State Plan, 1915(b) STAR+PLUS waiver and/or the 1915(b) STAR waiver, as applicable to the HMO Program.
Revision	1.16	September 1, 2010	“Acute Care Services” is modified to add an enhanced benefit (waiver of 30 visit limit for outpatient mental health services). “Services included under the HMO capitation payment” is modified to clarify the substance abuse services added by the last amendment; and to replace “certified nurse midwife” with “physician or Advanced Practice Nurse” and add the word “licensed” to Birthing Services. In addition, “mastectomy, breast reconstruction, and related follow-up procedures” and “Birthing services provided by a licensed birthing center” are added.
Revision	1.17	December 1, 2010	Contract Amendment did not revise Attachment B-2.1- STAR+PLUS Covered Services.
Revision	1.18	March 1, 2011	Services included under the HMO capitation payment is modified to remove the services effective prior to the effective dates of the State Plan and 1915(b) STAR Waiver. Services included under the HMO capitation payment is modified to add "Cancer screening, diagnostic, and treatment services". These services are already 1905(a) covered services, therefore adding this reference does not impact the HMOs' rates.
Revision	1.19	September 1, 2011	Attachment B-2.1 is modified to remove the waiver of the 30-day spell of illness for physical health in conformance with the 1915(b) waiver. In addition, effective September 1, 2011 and subject to CMS approval, the waiver of the three prescription limit for adults is removed.
Revision	1.20	January 1, 2012	

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

STAR+PLUS Covered Services

Acute Care Services

The following is a non-exhaustive, high-level listing of Acute Care Covered Services included under the STAR+PLUS Medicaid managed care program.
Medicaid HMO Contractors are responsible for providing a benefit package to Members that includes all medically necessary services covered under the traditional, fee-for-service Medicaid programs except for Non-capitated Services provided to Medicaid Members outside of the HMO capitation and listed in Attachment B-1, Section 8.2.2.8. In accordance with Attachment B-1, Section 8.2.2.8, Hospital Inpatient Stays and Nursing Facility Services are examples of services that are excluded from the capitation payment to STAR+PLUS HMOs and are paid through HHSC’s Administrative Contractor responsible for payment of Traditional Medicaid fee-for-service claims. Medicaid HMO Contractors must coordinate care for Members for these Non-capitated Services so that Members have access to a full range of medically necessary Medicaid services, both capitated and non-capitated. A Contractor may elect to offer additional acute care Value-added Services.
Adult STAR+PLUS Members are provided with two enhanced benefits compared to the traditional, fee-for-service Medicaid coverage:

1. waiver of the three-prescription per month limit, for members not covered by Medicare; and

2. waiver of the 30-day spell-of-illness limit for inpatient behavioral health services.

Subject to CMS approval, the waiver of the three-prescription per month limit will no longer be an enhanced benefit for adult STAR+PLUS members. HHSC will provide Medicaid HMOs advance written notice of the effective date of this change, which it anticipates will be on or after September 1, 2011. Members enrolled in a 1915(c) STAR+PLUS waiver program will have access to unlimited prescriptions as a benefit of that program.
Prescription drug benefits to HMO Members are provided outside of the HMO capitation.
STAR+PLUS HMO Contractors should refer to the current ***Texas Medicaid Provider Procedures Manual*** and the bi-monthly ***Texas Medicaid Bulletin*** for a more inclusive listing of limitations and exclusions that apply to each Medicaid benefit category. (These documents can be accessed online at: http://www.tmhp.com.)

The services listed in this Attachment are subject to modification based on Federal and State laws and regulations and Programs policy updates.

Services included under the HMO capitation payment

- Ambulance services
- Audiology services, including hearing aids, for adults (audiology services and hearing aids for children are a non-capitated service)
- (These services are not subject to the quantitative treatment limitations that apply under traditional, fee-for-service Medicaid coverage. The services may be subject to the HMO's non-quantitative treatment limiations, provided such limitations comply with the requirments of the Mental Health Parity and Addiction Equity Act of 2008.) Behavioral Health Services, including:
  - Inpatient mental health services for Adults and Children (Effective 6/01/07 in the Harris Service Area; and effective 9/01/07 in the Bexar, Nueces and Travis Service Areas.)
  - Outpatient mental health services for Adults and Children
  - Psychiatry services
  - Counseling services for adults (21 years of age and over)
  - Substance use disorder treatment services, including
    - Outpatient services, including:
      - Assessment
      - Detoxification services
      - Counseling treatment
      - Medication assisted therapy
    - Residential services, including
      - Detoxification services
      - Substance use disorder treatment (including room and board)
    - Medication assisted therapy
- Birthing services provided by a physician or Advanced Practice Nurse in a licensed birthing center
- Birthing services provided by a licensed birthing center
- Cancer screening, diagnostic, and treatment services
- Chiropractic services
- Dialysis
- Durable medical equipment and supplies
- Emergency Services
- Family planning services
- Home health care services
- Hospital services, outpatient
- Laboratory
- Mastectomy, breast reconstruction, and related follow-up procedures, including:
  - outpatient services provided at an outpatient hospital and ambulatory health care center as clinically appropriate; and physician and professional services provided in an office, inpatient, or outpatient setting for:
    - all stages of reconstruction on the breast(s) on which medically necessary mastectomy procedure(s) have been performed;
    - surgery and reconstruction on the other breast to produce symmetrical appearance;
    - treatment of physical complications from the mastectomy and treatment of lymphedemas; and
    - prophylactic mastectomy to prevent the development of breast cancer.
  - external breast prosthesis for the breast(s) on which medically necessary mastectomy procedure(s) have been performed.
- Medical checkups and Comprehensive Care Program (CCP) Services for children (under age 21) through the Texas Health Steps Program
- Oral evaluation and fluoride varnish in the Medical Home in conjunction with Texas Health Steps medical checkup for children 6 months through 35 months of age.
- Optometry, glasses, and contact lenses, if medically necessary
- Podiatry
- Prenatal care

- Primary care services
- Preventive services including an annual adult well check for patients 21 years of age and over
- Radiology, imaging, and X-rays
- Specialty physician services
- Therapies – physical, occupational and speech
- Transplantation of organs and tissues
- Vision

Community Based Long Term Care Services

The following is a non-exhaustive, high-level listing of Community Based Long Term Care Covered Services included under the STAR+PLUS Medicaid managed care program.

• Community Based Long Term Care Services for all Members

  o Personal Attendant Services – All Members of a STAR+PLUS HMO may receive medically and functionally necessary Personal Attendant Services (PAS).

  o Day Activity and Health Services – All Members of a STAR+PLUS HMO may receive medically and functionally necessary Day Activity and Health Care Services (DAHS).

• 1915 (c) Nursing Facility Waiver Services for those Members who qualify for such services

The state provides an enriched array of services to clients who would otherwise qualify for nursing facility care through a Home and Community Based Medicaid Waiver. In traditional Medicaid, this is known as the Community Based Alternatives (CBA) waiver. The STAR+PLUS HMO must also provide the services that are available to clients through the CBA waiver in traditional Medicaid to those clients that meet the functional and financial eligibility for the 1915 (c) Nursing Facility Waiver Services.

  o Personal Attendant Services (including the three service delivery options: Self-Directed; Agency Model, Self-Directed; and Agency Model)
  o In-Home or Out-of-Home Respite Services
  o Nursing Services (in home)
  o Emergency Response Services (Emergency call button)
  o Home Delivered Meals
  o Minor Home Modifications
  o Adaptive Aids and Medical Equipment
  o Medical Supplies
  o Physical Therapy, Occupational Therapy, Speech Therapy
  o Adult Foster Care
  o Assisted Living
  o Transition Assistance Services (These services are limited to a maximum of $2,500.00. If the HMO determines that no other resources are available to pay for the basic services/items needed to assist a Member, who is leaving a nursing facility, with setting up a household, the HMO may authorize up to $2,500.00 for Transition Assistance Services (TAS). The $2,500.00 TAS benefit is part of the expense ceiling when determining the Total Annual Individual Service Plan (ISP) Cost.)

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version of Attachment B-2, Covered Services
Revision	1.1	June 30, 2006	Revised Attachment B-2, Covered Services, by adding Attachment B-2.1, STAR+PLUS Covered Services.
Revision	1.2	September 1, 2006	Revised Attachment B-2, Covered Services, by updating provisions applicable to MCOs participating in the STAR and CHIP Programs.
Revision	1.3	September 1, 2006	Revised Attachment B-2, Covered Services, by adding Attachment B-2.2, CHIP Perinatal Covered Services. This is the initial version of Attachment B-2.2, which lists the CHIP Perinatal Covered Services, exclusions and DME/Supplies.
Revision	1.4	September 1, 2006	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.5	January 1, 2007	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.6	February 1, 2007	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.7	July 1, 2007	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.8	September 1, 2007	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.9	December 1, 2007	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.10	March 1, 2008	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.11	September 1, 2008	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.12	March 1, 2009	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.13	September 1, 2009	CHIP Perinatal Covered Services “Inpatient General Acute and Inpatient Rehabilitation Hospital Services” is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. CHIP Perinatal Covered Services “Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center” is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. CHIP Perinatal Covered Services “Physician/Physician Extender Professional Services” is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. CHIP Perinatal Covered Services “Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services” is modified to clarify the requirements regarding miscarriage and non-viable pregnancy. “Outpatient Mental Health Services” is revised to provide additional clarity as it relates to Qualified Mental Health Providers – Community Services (QMHP-CS). CHIP Perinatal Program Exclusions From Covered Services For CHIP Perinates is modified to clarify the requirements regarding miscarriage and non-viable pregnancy.
Revision	1.14	December 1, 2009	Outpatient Mental Health Services is revised to update the TAC citation.
Revision	1.15	March 1, 2010	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.16	September 1, 2010	Attachment B-2.2 is modified to clarify the 12-month enrollment period is for the CHIP Perinate Newborn beginning with the month of enrollment as a CHIP Perinate. CHIP Perinatal Covered Services “Inpatient General Acute and Inpatient Rehabilitation Hospital Services” for Perinate Newborns is modified to remove the CHIP Perinate Newborn 0% to 185% category and to add outpatient services and orthodontic services to conform to CHIP Covered Services in Attachment B-2. CHIP Perinatal Covered Services “Inpatient General Acute and Inpatient Rehabilitation Hospital Services” for Perinates is modified to remove the CHIP Perinate Newborn 0% to 185% category. CHIP Perinatal Covered Services “Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center” for Perinate Newborns is modified to add outpatient services

			and orthodontic services to conform to CHIP Covered Services in Attachment B-2. CHIP Perinatal Covered Services "Physician/Physician Extender Professional Services" for Perinate Newborns is modified to add outpatient services and orthodontic services to conform to CHIP Covered Services in Attachment B-2. CHIP Perinatal Covered Services "Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies" for Perinate Newborns is modified to add dental devices and external breast prostheses to conform to CHIP Covered Services in Attachment B-2. The first bullet under "Exclusions from Covered Services for CHIP Perinates" is clarified. The first bullet under "Exclusions from Covered Services for CHIP Perinate Newborns" is removed. "Dental Devices solely for cosmetic purposes" is added to conform to CHIP Covered Services in Attachment B-2. "CHIP & CHIP Perinatal Program DME/Supplies" is modified to add "Dental Devices" to conform to CHIP Covered Services in Attachment B-2.
Revision	1.17	December 1, 2010	CHIP Hospice Care Services is modified to require concurrent CHIP and hospice care services to comply with the federal requirements from Section 2302 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148). By law, CHIP health plans were required to provide concurrent hospice care services effective August 1, 2010.
Revision	1.18	March 1, 2010	Inpatient Mental Health Services for CHIP Perinate Newborns is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Also modified to clarify the court-ordered service requirement. Outpatient Mental Health Services for CHIP Perinate Newborns is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as applied to CHIP by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3). Also modified to clarify the court-ordered service requirement. Inpatient Substance Abuse Treatment Services for CHIP Perinate Newborns is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as applied to CHIP by the CHIP Reauthorization Act of 2009 (P.L. 111-3). Outpatient Substance Abuse Treatment Services for CHIP Perinate Newborns is modified to comply with the federal requirements of the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) as applied to CHIP by the CHIP Reauthorization Act of 2009 (P.L. 111-3). CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinates is modified to clarify that CHIP does not provide coverage for members traveling outside of the U.S. CHIP Perinatal Program Exclusions from Covered Services for CHIP Perinate Newborns is modified to clarify that CHIP does not provide coverage for members traveling outside of the U.S.
Revision	1.19	September 1, 2011	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.
Revision	1.20	January 1, 2012	Contract Amendment did not revise Attachment B-2.2- CHIP Perinatal Covered Services.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

CHIP Perinatal Program Covered Services

Covered CHIP Perinatal Program services must meet the definition of Medically Necessary Covered Services as defined in this **Contract**. There is no lifetime maximum on benefits; however, 12-month enrollment period or lifetime limitations do apply to certain services, as specified in the following chart. Co-pays do not apply to CHIP Perinatal Program Members. CHIP Perinate Newborns are eligible for 12-months continuous coverage, beginning with the month of enrollment as a CHIP Perinate.

Covered Benefit	CHIP Perinate Newborn	CHIP Perinate
Inpatient General Acute and Inpatient Rehabilitation Hospital Services	Services include, but are not limited to, the following: Hospital-provided Physician or Provider services Semi-private room and board (or private if medically necessary as certified by attending) General nursing care Special duty nursing when medically necessary ICU and services Patient meals and special diets Operating, recovery and other treatment rooms Anesthesia and administration (facility technical component) Surgical dressings, trays, casts, splints Drugs, medications and biologicals Blood or blood products that are not provided free-of-charge to the patient and their administration	For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, the facility charges are not a covered benefit; however, professional services charges associated with labor with delivery are a covered benefit. For CHIP Perinates in families with incomes between 185% and 200% of the Federal Poverty Level, benefits are limited to professional service charges and facility charges associated with labor with delivery until birth, and services related tomiscarriage or a non-viable pregnancy. Services include: Operating, recovery and other treatment rooms Anesthesia and administration (facility technical component Medically necessary surgical services are limited to services that directly relate to the delivery of the unborn child, and services related to miscarriage or non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero).

	X-rays, imaging and other radiological tests (facility technical component) Laboratory and pathology services (facility technical component) Machine diagnostic tests (EEGs, EKGs, etc.) Oxygen services and inhalation therapy Radiation and chemotherapy Access to DSHS-designated Level III perinatal centers or Hospitals meeting equivalentlevels of care In-network or out-of-network facility and Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. Hospital, physician and related medical services, such as anesthesia, associated with dental care Surgical implants Other artificial aids including surgical implants Inpatient services for a mastectomy and breast reconstruction include: all stages of reconstruction on the affected breast; surgery and reconstruction on the other breast to produce symmetrical appearance; and treatment of physical complications from the mastectomy and treatment of lymphedemas. Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: cleft lip and/or palate; or severe traumatic skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	Inpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures; appropriate provider-administered medications; ultrasounds, and histological examination of tissue samples
Skilled Nursing Facilities (Includes Rehabilitation Hospitals)	Services include, but are not limited to, the following: Semi-private room and board Regular nursing services Rehabilitation services Medical supplies and use of appliances and equipment furnished by the facility	Not a covered benefit.
Outpatient Hospital, Comprehensive Outpatient Rehabilitation Hospital, Clinic (Including Health Center) and Ambulatory Health Care Center	Services include, but are not limited to, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: X-ray, imaging, and radiological tests (technical component) Laboratory and pathology services (technical component) Machine diagnostic tests Ambulatory surgical facility services Drugs, medications and biologicals Casts, splints, dressings Preventive health services Physical, occupational and speech therapy Renal dialysis Respiratory services Radiation and chemotherapy Blood or blood products that are not provided free-of-charge to the patient and the administration of these products Facility and related medical services, such as anesthesia, associated with dental care, when provided in a licensed ambulatory surgical facility. Surgical implants Other artificial aids including surgical implants Outpatient services provided at an outpatient hosptial or ambulatory health care center for a mastectomy and breast reconstruction as clinically appropriate, include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produces symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. Implantable devices are covered under Inpatient and Outpatient services and do not count towards the DME 12-month period limit. Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: cleft lip and/or palate; or severe traumatic skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	Services include, the following services provided in a hospital clinic or emergency room, a clinic or health center, hospital-based emergency department or an ambulatory health care setting: X-ray, imaging, and radiological tests (technical component) Laboratory and pathology services (technical component) Machine diagnostic tests Drugs, medications and biologicals that are medically necessary prescription and injection drugs. Outpatient services associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures; appropriate provider-administered medications; ultrasounds, and histological examination of tissue samples (1) Laboratory and radiological services are limited to services that directly relate to ante partum care and/or the delivery of the covered CHIP Perinate until birth. (2) Ultrasound of the pregnant uterus is a covered benefit when medically indicated. Ultrasound may be indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation or miscarriage or non-viable pregnancy. (3) Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Cordocentesis, FIUT are covered benefits with an appropriate diagnosis. (4) Laboratory tests are limited to: nonstress testing, contraction, stress testing, hemoglobin or hematocrit repeated once a trimester and at 32-36 weeks of pregnancy; or complete blood count (CBC), urinanalysis for protein and glucose every visit, blood type and RH antibody screen; repeat antibody screen for Rh negative women at 28 weeks followed by RHO immune globulin administration if indicated; rubella antibody titer, serology for syphilis, hepatitis B surface antigen, cervical cytology, pregnancy test, gonorrhea test, urine culture, sickle cell test, tuberculosis (TB) test, human immunodeficiency virus (HIV) antibody screen, Chlamydia test, other laboratory tests not specified but deemed medically necessary, and multiple marker screens for neural tube defects (if the client initiates care between 16 and 20 weeks); screen for gestational diabetes at 24-28 weeks of pregnancy; other lab tests as indicated by medical condition of client.
Physician/ Physician Extender Professional Services	Services include, but are not limited to, the following: American Academy of Pediatrics recommended well-child exams and preventive health services (including, but not limited to, vision and hearing screening and immunizations) Physician office visits, in-patient and out-patient services Laboratory, x-rays, imaging and pathology services, including technical component and/or professional interpretation Medications, biologicals and materials administered in Physician's office Allergy testing, serum and injections Professional component (in/outpatient) of surgical services, including: - Surgeons and assistant surgeons for surgical procedures including appropriate follow-up care - Administration of anesthesia by Physician (other than surgeon) or CRNA - Second surgical opinions - Same-day surgery performed in a Hospital without an over-night stay - Invasive diagnostic procedures such as endoscopic examinations	Services include, but are not limited to the following: Medically necessary physician services are limited to prenatal and postpartum care and/or the delivery of the covered unborn child until birth Physician office visits, in-patient and out-patient services Laboratory, x-rays, imaging and pathology services including technical component and /or professional interpretation Medically necessary medications, biologicals and materials administered in Physician's office Professional component (in/outpatient) of surgical services, including: o Surgeons and assistant surgeons for surgical procedures directly related to the labor with delivery of the covered unborn child until

	Hospital-based Physician services (including Physician-performed technical and interpretive components) Physician and professional services for mastectomy and breast reconstruction include: - all stages of reconstruction on the affected breast; - surgery and reconstruction on the other breast to produces symmetrical appearance; and - treatment of physical complications from the mastectomy and treatment of lymphedemas. In-network and out-of-network Physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section. Physician services medically necessary to support a dentist providing dental services to a CHIP member such as general anesthesia or intravenous (IV) sedation. Pre-surgical or post-surgical orthodontic services for medically necessary treatment of craniofacial anomalies requiring surgical intervention and delivered as part of a proposed and clearly outlined treatment plan to treat: cleft lip and/or palate; or severe traumatic skeletal and/or congenital craniofacial deviations; or severe facial asymmetry secondary to skeletal defects, congenital syndromal conditions and/or tumor growth or its treatment.	birth. o Administration of anesthesia by Physician (other than surgeon) or CRNA o Invasive diagnostic procedures directly related to the labor-with delivery of the unborn child. Hospital-based Physician services (including Physician performed technical and interpretive components) Professional component of the ultrasound of the pregnant uterus when medically indicated for suspected genetic defects, high-risk pregnancy, fetal growth retardation, or gestational age confirmation. Professional component of Amniocentesis, Cordocentesis, Fetal Intrauterine Transfusion (FIUT) and Ultrasonic Guidance for Amniocentesis, Cordocentrsis, and FIUT. Professional component associated with (a) miscarriage or (b) a non-viable pregnancy (molar pregnancy, ectopic pregnancy, or a fetus that expired in utero) are a covered benefit. Inpatient services associated with miscarriage or non-viable pregnancy include, but are not limited to: dilation and curettage (D&C) procedures; appropriate provider-administered medications; ultrasounds, and histological examination of tissue samples
Prenatal Care and Pre-Pregnancy Family Services and Supplies	Not a covered benefit.	Services are limited to an initial visit and subsequent prenatal (ante partum) care visits that include: (1) One visit every four weeks for the first 28 weeks or pregnancy; (2) one visit every two to three weeks from 28 to 36 weeks of pregnancy; and (3) one visit per week from 36 weeks to delivery. More frequent visits are allowed as Medically Necessary. Benefits are limited to: Limit of 20 prenatal visits and 2 postpartum visits (maximum within 60 days) without documentation of a complication of pregnancy. More frequent visits may be necessary for high-risk pregnancies. High-risk prenatal visits are not limited to 20 visits per pregnancy. Documentation supporting medical necessity must be maintained in the physician's files and is subject to retrospective review. Visits after the initial visit must include: interim history (problems, marital status, fetal status); physical examination (weight, blood pressure, fundalheight, fetal position and size, fetal heart rate, extremities) and laboratory tests (urinanalysis for protein and glucose every visit; hematocrit or hemoglobin repeated once a trimester and at 32-36 weeks of pregnancy; multiple marker screen for fetal abnormalities offered at 16-20 weeks of pregnancy; repeat antibody screen for Rh negative women at 28 weeks followed by Rho immune globulin administration if indicated; screen for gestational diabetes at 24-28 weeks of pregnancy; and other lab tests as indicated by medical condition of client).
Durable Medical Equipment (DME), Prosthetic Devices and Disposable Medical Supplies	$20,000 12-month period limit for DME, prosthetics, devices and disposable medical supplies (diabetic supplies and equipment are not counted against this cap). Services include DME (equipment which can withstand repeated use and is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of Illness, Injury, or Disability, and is appropriate for use in the home), including devices and supplies that are medically necessary and necessary for one or more activities of daily living and appropriate to assist in the treatment of a medical condition, including: Orthotic braces and orthotics Dental devices Prosthetic devices such as artificial eyes, limbs, braces and external breast prostheses Prosthetic eyeglasses and contact lenses for the management of severe ophthalmologic disease Hearing aids Diagnosis-specific disposable medical supplies, including diagnosis-specific prescribed specialty formula and dietary supplements. (See Attachment A)	Not a covered benefit.
Home and Community Health Services	Services that are provided in the home and community, including, but not limited to: Home infusion Respiratory therapy Visits for private duty nursing (R.N., L.V.N.) Skilled nursing visits as defined for home health purposes (may include R.N. or L.V.N.). Home health aide when included as part of a plan of care during a period that skilled visits have been approved. Speech, physical and occupational therapies. Services are not intended to replace the CHILD'S caretaker or to provide relief for the caretaker Skilled nursing visits are provided on intermittent level and not intended to provide 24-hour skilled nursing services Services are not intended to replace 24-hour inpatient or skilled nursing facility services	Not a covered benefit.
Inpatient Mental Health Services	Mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities, including, but not limited to: Neuropsychological and psychological testing. When inpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination Does not require PCP referral	Not a covered benefit.
Outpatient Mental Health Services	Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: Medication management visits do not count against the outpatient visit limit.	

	The visits can be furnished in a variety of community-based settings (including school and home-based) or in a state-operated facility Neuropsychological and psychological testing Medication management Rehabilitative day treatments Residential treatment services Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) Skills training (psycho-educational skill development) When outpatient psychiatric services are ordered by a court of competent jurisdiction under the provisions of Chapters 573 and 574 of the Texas Health and Safety Code, relating to court ordered commitments to psychiatric facilities, the court order serves as binding determination of medical necessity. Any modification or termination of services must be presented to the court with jurisdiction over the matter for determination A Qualified Mental Health Provider – Community Services (QMHP-CS), is defined by the Texas Department of State Health Services (DSHS) in Title 25 T.A.C., Part I, Chapter 412, Subchapter G, Division 1, §412.303(48). QMHP-CSs shall be providers working through a DSHS-contracted Local Mental Health Authority or a separate DSHS-contracted entity. QMHP-CSs shall be supervised by a licensed mental health professional or physician and provide services in accordance with DSHS standards. Those services include individual and group skills training (which can be components of interventions such as day treatment and in-home services), patient and does not require PCP referral	

Not a covered benefit.

Inpatient Substance Abuse Treatment Services	Services include, but are not limited to: Inpatient and residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs Does not require PCP referral	Not a covered benefit.
Outpatient Substance Abuse Treatment Services	Services include, but are not limited to, the following: Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. Intensive outpatient services Partial hospitalization Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day Outpatient treatment service is defined as consisting of at least one to two hours per week providing structured group and individual therapy, educational services, and life skills training Does not require PCP referral	Not a covered benefit.
Rehabilitation Services	Services include, but are not limited to, the following: Habilitation (the process of supplying a child with the means to reach age-appropriate developmental milestones through therapy or treatment) and rehabilitation services include, but are not limited to the following: Physical, occupational and speech therapy Developmental assessment	Not a covered benefit.
Hospice Care Services	Services include, but are not limited to: Palliative care, including medical and support services, for those children who have six months or less to live, to keep patients comfortable during the last weeks and months before death Treatment services, including treatment related to the terminal illness Up to a maximum of 120 days with a 6 month life expectancy Patients electing hospice services may cancel this election at anytime Services apply to the hospice diagnosis	Not a covered benefit.
Emergency Services, including Emergency Hospitals, Physicians, and Ambulance Services	HMO cannot require authorization as a condition for payment for emergency conditions labor and delivery. Covered services include, but are not limited to, the following: Emergency services based on prudent lay person definition of emergency health condition Hospital emergency department room and ancillary services and physician services 24 hours a day, 7 days a week, both by in-network and out-of-network providers Medical screening examination Stabilization services Access to DSHS designated Level 1 and Level II trauma centers or hospitals meeting equivalent levels of care for emergency services Emergency ground, air and water transportation Emergency dental services, limited to fractured or dislocated jaw, traumatic damage to teeth, and removal of cysts.	HMO cannot require authorization as a condition for payment for emergency conditions related to labor with delivery. Covered services are limited to those emergency services that are directly related to the delivery of the unborn child until birth. Emergency services based on prudent lay person definition of emergency health condition Medical screening examination to determine emergency when directly related to the delivery of the covered unborn child. Stabilization services related to the labor with delivery of the covered unborn child. Emergency ground, air and water transportation for labor and threatened labor is a covered benefit Benefit limits: Post-delivery services or complications resulting in the need for emergency services for the mother of the CHIP Perinate are not a covered benefit.
Transplants	Services include, but are not limited to, the following: Using up-to-date FDA guidelines, all non-experimental human organ and tissue transplants and all forms of non-experimental corneal, bone marrow and peripheral stem cell transplants, including donor medical expenses.	Not a covered benefit.
Vision Benefit	The health plan may reasonably limit the cost of the frames/lenses. Services include:	Not a covered benefit.

	One examination of the eyes to determine the need for and prescription for corrective lenses per 12-month period, without authorization One pair of non-prosthetic eyewear per 12-month period	
Chiropractic Services	Services do not require physician prescription and are limited to spinal subluxation.	Not a covered benefit.
Tobacco Cessation Program	Covered up to $100 for a 12- month period limit for a plan- approved program Health Plan defines plan-approved program. May be subject to formulary requirements.	Not a covered benefit.
Case Management and Care Coordination Services	These services include outreach informing, case management, care coordination and community referral.	Covered benefit.
Value-added services	*See Attachment B-3.2*	

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATES

For CHIP Perinates in families with incomes at or below 185% of the Federal Poverty Level, inpatient facility charges are not a covered benefit if associated with the initial Perinatal Newborn admission. "Initial Perinatal Newborn admission" means the hospitalization associated with the birth.
Inpatient and outpatient treatments other than prenatal care, labor with delivery, and postpartum care related to (a) miscarriage and (b) a non-viable pregnancy, and postpartum care related to the covered unborn child until birth.
Inpatient mental health services.
Outpatient mental health services.
Durable medical equipment or other medically related remedial devices.
Disposable medical supplies.
Home and community-based health care services.
Nursing care services.
Dental services.
Inpatient substance abuse treatment services and residential substance abuse treatment services.
Outpatient substance abuse treatment services.
Physical therapy, occupational therapy, and services for individuals with speech, hearing, and language disorders.
Hospice care.
Skilled nursing facility and rehabilitation hospital services.
Emergency services other than those directly related to the labor with delivery of the covered unborn child.
Transplant services.
Tobacco Cessation Programs.
Chiropractic Services.
Medical transportation not directly related to the labor or threatened labor and/or delivery of the covered unborn child.
Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment related to labor with delivery or post partum care.
Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
Coverage while traveling outside of the United States and U.S. Terriotries (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).
Mechanical organ replacement devices including, but not limited to artificial heart
Hospital services and supplies when confinement is solely for diagnostic testing purposes and not a part of labor with delivery
Prostate and mammography screening
Elective surgery to correct vision
Gastric procedures for weight loss
Cosmetic surgery/services solely for cosmetic purposes
Out-of-network services not authorized by the Health Plan except for emergency care related to the labor with delivery of the covered unborn child.
Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity
Acupuncture services, naturopathy and hypnotherapy
Immunizations solely for foreign travel
Routine foot care such as hygienic care
Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
Corrective orthopedic shoes
Convenience items
Orthotics primarily used for athletic or recreational purposes
Custodial care (care that assists with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually self-administered or provided by a caregiver. This care does not require the continuing attention of trained medical or paramedical personnel.)
Housekeeping
Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
Services or supplies received from a nurse, which do not require the skill and training of a nurse
Vision training, vision therapy, or vision services
Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered
Donor non-medical expenses
Charges incurred as a donor of an organ

CHIP PERINATAL PROGRAM EXCLUSIONS FROM COVERED SERVICES FOR CHIP PERINATE NEWBORNS

All the following exclusions match those found in the CHIP Program.

Inpatient and outpatient infertility treatments or reproductive services other than prenatal care, labor and delivery, and care related to disease, illnesses, or abnormalities related to the reproductive system
Personal comfort items including but not limited to personal care kits provided on inpatient admission, telephone, television, newborn infant photographs, meals for guests of patient, and other articles which are not required for the specific treatment of sickness or injury
Experimental and/or investigational medical, surgical or other health care procedures or services which are not generally employed or recognized within the medical community
Treatment or evaluations required by third parties including, but not limited to, those for schools, employment, flight clearance, camps, insurance or court
Private duty nursing services when performed on an inpatient basis or in a skilled nursing facility.
Coverage while traveling outside of the United States and U.S. Terriotries (including Puerto Rico, U.S. Virgin Islands, Commonwealth of Northern Mariana Islands, Guam, and American Samoa).
Mechanical organ replacement devices including, but not limited to artificial heart
Hospital services and supplies when confinement is solely for diagnostic testing purposes, unless otherwise pre-authorized by Health Plan
Prostate and mammography screening
Elective surgery to correct vision
Gastric procedures for weight loss
Cosmetic surgery/services solely for cosmetic purposes
Dental Devices solely for cosmetic purposes
Out-of-network services not authorized by the Health Plan except for emergency care and physician services for a mother and her newborn(s) for a minimum of 48 hours following an uncomplicated vaginal delivery and 96 hours following an uncomplicated delivery by caesarian section
Services, supplies, meal replacements or supplements provided for weight control or the treatment of obesity, except for the services associated with the treatment for morbid obesity as part of a treatment plan approved by the Health Plan
Acupuncture services, naturopathy and hypnotherapy
Immunizations solely for foreign travel
Routine foot care such as hygienic care
Diagnosis and treatment of weak, strained, or flat feet and the cutting or removal of corns, calluses and toenails (this does not apply to the removal of nail roots or surgical treatment of conditions underlying corns, calluses or ingrown toenails)
Replacement or repair of prosthetic devices and durable medical equipment due to misuse, abuse or loss when confirmed by the Member or the vendor
Corrective orthopedic shoes
Convenience items
Orthotics primarily used for athletic or recreational purposes
Custodial care (care that assists a child with the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, toileting, special diet preparation, and medication supervision that is usually

self-administered or provided by a parent. This care does not require the continuing attention of trained medical or paramedical personnel.) This exclusion does not apply to hospice services.
Housekeeping
Public facility services and care for conditions that federal, state, or local law requires be provided in a public facility or care provided while in the custody of legal authorities
Services or supplies received from a nurse, which do not require the skill and training of a nurse
Vision training and vision therapy
Reimbursement for school-based physical therapy, occupational therapy, or speech therapy services are not covered except when ordered by a Physician/PCP
Donor non-medical expenses
Charges incurred as a donor of an organ when the recipient is not covered under this health plan

CHIP & CHIP PERINATAL PROGRAM DME/SUPPLIES

Note: DME/SUPPLIES are not a covered benefit for CHIP Perinate Members but are a benefit for CHIP Perinate Newborns.

SUPPLIES	COVERED	EXCLUDED	COMMENTS/MEMBER CONTRACT PROVISIONS
Ace Bandages		X	Exception: If provided by and billed through the clinic or home care agency it is covered as an incidental supply.
Alcohol, rubbing		X	Over-the-counter supply.
Alcohol, swabs (diabetic)	X		Over-the-counter supply not covered, unless RX provided at time of dispensing.
Alcohol, swabs	X		Covered only when received with IV therapy or central line kits/supplies.
Ana Kit Epinephrine	X		A self-injection kit used by patients highly allergic to bee stings.
Arm Sling	X		Dispensed as part of office visit.
Attends (Diapers)	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan.
Bandages		X	
Basal Thermometer		X	Over-the-counter supply.
Batteries – initial	X	.	For covered DME items
Batteries – replacement	X		For covered DME when replacement is necessary due to normal use.
Betadine		X	See IV therapy supplies.
Books		X	
Clinitest	X		For monitoring of diabetes.
Colostomy Bags			See Ostomy Supplies.
Communication Devices		X	
Contraceptive Jelly		X	Over-the-counter supply. Contraceptives are not covered under the plan.
Cranial Head Mold		X	
Dental Devices	X		Coverage limited to dental devices used for treatment of craniofacial anomalies requiring surgical intervention.
Diabetic Supplies	X		Monitor calibrating solution, insulin syringes, needles, lancets, lancet device, and glucose strips.
Diapers/Incontinent Briefs/Chux	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Diaphragm		X	Contraceptives are not covered under the plan.
Diastix	X		For monitoring diabetes.
Diet, Special		X	
Distilled Water		X	
Dressing Supplies/Central Line	X		Syringes, needles, Tegaderm, alcohol swabs, Betadine swabs or ointment, tape. Many times these items are dispensed in a kit when includes all necessary items for one dressing site change.
Dressing Supplies/Decubitus	X		Eligible for coverage only if receiving covered home care for wound care.
Dressing Supplies/Peripheral IV Therapy	X		Eligible for coverage only if receiving home IV therapy.
Dressing Supplies/Other		X	
Dust Mask		X	
Ear Molds	X		Custom made, post inner or middle ear surgery
Electrodes	X		Eligible for coverage when used with a covered DME.
Enema Supplies		X	Over-the-counter supply.
Enteral Nutrition Supplies	X		Necessary supplies (e.g., bags, tubing, connectors, catheters, etc.) are eligible for coverage. Enteral nutrition products are not covered except for those prescribed for hereditary metabolic disorders, a non-function or disease of the structures that normally permit food to reach the small bowel, or malabsorption due to disease
Eye Patches	X		Covered for patients with amblyopia.
Formula		X	Exception: Eligible for coverage only for chronic hereditary metabolic disorders a non-function or disease of the structures that normally permit food to reach the small bowel; or malabsorption due to disease (expected to last longer than 60 days when prescribed by the physician and authorized by plan.) Physician documentation to justify prescription of formula must include: • Identification of a metabolic disorder, dysphagia that results in a medical need for a liquid diet, presence of a gastrostomy, or disease resulting in malabsorption that requires a medically necessary nutritional product Does not include formula: • For members who could be sustained on an age-appropriate diet. • Traditionally used for infant feeding • In pudding form (except for clients with documented oropharyngeal motor dysfunction who receive greater than 50 percent of their daily caloric intake from this product) • For the primary diagnosis of failure to thrive, failure to gain weight, or lack of growth or for infants less than twelve months of age unless medical necessity is documented and other criteria, listed above, are met. Food thickeners, baby food, or other regular grocery products that can be blenderized and used with an enteral system that are *not* medically necessary, are not covered, regardless of whether these regular food products are taken orally or parenterally.
Gloves		X	Exception: Central line dressings or wound care provided by home care agency.
Hydrogen Peroxide		X	Over-the-counter supply.
Hygiene Items		X	
Incontinent Pads	X		Coverage limited to children age 4 or over only when prescribed by a physician and used to provide care for a covered diagnosis as outlined in a treatment care plan
Insulin Pump (External) Supplies	X		Supplies (e.g., infusion sets, syringe reservoir and dressing, etc.) are eligible for coverage if the pump is a covered item.
Irrigation Sets, Wound Care	X		Eligible for coverage when used during covered home care for wound care.
Irrigation Sets, Urinary	X		Eligible for coverage for individual with an indwelling urinary catheter.
IV Therapy Supplies	X		Tubing, filter, cassettes, IV pole, alcohol swabs, needles, syringes and any other related supplies necessary for home IV therapy.
K-Y Jelly		X	Over-the-counter supply.
Lancet Device	X		Limited to one device only.
Lancets	X		Eligible for individuals with diabetes.
Med Ejector	X		
Needles and Syringes/Diabetic			See Diabetic Supplies
Needles and Syringes/IV and Central Line			See IV Therapy and Dressing Supplies/Central Line.
Needles and Syringes/Other	X		Eligible for coverage if a covered IM or SubQ medication is being administered at home.
Normal Saline			See Saline, Normal
Novopen	X		

Ostomy Supplies	X		Items eligible for coverage include: belt, pouch, bags, wafer, face plate, insert, barrier, filter, gasket, plug, irrigation kit/sleeve, tape, skin prep, adhesives, drain sets, adhesive remover, and pouch deodorant. Items not eligible for coverage include: scissors, room deodorants, cleaners, rubber gloves, gauze, pouch covers, soaps, and lotions.
Parenteral Nutrition/Supplies	X		Necessary supplies (e.g., tubing, filters, connectors, etc.) are eligible for coverage when the Health Plan has authorized the parenteral nutrition.
Saline, Normal	X		Eligible for coverage: a) when used to dilute medications for nebulizer treatments; b) as part of covered home care for wound care; c) for indwelling urinary catheter irrigation.
Stump Sleeve	X		
Stump Socks	X		
Suction Catheters	X		
Syringes			See Needles/Syringes.
Tape			See Dressing Supplies, Ostomy Supplies, IV Therapy Supplies.
Tracheostomy Supplies	X		Cannulas, Tubes, Ties, Holders, Cleaning Kits, etc. are eligible for coverage.
Under Pads			See Diapers/Incontinent Briefs/Chux.
Unna Boot	X		Eligible for coverage when part of wound care in the home setting. Incidental charge when applied during office visit.
Urinary, External Catheter & Supplies		X	Exception: Covered when used by incontinent male where injury to the urethra prohibits use of an indwelling catheter ordered by the PCP and approved by the plan
Urinary, Indwelling Catheter & Supplies	X		Cover catheter, drainage bag with tubing, insertion tray, irrigation set and normal saline if needed.
Urinary, Intermittent	X		Cover supplies needed for intermittent or straight catherization.
Urine Test Kit	X		When determined to be medically necessary.
Urostomy supplies			See Ostomy Supplies.

Subject: Attachment B-3 - STAR Value-added Services

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version of Attachment B-3, Value-added Services.
Revision	1.1	June 30, 2006	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.2	September 1, 2006	Revised the Physical Health Value-added Services to include Home Visits to New Mothers. Revised the certification provision by changing the start date for the 12-month provision of services.
Revision	1.3	September 1, 2006	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.4	September 1, 2006	Contract amendment removed the separate signature requirement for Attachment B-3, Value-added Services. By signing the Contract and/or Contract Amendment, the HMO certifies that it will provide the Value-added Services from September 1, 2006 through August 31, 2007.
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.8	September 1, 2007	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2008.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.11	September 1, 2008	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2009.
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.13	September 1, 2009	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2010.
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.16	September 1, 2010	Revised Attachement B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2011.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.18	March 1, 2011	Revised Attachement B-3, Value-added Services, to reflect mid-year negotiated Value-added Services for FY 2011.
Revision	1.19	September 1, 2011	Revised Attachment B-3, Value-added Services, to add the Bexar, El Paso, Lubbock, Nueces, and Travis contiguous counties as a result of the Contiguous Counties Expansion and to reflect negotiated Value-added Services for FY 2012.
Revision	1.20	January 1, 2012	

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

ATTACHMENT B-3: VALUE-ADDED SERVICES
September 1, 2011 – August 31, 2012

HMO: Superior HealthPlan, Inc.

HMO PROGRAM: Medicaid

SERVICE AREA(S):Bexar, El Paso, Lubbock, Nueces, and Travis

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
NurseWise	Twenty-four hour nurse advice line	Available to all members by calling the Member Services toll-free number	NurseWIse, an affiliate of Centene Corporation
Transportation	HMO will offer alternative transportation to HMO members that have trouble accessing the State's Medical Transportation Program in a timely manner to ensure access to their provider appointments. In addition, HMO will provide transportation to non-medical services such as health education programs, nutrition classes, and birth preparation classes. HMO's member service staff will approve and coordinate the transportation service and the type of transportation provided.	Members in the Nueces Service Area. The Transportation Authority in this area will not agree to allow the plan to purchase bus vouchers or tokens. The bus tokens or other alternative transportation must be requested in advance of a provider visit and authorized by Superior’s Member Services Department.	Transit Authorities in applicable Service Area.
Dental Benefit	Basic dental benefits for pregnant Members age 21 and over. The following services, categorized by procedural code, are covered: Preventive D0120 Periodic oral evaluation D0140 Limited oral evaluation D0150 Comprehensive oral evaluation (initial) D0170 Re-evaluation limited, problem focused Radiographs D0220 Intraoral periapical first film D0230 Intraoral periapical each add'l film D0270 Bitewing single film D0272 Bitewings two film D0274 Bitewings four film D0330 Panoramic Cleanings D1110 Prophy-adult D1204 Topical application of fluoride (prophy not included) adult D1206 Fluoride varnish	Each Member is eligible to receive $250 in dental services per benefit year, from dentists who are contracted with Delta Dental Insurance Company. The Member must be pregnant at the time of receiving any dental service to be covered under this benefit.	Licensed dentists under contract with Delta Dental Insurance Company
Vision	Members can choose between an enhanced selection of prescription eyeglasses OR $100 towards the cost of any features or frames not covered under Medicaid. Members will be offered a selection of 50 standard-size frames at no cost to Member. Member will be	If Member opts for the $100 allowance, Members are responsible for any charges that exceed the $100 allowance. Disposable contact lenses are excluded from this $100 allowance. This Value-Added benefit is only allowed one time per benefit period (i.e. 24-months). OR	Total Vision Health Plan’s provider network which includes Optometrists and Opticians

	able to choose from three frame styles, each in a choice of three colors.	The enhanced choice of new prescription eyeglasses is available once per 24-month period. Coverage is for new frames and lenses and does not cover additional features such as tints and coating. Providers must prescribe new glasses in compliance with the following specifications: **Frames** • American-made, unless foreign-made frames are comparable in quality and are less expensive • Serviceable and able to meet statutory quality standards • Composed of new materials **Lenses** • Plastic or clear glass (if applicable) • Heat or chemically treated dress eyewear able to meet standards of the American Standard Prescription Requirements for first-quality glass lenses • Composed of new materials • A minimum kryptoc of 22 mm flat top lens or equivalent if bifocal • A minimum flat top 7/25 lens or equivalent if trifocal	
Sports Physicals	One annual physical exam that is required for participation in sporting events for enrolled Members. Member must be currently enrolled and attending school, and the exam must be provided by a Superior contracted provider.	One exam in each 12 month enrollment period	Superior contracted providers
Pre-programmed Cell Phones for High-Risk Pregnant Women	Superior will provide pre-programmed cell phones to pregnant women who have been identified as high-risk through its OB case management program. The cell phones may be used to contact the Member's OB, Superior, NurseWise and any other key representative of Member's choice at any time the Member has a concern she wishes to discuss over the telephone, including the appropriateness of seeking medical care in person.	Only one cell phone will be provided per high-risk pregnant Member (although lost phones will be replaced). The phone must be returned to Superior within 4 weeks of the Member's delivery of the baby.	Superior HealthPlan Case Management staff
Prenatal health and birthing classes	Classes will be provided by SHP staff or facilitated by SHP and offered in SHP offices and other locations convenient to Members throughout the Service Areas. The classes are led by a registered nurse with the assistance of a CONNECTIONS/Promotoras representative. They cover the basics of prenatal care, including nutrition; the risk of smoking and benefits of smoking cessation; the progress of a fetus through the pregnancy; the importance of regular follow-up with medical providers; common health issues that occur during pregnancy; and, a review of SHP StartSmart and CONNECTIONS programs (e.g., availability of pre-programmed cell phones for high-risk pregnant women without good telecommunication support).	None	Superior's CONNECTIONS staff
Home visits to New Mothers	Superior Social Work and/or CONNECTIONS staff will make home visits to any Member with a new baby. This visit provides for resource and education coordination as identified in the visit, and ensures Members and the new babies are keeping all post natal and newborn doctor visits. This benefit is available to all Superior Members who have delivered a baby.	Only that a member consent to the home visit.	Superior's CONNECTIONS and Social Work staff provide this service.
Gift Program for Pregnant Women	Infant Car Safety seat for members who attend at least one baby shower. Baby Showers will be held no less than monthly, in each of the El Paso and Nueces SDAs. Members will be allowed one care seat per pregnancy and must show their Superior ID card at the shower to qualify. Member must be pregnant and currently enrolled with Superior to be eligible for the infant car seat.	STAR Pregnant women in Nueces and El Paso SDA ONLY	MCA

Behavioral Health Value-added Services for Members Under 21

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Behavioral Health	Diversionary Services: These are services intended to provide support to Members at high risk for hospitalization or acute care readmission by helping them remain in the community setting, where they will be eligible to receive wraparound care, acute residential treatment, crisis stabilization services or other services that would help avoid unnecessary hospitalization.	These services must be authorized by Superior's Behavioral Health Subcontractor on a case-by-case basis.	It is anticipated that these services will be rendered by providers under contract with Superior's Behavioral Health Subcontractor.
Behavioral Health	Superior's Behavioral Health Subcontractor will authorize Behavioral Health practitioners in medical settings to provide health psychology interventions focused on the effective management of chronic medical conditions. These might include psycho-educational groups for chronic conditions, individual coaching for patients with chronic disease states, or skills training activities.	These services must be authorized by Superior's Behavioral Health Subcontractor. The authorization will be tied to medical necessity.	It is anticipated that these services will be rendered by Superior's behavioral health practitioners located in Superior's contracted Federally Qualified Health Centers.
Behavioral Health	Intensive Outpatient Treatment/Day Treatment (IOP)- Used as an alternative to or step down from more restrictive levels of care.	These services must be authorized by Superior's Behavioral Health Material Subcontractor. In addition, the service will be authorized for greater than one and one half hours, but less than five hours per day. Amount, duration, and scope are based on medical necessity.	It is anticipated that Superior's contracted Behavioral Health Providers in each Service Area will render this service.
Behavioral Health	Partial Hospitalization/Extended Day Treatment- An alternative to, or a step down from, inpatient care.	These services must be authorized by Superior's Behavioral Health Subcontractor. Services are authorized for a minimum of five hours, but for less than 24-hours per day. The amount, duration, and scope will be based on medical necessity.	It is anticipated that Superior's contracted Behavioral Health Providers in each Service Area will render this service.
Behavioral Health	Rehabilitation/skills training. These are services provided to pregnant and parenting substance abusers at MHMR centers or in other treatment settings, focusing both on substance abuse and parenting issues. An augmentation of standard substance abuse treatment to focus on the special needs of this population. This benefit is available to all Members. It is geared to pregnant women and parenting Members.	These services must be authorized by Superior's Behavioral Health Subcontractor. In addition, the service will be authorized for15-minute increments. The amount, duration, and scope are based on medical necessity.	It is anticipated that Superior's contracted MHMR providers specializing in Rehabilitation/Skills training in each Service Area will render this service.

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Behavioral Health	Diversionary Services: These are services		It is anticipated that these services will be

	intended to provide support to Members at high risk for hospitalization or acute care readmission by helping them remain in the community setting, where they will be eligible to receive wraparound care, acute residential treatment, crisis stabilization services or other services that would help avoid unnecessary hospitalization.	These services must be authorized by Superior's Behavioral Health Subcontractor on a case-by-case basis.	rendered by providers under contract with Superior's Behavioral Health Subcontractor.
Behavioral Health	Superior's Behavioral Health Subcontractor, will authorize Behavioral Health practitioners in medical settings to provide health psychology interventions focused on the effective management of chronic medical conditions. These might include psycho-educational groups for chronic conditions, individual coaching for patients with chronic disease states, or skills training activities.	These services must be authorized by Superior's Behavioral Health Subcontractor. The authorization will be tied to medical necessity.	It is anticipated that these services will be rendered by Superior's behavioral health practitioners located in Superior's contracted Federally Qualified Health Centers.
Behavioral Health	Intensive Outpatient Treatment/Day Treatment (IOP)- Used as an alternative to or step down from more restrictive levels of care.	These services must be authorized by Superior's Behavioral Health Subcontractor. In addition, the service will be authorized for greater than one and one half hours, but less than five hours per day. Amount, duration, and scope are based on medical necessity.	It is anticipated that Superior's contracted Behavioral Health Providers in each Service Area will render this service.
Behavioral Health	Partial Hospitalization/Extended Day Treatment- An alternative to, or a step down from, inpatient care.	These services must be authorized by Superior's Behavioral Health Subcontractor. Services are authorized for a minimum of five hours, but for less than 24-hours per day. The amount, duration, and scope will be based on medical necessity.	It is anticipated that Superior's contracted Behavioral Health Providers in each Service Area will render this service.
Behavioral Health	Rehabilitation/skills training. These are services provided to pregnant and parenting substance abusers at MHMR centers or in other treatment settings, focusing both on substance abuse and parenting issues. An augmentation of standard substance abuse treatment to focus on the special needs of this population. This benefit is available to all Members. It is geared to pregnant women and parenting Members.	These services must be authorized by Superior's Behavioral Health Subcontractor. In addition, the service will be authorized for15-minute increments. The amount, duration, and scope are based on medical necessity.	It is anticipated that Superior's contracted MHMR providers specializing in Rehabilitation/Skills training in each Service Area will render this service.

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

Value Added Services information will be included in the Superior Provider Manual and also during training sessions. Members will receive this information via the Plan Comparison Chart, in the Member Handbook, with New Member Packets, Connections/Promotoras and during orientations. Periodically, Superior will also highlight Value Added Services in the Provider and Member Newsletters.

Members in the Nueces and El Paso SDAs will be made aware of this benefit, in addition to the mediums listed above, also through Member Advisory Committees, OB Case Management Program materials and staff, Plan-sponsored baby showers, OB START SMART Pregnancy Program and Materials, Plan-sponsored health events, or other HHSC-approved/sponsored events in which Superior participates. In addition, Providers will be informed about this VAS through email communications, and face to face orientations and visits with providers.

2. Describe how a Member may obtain or access the value-added services to be provided.

See explanations provided above for accessing services.

A Member may access the Home Visits to New Mothers service by accepting a home visit appointment from a Superior Social Work or CONNECTIONS staff member.

With respect to the Transportation Value-added Service, "alternative transportation" refers to taxi cab services, which will be pre-authorized on a case-by-case basis for Members with respect to whom bus service is not accessible or convenient or where the particular health condition of the Member makes taxi cab services a medically preferable alternative to waiting for and riding a bus to a medical appointment.

The Member can visit any Superior network provider to receive the sports physical. The Member must be enrolled with Superior at the time of the exam, and the provider must bill the appropriate code for reimbursement.

With respect to the Car Safety seat, the Member will be able to receive the seat immediately following attendance at one of Superior's Start Smart baby shower education classes. Member must show ID and Superior membership card to receive this benefit.

3. Describe how the HMO will identify the Value-added Service in administrative (encounter) data.

Superior will track the value added services through our claims system for those value-adds for which HIPAA-compliant procedural codes are available (vision, dental, behavioral health). Superior will create a specific benefit category to track and report the value added services 'separately' from our 'capitated' service data. In addition, Superior will have the ability to pass this information to the State utilizing the encounter submission process, as long as the State is able to segregate the value adds data from the capitated services data.

For transportation services, Superior will maintain an electronic file of transportation services provided for Superior's membership.

Sports physicals will be included with encounter data and identified with the applicable procedural code.

Home visits to new mothers are tracked through Superior's case management system. Each staff member logs each member visit and the outcome/findings of the visit in Superior's computer system. Superior will work with HHSC to establish the most efficient transmission of the data.

Distribution of pre-programmed cell phones will be tracked via the OB Case Management Team

Attendance at prenatal classes will be tracked via Connections/Promotoras staff.

The Diversionary Behavioral Health Services will be identified by Rev 900, CPT 90899, and HCPC code H2021/H2022.

4. By signing the Contract and/or Contract Amendment HMO certifies that it will provide the approved Value-added Services described herein from September 1, 2010 through August 31, 2011.

Subject: Attachment B-3 - CHIP Value-added Services

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version of Attachment B-3, Value-added Services.
Revision	1.1	June 30, 2006	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.2	September 1. 2006	Revised Physical Health Value-added Services to include Home Visits to New Mothers. Revised the certification provision by changing the start date for the 12-month provision of services.
Revision	1.3	September 1, 2006	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.4	September 1, 2006	Contract amendment removed the separate signature requirement for Attachment B-3, Value-added Services. By signing the Contract and/or Contract Amendment, the HMO certifies that it will provide the Value-added Services from September 1, 2006 through August 31, 2007.
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.8	September 1, 2007	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2008.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.11	September 1, 2008	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2009.
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.13	September 1, 2009	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2010.
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.16	September 1, 2010	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2011.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.18	March 1, 2011	Contract amendment did not revise Attachment B-3, Value-added Services.
Revision	1.19	September 1, 2011	Revised Attachment B-3, Value-added Services, to reflect newly negotiated Value-added Services for FY 2011.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment B-3, Value-added Services.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

ATTACHMENT B-3: VALUE-ADDED SERVICES
September 1, 2011 – August 31, 2012

HMO: Superior HealthPlan, Inc.

HMO PROGRAM: CHIP

SERVICE AREA(S):Bexar, El Paso, Lubbock, Nueces, and Travis

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
NurseWise	Twenty-four hour nurse advice line	Available to all members by calling the Member Services toll-free number	NurseWise, an affiliate of Centene Corporation
Transportation	For Members in need of transportation that cannot access transportation in a timely manner, Superior will provide alternative transportation to ensure that Members have a means of accessing their provider appointment.	Members in the Nueces Service Area. The Transportation Authority in this area will not agree to allow the plan to purchase bus vouchers or tokens. The bus tokens or other alternative transportation must be requested in advance of a provider visit and authorized by Superior’s Member Services Department.	Transit Authorities in applicable Service Area.
Vision	20% discount off of Upgraded Hardware- The Member will receive a 20% discount on upgraded hardware.	There is no limitation on the number of times the discount can be utilized.	TVHP contracted providers.
Sports Physicals	One annual physical exam that is required for participation in sporting events for enrolled Members. Member must be currently enrolled and attending school, and the exam must be provided by a Superior contracted provider.	One exam in each 12 month CHIP enrollment period	Superior contracted providers
Pre-programmed Cell Phones for High-Risk Pregnant Women	Superior will provide pre-programmed cell phones to pregnant women who have been identified as high-risk through its OB case management program. The cell phones may be used to contact the Member’s OB, Superior, NurseWise and any other key representative of Member’s choice at any time the Member has a concern she wishes to discuss over the telephone, including the appropriateness of seeking medical care in person.	Only one cell phone will be provided per high-risk pregnant Member (although lost phones will be replaced). The phone must be returned to Superior within 4 weeks of the Member’s delivery of the baby.	Superior HealthPlan Case Management staff.
Prenatal health and birthing classes	Classes will be provided by SHP staff or facilitated by SHP and offered in SHP offices and other locations convenient to Members throughout the Service Areas. The classes are led by a registered nurse with the assistance of a CONNECTIONS/Promotoras representative. They cover the basics of prenatal care, including nutrition; the risk of smoking and benefits of smoking cessation; the progress of a fetus through	None	Superior's CONNECTIONS staff

	the pregnancy; the importance of regular follow-up with medical providers; common health issues that occur during pregnancy; and, a review of SHP StartSmart and CONNECTIONS programs (e.g., availability of pre-programmed cell phones for high-risk pregnant women without good telecommunication support).		
Home visits to New Mothers	Superior Social Work and/or CONNECTIONS staff will make home visits to any Member with a new baby. This visit provides for resource and education coordination as identified in the visit, and ensures Members and the new babies are keeping all post natal and newborn doctor visits. This benefit is available to all Superior Members who have delivered a baby.	Only that a Member consent to the home visit.	Superior's CONNECTIONS and Social Work staff
Gift Program for Pregnant Women	Infant Car Safety seat for members who attend at least one baby shower. Baby Showers will be held no less than monthly, in each of the El Paso and Nueces SDAs. Members will be allowed one car seat per pregnancy and must show their Superior ID card at the shower to qualify. Member must be pregnant and currently enrolled with Superior to be eligible for the infant car seat.	CHIP Pregnant women in Nueces, Bexar and El Paso SDA ONLY	MCA

Behavioral Health Value-added Services for Members Birth Through Age 20

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

Value Added Services information will be included in the Superior Provider Manual and also during training sessions. Members will receive this information via the Plan Comparison Chart, in the Member Handbook, with New Member Packets and during orientations. Periodically, Superior will also highlight Value Added Services in the Provider and Member Newsletters.

2. Describe how a Member may obtain or access the value-added services to be provided.

See explanations provided above for accessing services.

With respect to the Transportation Value-added Service, “alternative transportation” refers to taxi cab services, which will be pre-authorized on a case-by-case basis for members with respect to whom bus service is not accessible or convenient or where the particular health condition of the member makes taxi cab services a medically preferable alternative to waiting for and riding a bus to a medical appointment.
The Member can visit any Superior network provider to receive the sports physical. The Member must be enrolled with Superior at the time of the exam, and the provider must bill the appropriate code for reimbursement.

3. Describe how the HMO will identify the Value-added Service in administrative (encounter) data.

Superior will track the value added services through our claims system for those value-adds for which HIPAA-compliant procedural codes are available (such as vision). Superior will create a specific benefit category to track and report the value added services 'separately' from our 'capitated' service data. In addition, Superior will have the ability to pass this information to the State utilizing the encounter submission process, as long as the State is able to segregate the value adds data from the capitated services data.

Sports physicals will be included with encouter data and identified with the applicable procedural code.

For transportation services, Superior will maintain an electronic file of transportation services provided for Superior’s membership.

4. By signing the Contract and/or Contract Amendment HMO certifies that it will provide the approved Value-added Services described herein from September 1, 2010 through August 31, 2011.

Subject: Attachment B-3.1 - STAR+PLUS Value-added services

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0		Initial version of Attachment B-3, Value-added Services
Revision	1.1	June 30, 2006	Revised Attachment B-3, Value Added Services, by adding Attachment B-3.1, STAR+PLUS Value Added Services. This is the initial version of Attachment B-3.1, STAR+PLUS VAS.
Revision	1.2	September 1, 2006	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revision	1.3	September 1, 2006	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revision	1.4	September 1, 2006	Contract amendment removed the separate signature requirement for Attachment B-3.1, STAR+PLUS Value-added Services. By signing the Contract and/or Contract Amendment, the HMO certifies that it will provide the Value-added Services from January 1, 2007 through August 31, 2007.
Revision	1.5	January 1, 2007	Revised Attachment B-3.1, STAR+PLUS Value Added Services to state that only non-dual members are eligible for dental benefits and to clarify description of Out-of-Home Respite.
Revision	1.6	February 1, 2007	Revised Attachment B-3.1, STAR+PLUS Value Added Services, to clarify the coverage period for the VAS.
Revision	1.7	July 1, 2007	Revised Attachment B-3.1, STAR+PLUS Value Added Services, to clarify the coverage period for the VAS.
Revision	1.8	September 1, 2007	Revised Attachment B-3-1, STAR+PLUS Value-added Services, to reflect newly negotiated Value-added Services for FY 2008.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revision	1.10	March 1, 2008	Revised Attachment B-3-1, STAR+PLUS Value-added Services, to reflect mid year negotiated Value-added Services for FY 2008.
Revision	1.11	September 1, 2008	Revised Attachment B-3-1, STAR+PLUS Value-added Services, to reflect newly negotiated Value-added Services for FY 2009.
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revision	1.13	September 1, 2009	Revised Attachment B-3-1, STAR+PLUS Value-added Services, to reflect newly negotiated Value-added Services for FY 2010.
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revision	1.16	September 1, 2010	Revised Attachment B-3-1, STAR+PLUS Value-added Services, to reflect newly negotiated Value-added Services for FY 2011.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revision	1.18	March 1, 2011	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services
Revisions	1.19	September 1, 2011	Revised Attachment B-3-1, STAR+PLUS Value-added Services, to add the Bexar and Nueces contiguous counties as a result of the Contiguous Counties Expansion and to reflect negotiated Value-added Services for FY 2012.
Revisions	1.20	January 1, 2012	Contract amendment did not revise Attachment B-3.1, STAR+PLUS Value Added Services

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

ATTACHMENT B-3.1: STAR+PLUS VALUE-ADDED SERVICES
September 1, 2011 – August 31, 2012

HMO: Superior HealthPlan, Inc.

SERVICE AREA(S): Bexar & Nueces

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
NurseWise	Twenty-four hour nurse advice line	Available to all members by calling the Member Services toll-free number	NurseWise, an affiliate of Centene Corporation
Dental	Basic dental coverage. The following services, categorized by CPT code, are covered: Preventive D0120 Periodic oral evaluation D0140 Limited oral evaluation D0150 Comprehensive oral evaluation (initial) D0170 Re-evaluation limited, problem focused Radiographs D0220 Intraoral periapical first film D0230 Intraoral periapical each add'l film D0270 Bitewing single film D0272 Bitewings two film D0274 Bitewings four film D0330 Panoramic Cleanings D1110 Prophy-adult D1204 Topical application of fluoride (prophy not included) adult D1206 Fluoride varnish	Only non-dual Members aged 21 years and over are eligible for dental benefits. Each non-dual Member is eligible to receive $250 in dental services per benefit year, from dentists who are contracted with Delta Dental Insurance Company.	Licensed dentists under contract with Delta Dental Insurance Company
Vision	Members will be provided an enhanced choice of prescription eyeglasses. Members will be offered a selection of 50 standard-size frames at no cost to Member. The Member will be able to choose from three frame styles, each in a choice of three colors. The provider must include an all-metal frame in lieu of a colored frame.	Only non-dual Members aged 21 years and over are eligible for vision benefits. The enhanced choice of new prescription eyeglasses is available once per 24-month period. Coverage is for new frames and lenses and does not cover additional features such as tints and coating.	Total Vision Health Plan’s provider network which includes Optometrists and Opticians

		Providers must prescribe new glasses in compliance with the following specifications: **Frames** • American-made, unless foreign-made frames are comparable in quality and are less expensive • Serviceable and able to meet statutory quality standards • Composed of new materials **Lenses** • Plastic or clear glass (if applicable) • Heat or chemically treated dress eyewear able to meet standards of the American Standard Prescription Requirements for first-quality glass lenses • Composed of new materials • A minimum kryptoc of 22 mm flat top lens or equivalent if bifocal • A minimum flat top 7/25 lens or equivalent if trifocal	
Pre-programmed Cell Phones for High-Risk Pregnant Women	Superior will provide pre-programmed cell phones to pregnant women who have been identified as high-risk through its OB case management program. The cell phones may be used to contact the Member's OB, Superior, NurseWise and any other key representative of Member's choice at any time the Member has a concern she wishes to discuss over the telephone, including the appropriateness of seeking medical care in person	Only non-dual Members are eligible for the cell phone Only one cell phone will be provided per high-risk pregnant Member (although lost phones will be replaced). The phone must be returned to Superior within 4 weeks of the Member's delivery of the baby.	Superior HealthPlan Case Management staff
Prenatal health and birthing classes	Classes will be provided by SHP staff or facilitated by SHP and offered in SHP offices and other locations convenient to Members throughout the Service Areas. The classes are led by a registered nurse with the assistance of a CONNECTIONS/Promotoras representative. They cover the basics of prenatal care, including nutrition; the risk of smoking and benefits of smoking cessation; the progress of a fetus through the pregnancy; the importance of regular follow-up with medical providers; common health issues that occur during pregnancy; and, a review of SHP StartSmart and CONNECTIONS programs (e.g., availability of pre-programmed cell phones for high-risk pregnant women without good telecommunication support).	None.	Superior's CONNECTIONS staff
Nutritional Dietary Support	Members will have access to ten (10) home delivered prepared meals at the time of discharge planning resulting from an acute inpatient hospital stay or discharge from a Nursing facility back into the community setting.	Members must contact Service Coordination for authorization. Available only to non-STAR+PLUS Waiver (SPW) members only. Limited to 10 meals Per year.	Superior contracted Home Delivered Meals providers
Gift Program for Pregnant Members	Infant Car Safety seat for members who attend at least one baby shower. Baby Showers will be held no less than monthly, in Nueces SDA. Members will be allowed one car seat per pregnancy and must show their Superior ID card at the shower to qualify. Member must be pregnant and currently enrolled with Superior to be eligible for the infant car seat.	STAR+PLUS Pregnant women in Nueces SDA ONLY	MCA
Transportation	HMO will offer tokens or vouchers for alternative transportation to HMO members that have trouble accessing the State's Medical Transportation Program in a timely manner to ensure access to their provider appointments. HMO's Member Services staff will approve and coordinate the transportation service and the type of transportation provided.	Bus tokens or other alternative transportation must be requested in advance of a provider visit and authorized by Superior's Member Services Department.	Transit Authorities in applicable Service Area

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service
Behavioral Health	Health Psychology Interventions provided by a behavioral health practitioner in a medical setting that focuses on the effective management of chronic medical conditions. This might include psycho-educational groups for chronic conditions, individual coaching for patients with chronic disease states, or skills training activities.	Limited to non-dual Members only. Services must be authorized and is based on medical necessity.	Network Federally Qualified Health Centers (FQHCs)
Behavioral Health	Intensive Outpatient Treatment/Day Treatment (IOP)- Used as an alternative to step down from more restrictive levels of care.	Limited to non-dual Members only. Services must be authorized and is based on medical necessity. Services will be authorized for greater than one and one half hours, but less than five hours per day.	It is anticipated that behavioral health providers within the Service Area will render this service.
Behavioral Health	Partial Hospitalization/Extended Day Treatment- An alternative to, or a step down from, inpatient care.	Limited to non-dual Members only. Services must be authorized and is based on medical necessity. Services will be authorized for a minimum of five hours, but for less than 24-hours per day.	It is anticipated that behavioral health providers within the Service Area will render this service.
Behavioral Health	Diversionary Services: These are services intended to provide support to Members at high risk for hospitalization or acute care readmission by helping them remain in the community setting, where they will be eligible to receive wraparound care, acute residential treatment, crisis stabilization services or other services that would help avoid unnecessary hospitalization.	These services must be authorized by Superior's Behavioral Health Subcontractor on a case-by-case basis.	It is anticipated that behavioral health providers within the Service Area will render this service.

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

Value added services information will be included in the Superior Provider Manual and also during training sessions. Members will receive this information via the Plan Comparison Chart, in the Member Handbook, with New Member Packets, through Service Coordination and Member Services, and during orientations. Periodically, Superior will also highlight Value Added Services in the Provider and member Newsletters.

2. Describe how a Member may obtain or access the value-added services to be provided.

See explanations provided above for accessing services.

With respect to the Transportation Value-added Service, "alternative transportation" refers to taxi cab services, which will be pre-authorized on a case-by-case basis for Members with respect to whom bus service is not accessible or convenient or where the particular health condition of the Member makes taxi cab services a medically preferable alternative to waiting for and riding a bus to a medical appointment.

With respect to the Car Safety seat, the Member will be able to receive the seat immediately following attendance at one of Superior's Start Smart baby shower education classes. Member must show ID and Superior membership card to receive this benefit.

The purpose of the Diversionary BH Services for the STAR+PLUS population is flexibility to add services that meet individual needs. For example, the STAR+PLUS benefit package does not currently cover Residential Treatment Centers (RTCs). Under the Diversionary Services VAS benefit, IMHS would utilize RTC services with certain members based on identified need. In speaking of "Case Management," IMHS is referring to case management services that would be "on the ground," where someone would work with STAR+PLUS members to assist in getting them to appointments and other activities above and beyond the telephonic Case Management that IMHS already provides. Wraparound services that are not currently available through the STAR+PLUS benefit package and that would be covered under this VAS include skills training activities and crisis intervention activities.

Some of these services (such as the ACT (assertive community treatment) team) are at times available through the MHMR centers; however, they do not have sufficient access, and the HCPC code services IMHS proposes covering under this VAS are not in the current covered benefits. Many of IMHS's consumers are dual-diagnosed with chemical dependency issues and need additional support to avoid hospitalization. Peer supports are very effective for this population and are not currently a part of the covered benefits for STAR+PLUS.

3. Describe how the HMO will identify the Value-added Service in administrative (encounter) data.

Superior will track value added services through our claims system for those value-adds for which HIPAA-compliant procedural codes are available (podiatry, etc.). Superior will create specific benefit categories to track and report the value added services “separately” from our “capitated” service data. In addition, Superior will have the ability to pass this information to the State utilizing the encounter submission process, as long as the State is able to segregate the value adds data from the capitated services data.

For dental and vision services, Superior will receive a data file from the dental and vision vendors to capture all utilization of dental value added benefits.

Distribution of pre-programmed cell phones will be tracked via the Superior OB Case Management Team

Attendance at prenatal classes will be tracked via Superior’s Connections/Promotoras staff.

For transportation services, Superior will maintain an electronic file of transportation services provided for Superior’s membership.

The Diversionary Behavioral Health Services will be identified by Rev 900, CPT 90899, and HCPC code H2021/H2022.

4. By signing the Contract and/or Contract Amendment HMO certifies that it will provide the approved Value-added Services described herein from September 1, 2010– August 31, 2011.

Subject: Attachment B-3.2 CHIP Perinatal Program Value-added Services

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	1.0		Initial version of Attachment B-3, Value-added Services
Revision	1.1	June 30, 2006	Revised Attachment B-3, Value Added Services, by adding Attachment B-3.1, STAR+PLUS Value Added Services.
Revision	1.2	September 1, 2006	Contract amendment did not revise Attachment B-3, Value Added Services
Revision	1.3	September 1, 2006	Revised Attachment B-3, Value Added Services, by adding Attachment B-3.2, CHIP Perinatal Program Value Added Services. This is the initial version of Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.4	September 1, 2006	Contract amendment removed the separate signature requirement for Attachment B-3.2, CHIP Perinatal Program Value-added Services. By signing the Contract and/or Contract Amendment, the HMO certifies that it will provide the Value-added Services from January 1, 2007 through August 31, 2007.
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.8	September 1, 2007	Revised Attachment B-3.2, CHIP Perinatal Program Value-added Services, to reflect newly negotiated Value-added Services for FY 2008.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services
Revision	1.11	September 1, 2008	Revised Attachment B-3.2, CHIP Perinatal Program Value-added Services, to reflect newly negotiated Value-added Services for FY 2009.
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.13	September 1, 2009	Revised Attachment B-3.2, CHIP Perinatal Program Value-added Services, to reflect newly negotiated Value-added Services for FY 2010.
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.16	September 1, 2010	Revised Attachment B-3.2, CHIP Perinatal Program Value-added Services, to reflect newly negotiated Value-added Services for FY 2011.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.18	March 1, 2011	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.
Revision	1.19	September 1, 2011	Revised Attachment B-3.2, CHIP Perinatal Program Value-added Services, to reflect newly negotiated Value-added Services for FY 2012.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment B-3.2, CHIP Perinatal Program Value Added Services.

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

ATTACHMENT B-3.2: CHIP PERINATAL PROGRAM VALUE-ADDED SERVICES
September 1, 2011 – August 31, 2012

HMO: _____

SERVICE AREA(S): _____

Physical Health Value-added Services

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

Behavioral Health Value-added Services for Members Under 21

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

Behavioral Health Value-added Services for Members 21 and Over

Value-added Service	Description of Value-added Services and Members Eligible to Receive the Services	Limitations or Restrictions	Provider(s) responsible for providing this service

ADDITIONAL INFORMATION:

1. Explain how and when Providers and Members will be notified about the availability of the value-added services to be provided.

2. Describe how a Member may obtain or access the value-added services to be provided.

3. Describe how the HMO will identify the Value-added Service in administrative (encounter) data.

4. By signing the Contract and/or Contract Amendment HMO certifies that it will provide the approved Value-added Services described herein from September 1, 2010 through August 31, 2011.

Subject: Attachment B-4 - Performance Improvement Projects

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version Attachment B-4, Performance Improvement Goals.
Revision	1.1	June 30, 2006	Contract amendment to include STAR+PLUS Program. Revised Attachment B-4, Performance Improvement Goals Template, by adding Attachment B-4.1, FY2008 Performance Improvement Goals Template. No change to this Section.
Revision	1.2	September 1, 2006	Revised version of Attachment B-4 that includes provisions applicable to MCOs participating in the STAR and CHIP Programs. Updates the attachment to reflect the changes made in Attachment B-1, Section 8.1.1.1.
Revision	1.3	September 1, 2006	Contract amendment did not revise Attachment B-4, Performance Improvement Goals.
Revision	1.4	September 1, 2006	Contract amended to include Attachment B-4 Performance Improvement Goals for SFY2007 and format change
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-4, Performance Improvement Goals.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-4, Performance Improvement Goals.
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-4, Performance Improvement Goals.
Revision	1.8	September 1, 2007	Revised Attachment B-4, to replace FY2007 Performance Improvement Goals with newly negotiated FY2008 Performance Improvement Goals by Program and by Service Area. Attachment B-4.1, FY2008 Performance Improvement Goals Template, is deleted as duplicative.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-4, Performance Improvement Goals.
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-4, Performance Improvement Goals.
Revision	1.11	September 1, 2008	Revised Attachment B-4, to replace FY2008 Performance Improvement Goals with newly negotiated FY2009 Performance Improvement Goals by Program and by Service Area.
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-4, Performance Improvement Goals
Revision	1.13	September 1, 2009	Revised Attachment B-4, to replace FY2009 Performance Improvement Goals with newly negotiated FY2010 Performance Improvement Goals by Program and by Service Area. Attachment B-4 is modified to clarify the aplicability of Goals 1 and 2, updated Goal 3 for STAR, CHIP, and CHIP Perinatal, and add a Goal 3 for STAR+PLUS.
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-4, Performance Improvement Goals
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-4, Performance Improvement Goals
Revision	1.16	September 1, 2010	Revised Attachment B-4, to replace FY2010 Performance Improvement Goals with newly negotiated FY2011 Performance Improvement Goals by Program. Attachment B-4 is modified to remove Service Areas as a category for sub-goals; update Goal 1 for STAR, STAR+PLUS, CHIP, and CHIP Perinatal; update Goal 2 for STAR, STAR+PLUS, and CHIP; and remove Goal 3 for all programs.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-4, Performance Improvement Goals
Revision	1.18	March 1, 2011	Attachment B-4 is revised to change the name from "Performance Improvement Goals" to "Performance Improvement Projects" and to reflect negotiated Performance Improvement Projects for FY 2011.
Revision	1.19	September 1, 2011	Attachment B-4 is modified to reflect HHSC's two Overarching Goals for each Program and the negotiated third Overarching Goal for FY2012. The remainder of the template is deleted and the identification of the Performance Improvement Projects is moved to UMCM.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment B-4, Performance Improvement Projects

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

Additional information related to the Performance Improvement Projects can be found in **Attachment B-1, Section 8.1.1.1**, to the Contract

Texas Health and Human Services Commission
HMO Performance Improvement Project Template
for State Fiscal Year 2012
(September 1, 2011 – August 31, 2012)

A. Health Plan Information

Plan Name: Superior HealthPlan
HMO Program: CHIP

B. Overarching Goal

Goal 1:
Reduce emergency department utilization due to Ambulatory Care Sensitive Condition (ACSC) through improved treatment. (CHIP)

Goal 2:

Increase access or utilization of preventative care. (CHIP)

Goal 3:
Increase utilization of Disease Management programs.

Texas Health and Human Services Commission
HMO Performance Improvement Project Template
for State Fiscal Year 2012
(September 1, 2011 – August 31, 2012)

A. Health Plan Information

Plan Name: Superior HealthPlan
HMO Program: STAR

B. Overarching Goal

Goal 1:
Reduce emergency department utilization due to Ambulatory Care Sensitive Condition (ACSC) through improved treatment. (STAR)

Goal 2:
Improve access to specialty care. (STAR)

Goal 3:
Reduce NICU utilization through increased peripartum management.

Texas Health and Human Services Commission
HMO Performance Improvement Project Template
for State Fiscal Year 2012
(September 1, 2011 – August 31, 2012)

A. Health Plan Information

Plan Name: Superior HealthPlan
HMO Program: STAR+PLUS

B. Overarching Goal

Goal 1:
Improve member understanding and utilization of service coordination. (STAR+PLUS)

Goal 2:
Reduce Nursing Facility admission rates. (STAR+PLUS)

Goal 3:
Increase utilization of Disease Management programs.

Specific Performance Improvement Projects will be negotiated by HHSC and the HMO before the beginning of FY 2012.

Subject: Attachment B-5 - Deliverables/Liquidated Damages Matrix

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a		Initial version of Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.1	June 30, 2006	Contract amendment did not revise Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.2	September 1, 2006	Amended Attachment B-5, Deliverables/Liquidated Damages Matrix, to add a footnote clarifying the deliverable due dates. Also amended the provisions regarding Claims Processing Requirements and the Reporting Requirements for the Claims Summary Report.
Revision	1.3	September 1, 2006	Amended Attachment B-5, Deliverables/Liquidated Damages Matrix, performance standard for Provider Directories for the CHIP Perinatal Program.
Revision	1.4	September 1, 2006	Contract amendment did not revise Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.5	January 1, 2007	Contract amendment did not revise Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.7	July 1, 2007	Amended Attachment B-5, Deliverables/Liquidated Damages Matrix, to add clarifications to the provisions addressing Claims Processing Requirements and the Reporting Requirements for the Claims Summary Report.
Revision	1.8	September 1, 2007	Contract amendment did not revise Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.10	March 1, 2008	Amended Attachment B-5 to add or revise performance standards and liquidated damages regarding: Failure to Perform an Administrative Service; Failure to Provide a Covered Service; Behavioral Health Services Hotline; Member Services Hotline; and Provider Hotline.
Revision	1.11	September 1, 2008	Amended Attachment B-5 to revise performance standards regarding: Line 1 – Failure to Perform an Administrative Service and Line 2 – Failure to Provide a Covered Service; and to replace the MDS-HC instrument with the Community Medical Necessity and Level of Care Assessment Instrument in the Performance Standard for Line 21 – Contract Amendment B-1 RFP §8.3.3 – STAR+PLUS Assessment Instruments
Revision	1.12	March 1, 2009	Lines 8, 9, and 13 are modified to add a performance standard, measurement assessment, and damages for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time. Line 15 is modified to clarify reporting timeframes and requirements.
Revision	1.13	September 1, 2009	Line 16.5 Contract Attachment B-1 RFP §8.1.18.1 Encounter Data is added. Line 21 Performance Standard is amended to clarify type of waiver services.
Revision	1.14	December 1, 2009	Line 21 Service/Component is amended to clarify contract references and Performance Standard is modified to require that assessment instructions must be submitted within 45 days
Revision	1.15	March 1, 2010	Line 3 modified to conform to language in Attachment A, Sections 4.08(b)(3) and (4).
Revision	1.16	September 1, 2010	Item 3 is modified to conform to language in Attachment A, Sections 4.08(b)(3) and (4). Item 8 is added to add liquidated damages for Out-of-Network Utilization. Item 22 is added to add liquidated damages for timely HMO response to complaints. All subsequent items are renumbered.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-5, Deliverables/Liquidated Damage Matrix.
Revision	1.18	March 1, 2011	Item 11 modified to add liquidated damages for failing to submit timely HMO response to Provider complaints.
Revision	1.19	September 1, 2011	Item 11 modified to clarify liquidated damages for failing to submit timely HMO response to Provider complaints. Item 22 is modified to clarify liquidated damages for timely HMO response to complaints.
Revision	1.20	January 1, 2012	

[1] Status should be represented as "Baseline" for initial issuances, "Revision" for changes to the Baseline version, and "Cancellation" for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., "1.2" refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

Deliverables/Liquidated Damages Matrix

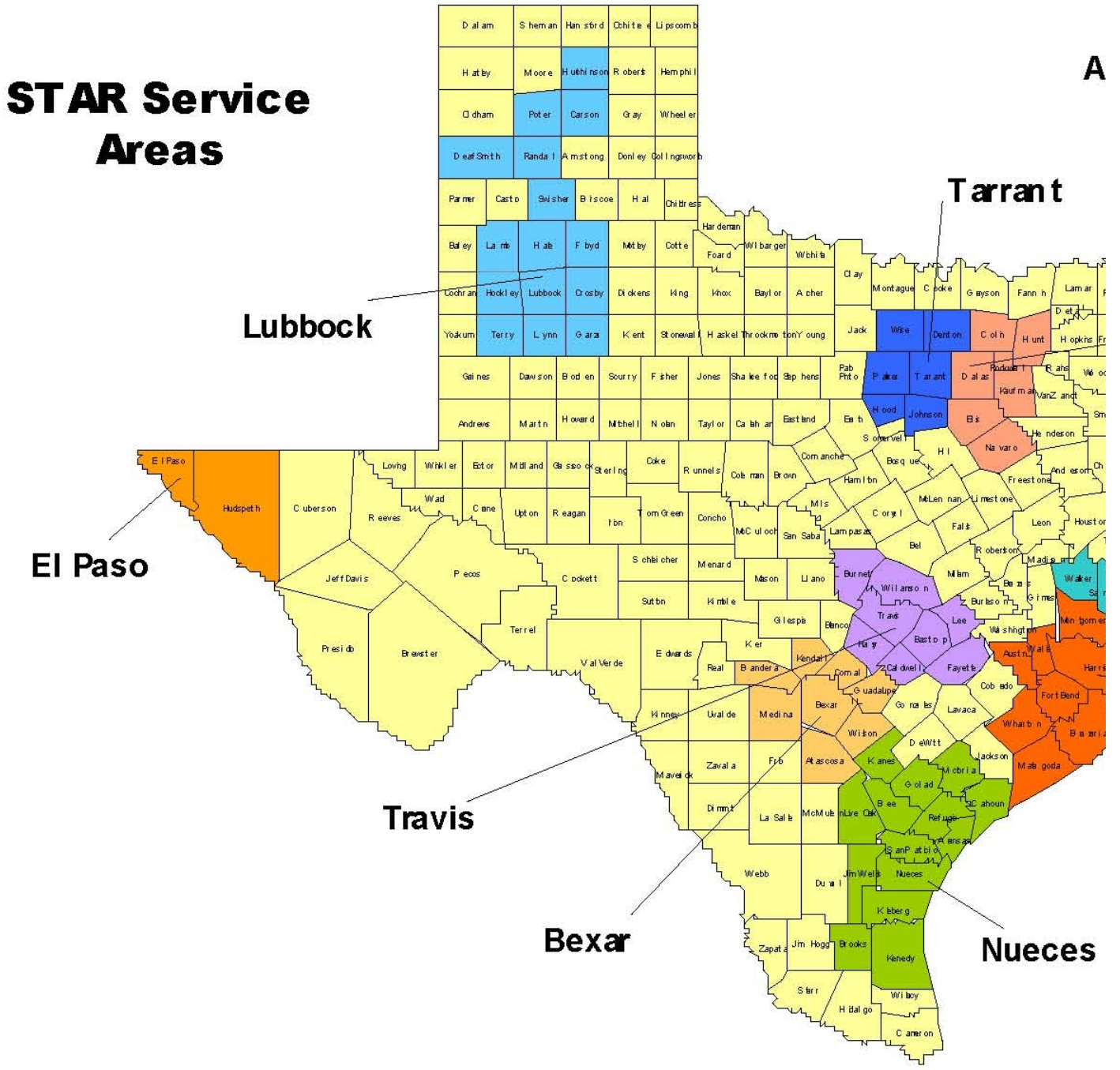
	Service/ Component[1]	Performance Standard[2]	Measurement Period[3]	Measurement Assessment[4]	Liquidated Damages
1.	General Requirement: Failure to Perform an Administrative Service Contract Attachment A HHSC Uniform Managed Care Contract Terms and Conditions, Contract Attachment B-1 RFP §§ 6, 7, 8 and 9	The HMO fails to timely perform an HMO Administrative Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure either: (1) results in actual harm to a Member or places a Member at risk of imminent harm, or (2) materially affects HHSC's ability to administer the Program(s).	Ongoing	Each incident of non-compliance per HMO Program and SA.	HHSC may assess up to $5,000 per calendar day for each incident of non-compliance per HMO Program and SA.
2.	General Requirement: Failure to Profide a Covered Service Contract Attachment A HHSC Uniform Managed Care Contract Terms and Conditions, Contract Attachment B-1 RFP §§ 6, 7, 8 and 9	The HMO fails to timely provide a HMO Covered Service that is not otherwise associated with a performance standard in this matrix and, in the determination of HHSC, such failure results in actual harm to a Member or places a Member at risk of imminent harm.	Ongoing	Each calendar day of non-compliance.	HHSC may assess up to $7,500.00 per day for each incident of non-compliance.
3.	Contract Attachment A HHSC Uniform Managed Care Contract Terms and Conditions, Section 4.08 Subcontractors	(i) three (3) Business Days after receiving notice from a Material Subcontractor of its intent to terminate a Subcontract; (ii) 180 calendar days prior to the termination date of a Material Subcontract for MIS systems operation or reporting; (iii) 90 calendar days prior to the termination date of a Material Subcontract for non-MIS HMO Administrative Services; and (iv) 30 calendar days prior to the termination date of any other Material Subcontract.	Transition, Measured Quarterly during the Operations Period	Each calendar day of non-compliance, per HMO Program, per SA..	HHSC may assess up to $5,000 per calendar day of non-compliance
4.	Contract Attachment B-1 RFP §§ 6, 7, 8 and 9	All reports and deliverables as specified in Sections 6, 7, 8 and 9 of Attachment B-1 must be submitted according to the	Transition Period, Quarterly during Operations Period	Each calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $250 per calendar day if the report/deliverable is late, inaccurate, or incomplete.

	Uniform Managed Care Manual	timeframes and requirements stated in the Contract (including all attachments) and HHSC's Uniform Managed Care Manual. (Specific Reports or deliverables listed separately in this matrix are subject to the specified liquidated damages.)			
5.	Contract Attachment B-1, RFP §7.3 -- Transition Phase Schedule Contract Attachment B-1, RFP §7.3.1 -- Transition Phase Tasks Contract Attachment B-1, RFP §8.1 -- General Scope	The HMO must be operational no later than the agreed upon Operations Start Date. HHSC, or its agent, will determine when the HMO is considered to be operational based on the requirements in Section 7 and 8 of Attachment B-1.	Operations Start Date	Each calendar da of non-compliance, per HMO Program, per Service Area (SA).	HHSC may asses up to $10,000 per calendar day for each day beyond the Operations Start date that the HMO is not operational until the day that the HMO is operational, including all systems.
6.	Contract Attachment B-1 RFP §7.3.1.5 -- Systems Readiness Review	The HMO must submit to HHSC or to the designated Readiness Review Contractor the following plans for review, by December 14, 2005 for STAR and CHIP, and by July 31, 2006 for STAR+PLUS: • Joint Interface Plan; • Disaster Recovery Plan; • Business Continuity Plan; • Risk Management Plan; and - Systems Quality Assurance Plan.	Transition Period	Each calendar day of non-compliance, per report, per HMO Program, and per SA.	HHSC may asses up to $1,000 per calendar day for each day a deliverable is late, inaccurate or incomplete.
7.	Contract Attachment B-1 RFP 7.3.1.7 - Operations Readiness	Final versions of the Provider Directory must be submitted to the Administrative Services Contractor no later than 95 days prior to the Operational Start Date for the CHIP, STAR, and STAR+PLUS HMOs, and no later than 30 days prior to the Operational Start Date for the CHIP Perinatal HMOs.	Transition Peroid	Each calendar day of non-compliance, per directory, per HMO Program and per SA.	HHSC may assess up to $1,000 per calendar day for each day the directory is late, inaccurate or incomplete.
8.	Contract Attachment B-1 RFP §8.1.4 Provider Network UMCM Chapter 5.38 Out of Network Utilization Report	(1) No more than 15 percent of an MCO's total hospital admissions, by service delivery area, may occur in out-of-network facilities. (2) No more than 20 percent of an MCO's total emergency room visits, by service delivery area, may occur in out-of-network facilities (3) No more than 20 percent of total dollars billed to an MCO for "other outpatient services" may be billed by out-of-network providers.	Measured Quarterly beginning March 1, 2010.	Per incident of non-compliance, per Medicaid HMO, per Service Area.	HHSC may assess up to $25,000 per quarter, per standard, per Medicaid HMO, per Service Area.
9.	Contract Attachment B-1 RFP §8.1.4.7 -- Provider Hotline	A. The HMO must operate a toll-free Provider telephone hotline that Provider inquiries from 8 AM - 5 PM, local time for the Service Area, Monday through Friday, excluding State-approved holidays. B. Performance Standards. 1. Call pickup rate - At least 99% of calls are answered on or before the fourth ring or an automated call pick up system is used. 2. Call hold rate - The average hold time is two minutes or less. 3. Call abandonment rate - Call abandonment rate is 7% or less. C. Average hold time is 2 minutes or less.	Operations and Turnover	A. Each incident of non-compliance per. HMO Program and SA. B. Each percentage point below the standard for 1 and 2 and each percentage point above the standard for 3 per HMO Program and SA. C Per month, for each 30 second time increment, or portion thereof, by which the average hold time exceeds the maximum acceptable hold time.	HHSC may assess: A. Per HMO Program and SA, up to $100.00 for each hour or portion thereof that appropriately staffed toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan. B.Up to $100.00 per HMO Program and SA for each percentage point for each standard that the HMO fails to meet the requirements for a monthly reporting period for any HMO operated toll-free lines. C. Up to $100.00 may be assessed fore each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.
10.	Contract Attachment B-1 RFP §8.1.5.6 -- Member Services Hotline	A. The HMO must operate a toll-free hotline that Members can call 24 hours a day, seven (7) days a week. B. Performance Standards. 1. Call pickup rate - At least 99% of calls are answered on or before the fourth ring or an automated call pick up system is used. 2. Call hold rate - At least 80% of calls must be answered by toll-free line staff within 30 seconds. 3. Call abandonment rate - Call abandonment rate is 7% or less. C. Averag hold time is 2 minutes or less.	Ongoing during Operations Turnover	A. Each incident of non-compliance per. HMO Program and SA. B. Each percentage point below the standard for 1 and 2 and each percentage point above the standard for 3 per HMO Program and SA. C. Per month, for each 30 second time increment, or portion threof, by which the average hold time exceeds the maximum acceptable hold time.	HHSC may assess: A. Per HMO Program and SA, up to $100.00 for each hour or portion thereof that toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan. B. Per HMO Program and SA, up to $100.00 for each percentage point for each standard that the HMO fails to meet the requirements for a monthly reporting period for any HMO operated toll-free lines. C. Up to $100.00 may be assessed fore each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.
11.	Contract Attachment B-1 RFP §8.1.5.9 -- Member Complaint and Appeal Process Contract Attachment B-1 RFP §8.2.5.1 -- Provider Complaints Contract Attachment B-1 RFP §8.2.7.1 -- Member Complaint Process Contract Attachment B-1 RFP §8.4.3 – CHIP Member Complaint and Appeal Process	The HMO must resolve at least 98% of Member and Provider Complaints within 30 calendar days from the date the Complaint is received by the HMO.	Measured Quarterly during the Operations Period	Per reporting period, per HMO Program, per SA.	HHSC may assess up to $250 per reporting period if the HMO fails to meet the performance standard.
12.	Contract Attachment B-1 RFP §8.1.5.9 -- Member Complaint and Appeal Process Contract Attachment B-1 RFP §8.2.7.2 -- Mediciad Standard Member Appeal Process Contract Attachment B-1 RFP §8.4.3 – CHIP Member Complaint and Appeal Process	The HMO must resolve at least 98% of Member Appeals within 30 calendar days from the date the Appeal is filed with the HMO.	Measured Quarterly during the Operations Period	Per reporting peorid, per HMO Program, per SA.	HHSC may assess up to $500 per reporting period if the HMO fails to meet the performance standard.
13.	Contract Attachment B-1 RFP §8.1.6 -- Marketing & Prohibited Practices Uniform Managed Care Manual	The HMO may not engage in prohobited marketing practices.	Transition, Measured Quarterly during the Operations Period	Per incident of non-compliance.	HHSC may assess up to $1,000 per incident of non-compliance.
14.	Contract Attachment B-1 RFP §8.1.15.3 -- Behavioral Health services Hotline	A. The HMO must have an emergency and crisis Behavioral Health services Hotline available 24 hours a day, seven (7) days a week, toll-free throught the Service Area(s). B. Crisis hotline staff must include or have access to qualified Behavioral Health Service professionals to assess behavioral health emergencies. C. The HMO must ensure that the toll-free Behavioral Health Services Hotline meets the	Operations and Turnover	A. Each incident of non-compliance per HMO Program and SA. B. Each incident of non-compliance per HMO Program and SA. C. Per HMO Program and SA, per month, each percentage point below the standard for 1 and 2 and each percentage point above the standard for 3.	HHSC may assess: A. Up to $100.00 for each hour or portion thereof that appropriately staffed toll-free lines are not operational. If the MCO's failure to meet the performance standard is caused by a Force Majeure Event, HHSC will not assess liquidated damages unless the MCO fails to implement its Disaster Recovery Plan. B. Up to $100.00 per incident for each occurence that HHSC identifies through its recurring monitoring process that toll-free line staff were not qualified or did not have

		following minimum requiremetns for the HMO Program: 1. Call pickup rate - At least 99% of calls are answered on or before the fourth ring or an automated call pick up system. 2. Call hold rate - At least 80% of calls must be answered by toll-free line staff within 30 seconds. 3. Call abandonment rate - Call abandonment rate is 7% or less.		D. Per month, for each 30 second time increment, or portion threof, by which the average hold time exceeds the maximum acceptable hold time.	access to qualified professionals to assess behavioral health emergencies. C.Up to $100.00 for each percentage point for each standard that the HMO fails to meet the requirements for a monthly reporting period for any HMO operated toll-free lines. D. Up to $100.00 may be assessed fore each 30 second time increment, or portion thereof, by which the MCO's average hold time exceeds the maximum acceptable hold time.
15.	Contract Attachment B-1 RFP §8.1.17.2 -- Financial Reporting Requirements Uniform Managed Care Manual - Chapter 5	Financial Statistical Reports (FSR): For each HMO Program and SA, the HMO must file quarterly and annual FSRs. Quarterly reports are due no later than 30 days after the conclusion of each State Fiscal Quarter (SFQ). The first annual report is due no later than 120 days after the end of each Contract Year and the second annual report is due no later than 365 days after the end of each Contract Year.	Quarterly during the Operations Period	Per calendar day of non-compliance, per HMO Program, per SA.	HHSC may assess up to $1,000 per calendar day, a quarterly or annual report is late, inaccurate or incomplete.
16.	Contract Attachment B-1 RFP §8.1.17.2 -- Financial Reporting Requirements: Uniform Managed Care Manual - Chapter 5	Medicaid Disproportionate Share Hospital (DSH) Reports: The Medicaid HMO must submit, on an annual basis, preliminary and final DSH Reports. The Preliminary report is due no later than June 1st after each reporting year, and the final report is due no later than July 1st after each reporting year. This standard does not apply to CHIP HMOs. Any claims added after July 1st shall include supporting claim documentation for HHSC validation.	Measured during 4th Quarter of the Operations Period (6/1 - 8/31)	Per calendar day of non-compliance per HMO Program, per SA.	HHSC may assess up to $1,000 per calendar day, per program, per service area, for each day the report is late, incorrect, inaccurate or incomplete
17.	Contract Attachment B-1 RFP §8.1.18 – Management Information System (MIS) Requirements	The HMO's MIS must be able to resume operations within 72 hours of employing its Disaster Recovery Plan.	Measured Quarterly during the Operations Period	Per calendar day of non-compliance per HMO Program, per SA.	HHSC may assess up to $5,000 per calendar day of non-compliance
18.	Contract Attachment B-1 RFP §8.1.18.n Encounter Data	The HMO must submit Encounter Data transmissions and include all Encounter Data and Encounter Data adjustments processed by the HMO on a monthly basis, not later than the 30th calendar day after the last day of the month in which the claim(s) are adjudicated. Additionally, the HMO will be subject to liquidated damages if the Quarterly Encounter Reconciliation Report (which reconciles the year-to-date paid claims reported in the Financial Statistical Report (FSR) to the appropriate paid dollars reported in the Texas Encounter Data (TED) Warehouse) includes more than a 2% variance (i.e., less than a 98% match).	Measured Quarterly during Operations Period	Per incident of non-compliance, per HMO Program, per Service Area (SA)	HHSC may assess up to $2,500 per Quarter, per Program, per SA if the HMO fails to submit monthly encounter data. HHSC may assess up to $5,000 per quarter, per Program, per SA for each additional quarter that the HMO fails to submit monthly Encounter Data. SA if the MCO falls below the 98% match standard. HHSC may assess up to $5,000 per Quarter, per Program, per SA for each additional Quarter that the MCO falls below the 98% match standard.
19.	Contract Attachment B-1 RFP §8.1.18.3 – Management Information System (MIS) Requirements: System-Wide Functions	The HMO's MIS system must meet all requirements in Section 8.1.18.3 of Attachment B-1.	Measured Quarterly during the Operations Period	Per calendar day of non-compliance per HMO Program, per SA.	HHSC may assess up to $5,000 per calendar day of non-compliance.
20.	Contract Attachment B-1 RFP §8.1.18.5 Claims Processing Requirements Unifrom Managed Care Manual Chapter 2	--The HMO must adjudicate all provider Clean Claims within 30 days of receipt by the HMO. The HMO must pay providers interest at an 18% per annum, calculated daily for the full period in which the Clean Claim remains unadjudicated beyond the 30-day claims processing deadline. Interest owed the provider must be paid on the same date that the claim is adjudicated.	Measured Quarterly during the Operations Period	Per incident of non-compliance.	HHSC may assess up to $1,000 per claim if the HMO fails to timely pay interest.
21.	Contract Attachment B-1 RFP §8.1.18.5 -- Claims Processing Requirements Unifrom Managed Care Manual - Chapter 2	The HMO must comply with the claims processing requirements and standards as described in Section 8.1.18.5 of Attachment B-1 and in Chapter 2 of the Uniform Managed Care Manual.	Measured Quarterly during the Operations Period	Per quarterly reporting period, per HMO Program, per Service Area, per claim type.	HHSC may assess liquidated damages of up to $5,000 for the first quarter that an HMO's Claims Performance percentages by claim type, by Program, and by service area, fall below the performance standards. HHSC may assess up to $25,000 per quarter for each additional quarter that the Claims Performance percentages by claim type, by Program, and by service area, fall below the performance standards.
22.	Attachment B-1 RFP §8.1.20 Reporting Requirements Attachment B-1 RFP §8.2.5.1 Provider Complaints Attachment B-1 RFP §8.2.7.1 Member Complaint Process	The HMO fails to submit a timely response to an HHSC Member or Provider Complaint received by HHSC and referred to the HMO by the specified due date. The HMO response must be submitted according to the timeframes and requirements stated within the HMO Notification Correspondence (letter, email, etc).	Measured on a Quarterly Basis	Each incident of non-compliance per HMO Program and SA	HHSC may assess up to $250 per calendar day for each day beyond the due date specified within the HMO Notification Correspondence.
23.	Contract Attachment B-1 RFP §8.1.20.2-- Reporting Requirements Uniform Managed Care Manual Chapters 2 and 5	Claims Summary Report: The HMO must submit quarterly, Claims Summary Reports to HHSC by HMO Program, by Service Area, and by claim type, by the 30th day following the reporting period unless otherwise specified.	Measured Quarterly during the Operations Period	Per calendar day of non-compliance, per HMO Program, Service Area, per claim type.	HHSC may assess up to $1,000 per calendar day the report is late, inaccurate, or incomplete.
24.	Contract Attachment B-1 RFP §8.3.3 – STAR+PLUS Assessment Instruments Attachment B-1 RFP §8.3.4.1 - For Members Attachment B-1 RFP §8.3.4.2 - For Medical Assistance Only (MAO) Non-Member Applicants	The Community Medical Necessity and Level of Care (MN LOC) Assessment Instrument must be completed and electronically submitted via the TMHP portal in the specified format within 45 days: 1) from the date of referral for 1915(c) Waiver services for MAO applicants; 2) from the date of the Member's request for 1915(c) Waiver services for current Members requesting an upgrade; or 3) prior to the annual ISP expiration date for all Members receiving 1915(c) Waiver services as specified in Section 8.3.3.	Operations, Turnover	Per calendar day of non-compliance, per Service Area.	HHSC may assess up to $500 per calendar day per Service Area, for each day a report is late, inaccurate or incomplete.
25.	Contract Attachment B-1 RFP §9.2 -- Transfer of Data	The HMO must transfer all data regarding the provision of Covered Services to Members to HHSC or a new HMO, at the	Measured at Time of Transfer of Data and ongoing after the Transfer of Data until satisfactorily completed	Per incident of non-compliance (failure to provide data and/or failure to provide data in	HHSC may assess up to $10,000 per calendar day the data is late, inaccurate or incomplete.

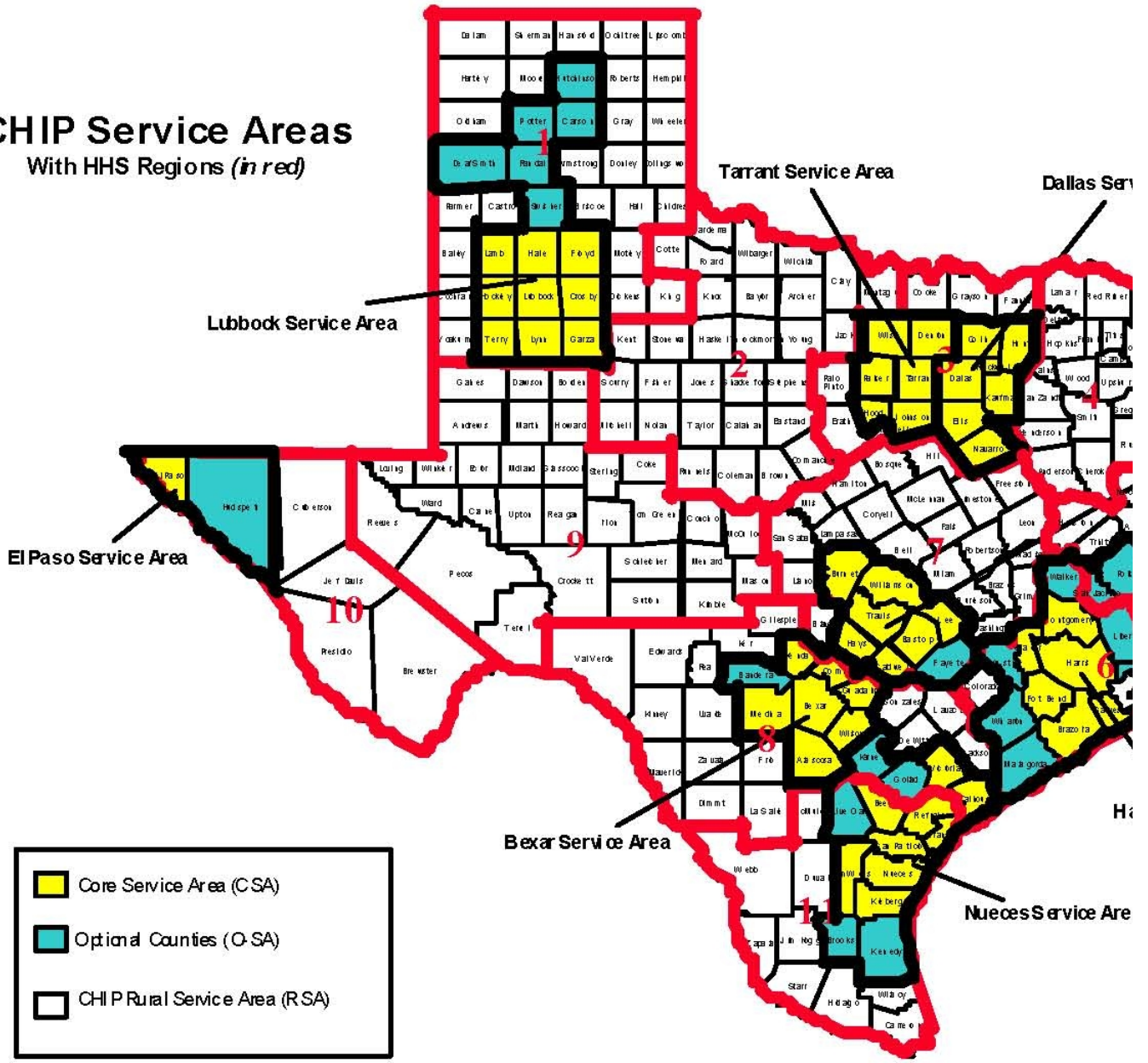
		sole discrection of HHSC and as directed by HHSC. All transferred data must comply with the Contract requirements, including HIPAA.		required format), per HMO Program, per SA.	
26.	Contract Attachment B-1 RFP §9.3 -- Turnover Services	Six months prior to the end of the contract period or any extension thereof, the HMO must propose a Turnover Plan covering the possible turnover of the records and information maintained to either the State (HHSC) or a successor HMO.	Measured at Six Months prior to the end of the contract period or any extension thereof and ongoing until satisfactorily completed	Each calendar day of non-compliance per HMO Program, per SA.	HHSC may assess up to $1,000 per calendar day the Plan is late, inaccurate, or incomplete.
27.	Contract Attachment B-1 RFP §9.4-- Post-Turnover Services	The HMO must provide the State (HHSC) with a Turnover Results report documenting the completion and results of each step of the Turnover Plan 30 days after the Turnover of Operations.	Measured 30 days after the Turnover of Operations	Each calendar day of non-compliance per HMO Program, per SA.	HHSC may assess up to $250 per calendar day the report is late, inaccurate or incomplete.

STAR Service Areas



Service Area	Counties Served
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Dallas	Collin, Dallas, Ellis, Hurt, Kaufman, Navarro, Rockwall
El Paso	El Paso, Hudspeth
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Walle
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jacint
Lubbock	Carson, Crosby, Deaf Smith, Floyd, Garza, Hale, Hockley, Hutchinson, Lamb, L

Lubbock	Randall, Swisher, Terry
Nueces	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Li Refugio, San Patricio, Victoria
Tarrant	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson



CHIP HMO Service Areas

Bexar	**Bexar**
	Atascosa
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson
Optional Counties Bexar O-SA	Bandera

Dallas	**Dallas**
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro

Harris	**Harris**
	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller
Optional Counties Harris O-SA	Austin
	Chambers
	Hardin
	Jasper
	Jefferson
	Liberty
	Matagorda
	Newton
	Orange
	Polk

Lubbock	**Lubbock**
	Crosby
	Floyd
	Garza
	Hale
	Hockley
	Lamb
	Lynn
	Terry
Optional Counties Lubbock O-SA	Carson
	Deaf Smith
	Hutchinson
	Potter
	Randall
	Swisher

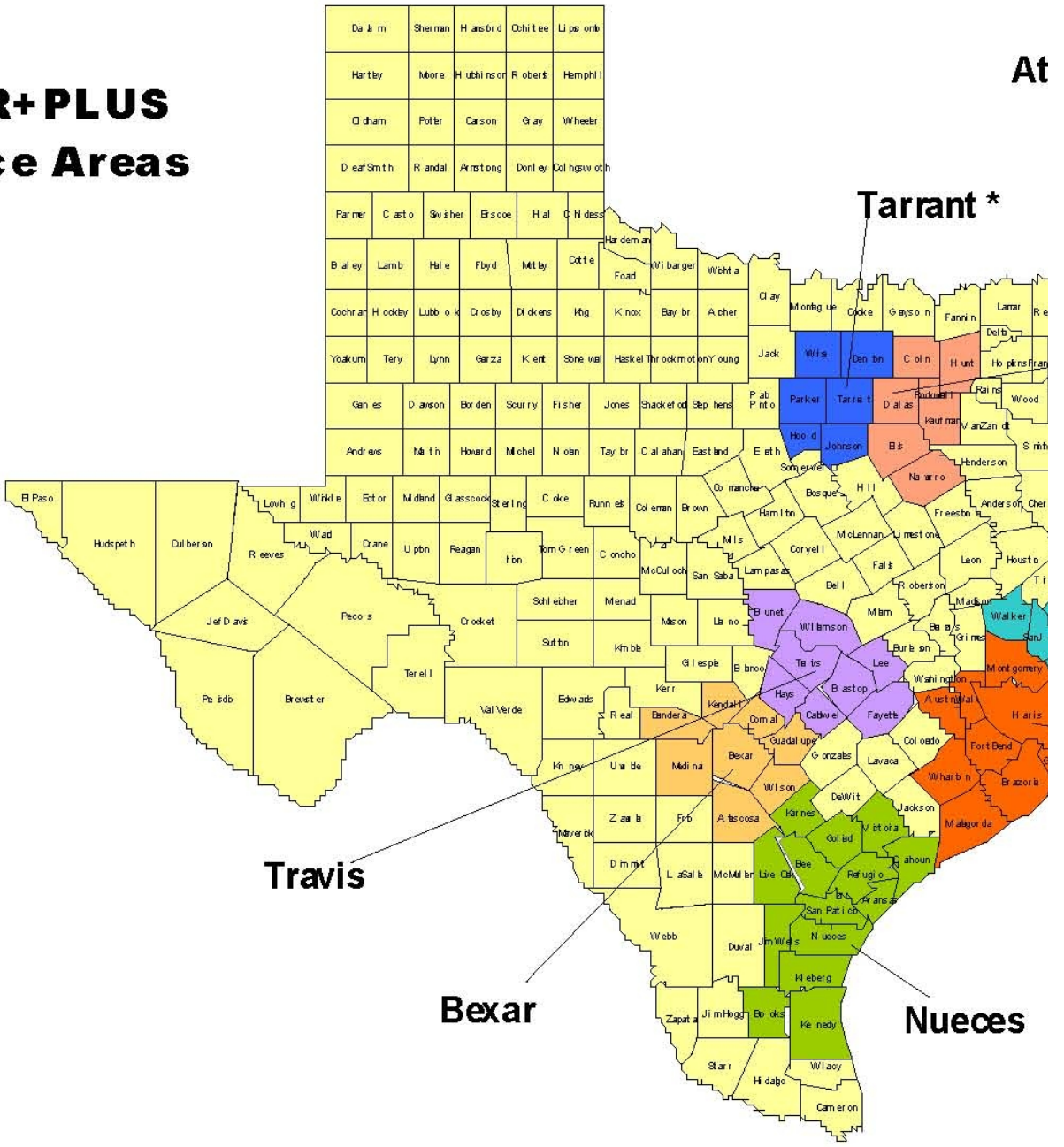
	Rockwall

El Paso	**El Paso**
Optional Counties El Paso O-SA	Hudspeth

	San Jacinto
	Tyler
	Walker
	Wharton

Nueces	**Nueces**
	Aransas
	Bee
	Calhoun
	Jim Wells
	Kleberg
	Refugio
	San Patricio
	Victoria
Optional Counties Nueces O-SA	Brooks
	Goliad
	Karnes
	Kenedy
	Live Oak

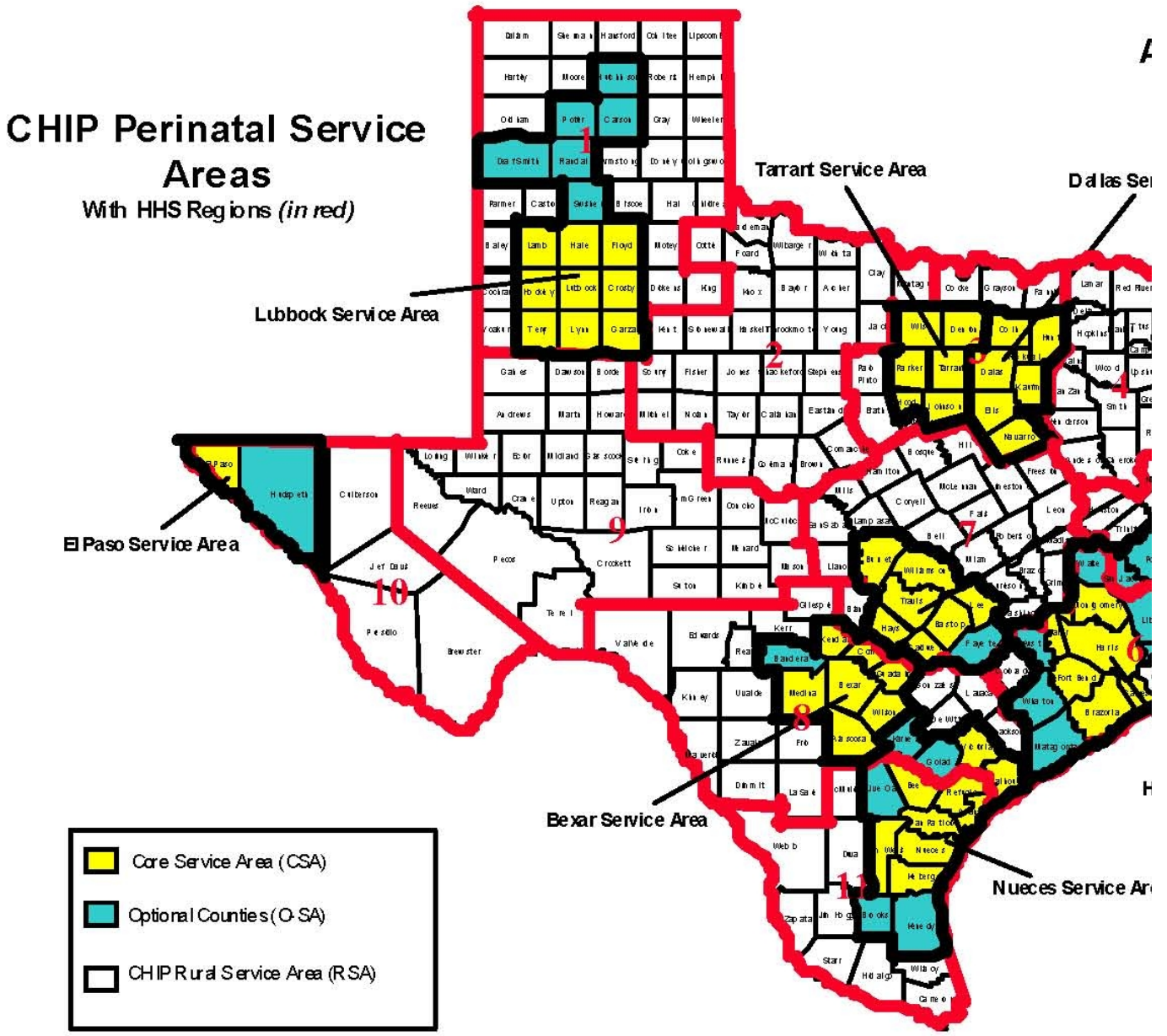
STAR+PLUS Service Areas



Service Area	Counties Served
Bexar	Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, Wilson
Dallas*	Collin, Dallas, Ellis, Hurt, Kaufman, Navarro, Rockwall
Harris	Austin, Brazoria, Fort Bend, Galveston, Harris, Matagorda, Montgomery, Wa
Jefferson	Chambers, Hardin, Jasper, Jefferson, Liberty, Newton, Orange, Polk, San Jac Walker
Nueces	Aransas, Bee, Brooks, Calhoun, Goliad, Jim Wells, Karnes, Kenedy, Kleberg, Refugio, San Patricio, Victoria

	Refugio, San Patricio, Victoria
Tarrant*	Denton, Hood, Johnson, Parker, Tarrant, Wise
Travis	Bastrop, Burnet, Caldwell, Fayette, Hays, Lee, Travis, Williamson

*Not included in this contract



CHIP Perinatal HMO Service Areas

Bexar	**Bexar**
	Atascosa
	Comal
	Guadalupe
	Kendall
	Medina
	Wilson
Optional Counties Bexar O-SA	Bandera

Dallas	**Dallas**
	Collin
	Ellis
	Hunt
	Kaufman
	Navarro
	Rockwall

El Paso	**El Paso**
Optional Counties El Paso O-SA	Hudspeth

Harris	**Harris**
	Brazoria
	Fort Bend
	Galveston
	Montgomery
	Waller
Optional Counties Harris O-SA	Austin
	Chambers
	Hardin
	Jasper
	Jefferson
	Liberty
	Matagorda
	Newton
	Orange
	Polk
	San Jacinto
	Tyler
	Walker
	Wharton

Lubbock	**Lubbock**
	Crosby
	Floyd
	Garza
	Hale
	Hockley
	Lamb
	Lynn
	Terry
Optional Counties Lubbock O-SA	Carson
	Deaf Smith
	Hutchinson
	Potter
	Randall
	Swisher

Nueces	**Nueces**
	Aransas
	Bee
	Calhoun
	Jim Wells

	Kleberg
	Refugio
	San Patricio
	Victoria
Optional Counties Nueces O-SA	Brooks
	Goliad
	Karnes
	Kenedy
	Live Oak

Subject: Attachment B-7 - STAR+PLUS Attendant Care Enhanced Payments Methodology

DOCUMENT HISTORY LOG

STATUS[1]	DOCUMENT REVISION[2]	EFFECTIVE DATE	DESCRIPTION[3]
Baseline	n/a	January 1, 2007	Initial version of Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology, was incorporated into Version 1.5 of the Contract.
Revision	1.6	February 1, 2007	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.7	July 1, 2007	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.8	September 1, 2007	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.9	December 1, 2007	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.10	March 1, 2008	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.11	September 1, 2008	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.12	March 1, 2009	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.13	September 1, 2009	Attachment B-7 is modified to remove references to the DADS enhancement program.
Revision	1.14	December 1, 2009	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.15	March 1, 2010	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.16	September 1, 2010	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.17	December 1, 2010	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Payments Methodology.
Revision	1.18	March 1, 2011	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Paymetns Methodology.
Revision	1.19	September 1, 2011	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Paymetns Methodology.
Revision	1.20	January 1, 2012	Contract amendment did not revise Attachment B-7, STAR+PLUS Attendant Care Enhanced Paymetns Methodology.

[1] Status should be represented as “Baseline” for initial issuances, “Revision” for changes to the Baseline version, and “Cancellation” for withdrawn versions
[2] Revisions should be numbered in accordance according to the version of the issuance and sequential numbering of the revision—e.g., “1.2” refers to the first version of the document and the second revision.
[3] Brief description of the changes to the document made in the revision.

ATTACHMENT B-7: STAR+PLUS ATTENDANT CARE ENHANCED PAYMENTS METHODOLOGY

HMO: Superior Health Plan

SERVICE AREA(S): Bexar & Nueces

I. Provider Contracting

(a) Description of criteria the HMO will use to allow participation in the STAR+PLUS Attendant Care Enhanced Payments.

(b) Description of any limitations or restrictions.

Superior HealthPlan will only allow those providers that are currently participating in the DADS Attendant Compensation Rate Enhancements to participate in the STAR+PLUS Attendant Care Enhanced Payments. SHP will have an enrollment period corresponding to the DADS enrollment period to allow new providers to participate in the SHP Attendant Care Enhanced Payments.

II. Payment for STAR+PLUS Attendant Care Enhanced Payments

Description of methodology the HMO will use to pay for the Attendant Care Enhanced Payments. Provide sufficient detail to fully explain the planned methodology.

Superior will not use the DADS rates. SHP will establish an additional amount to be added on to the unit rate by type of service.

III. Timing of the Attendant Care Enhanced Payments

Description of when the payments will be made to the Providers and the frequency of payments. Also include timeframes for Providers complaints and appeals regarding enhanced payments.

The enhanced rate payment amount will be paid at the time of claims payment so the frequency will depend on the frequency with which providers file their claims. Provider complaints and appeals will be handled through the normal complaint and appeal process and finalized within 30 days from receipt.

IV. Assurances from Participating Providers

Description of how the HMO will ensure that the participating Providers are using the enhancement funds to compensate direct care workers as intended by the 2000-01 General Appropriations Act (Rider 27, House Bill 1, 76th Legislature, Regular Session, 1999) and by T.A.C. Title 1, Part 15, Chapter 355.

Participating Providers will be required by contract to complete and submit an affidavit annually stating they applied the enhancement funds to the compensation for direct care staff. Compensation may include increased hourly rates, bonuses, paid holidays or additional benefits such as employer paid insurance.

V. Monitoring of Attendant Care Enhanced Payments

Explanation of the Monitoring Process that the HMO will use to monitor whether the Attendant Care Enhanced Payments are used for the purposes intended by the Texas Legislature.

Each Provider’s compliance with the attendant compensation spending requirement for the reporting period will be monitored on an annual basis via the submission of the affidavit stating they applied the enhancement funds to the compensation for direct care staff. Compensation may include increased hourly rates, bonuses, paid holidays or additional benefits such as employer paid insurance. In addition, providers may be audited on as as-needed basis to ensure financial records support the pass through of the enhanced funds. Enhanced payments could potentially be recouped for those Providers who fail to pass the funds to their direct care staff.

By signing the Contract and/or Contract Amendment, HMO certifies that the approved STAR+PLUS Attendant Care Enhanced Payments Methodology described herein is the methodology the HMO will use to make the legislatively mandated payments to its Long Term Services and Support (LTSS) Providers participating in the Attendant Care Enhanced Payments.

Additional information related to the Attendant Care Enhanced Payments can be found in Attachment B-1, Section 8.3.7.3 of the Contract.

Exhibit 12.1

Centene Corporation
Computation of ratio of earnings to fixed charges
($ in thousands)

	Year Ended December 31,				
	2011	2010	2009	2008	2007
Earnings:					
Pre-tax earnings from continuing operations	$ 174,885	$ 154,282	$ 137,508	$ 136,616	$ 64,071
Addback:					
Fixed charges	27,822	26,141	23,104	23,128	20,612
Subtract:					
Non-controlling interest	2,855	(3,435)	(2,574)	-	-
Interest capitalized	-	(1,089)	(116)	-	-
Total earnings	$ 205,562	$ 175,899	$ 157,922	$ 159,744	$ 84,683
Fixed Charges:					
Interest expensed and capitalized	$ 20,320	$ 19,081	$ 16,434	$ 16,673	$ 15,626
Interest component of rental payments (1)	7,502	7,060	6,670	6,455	4,986
Total fixed charges	$ 27,822	$ 26,141	$ 23,104	$ 23,128	$ 20,612
Ratio of earnings to fixed charges	7.39	6.73	6.84	6.91	4.11

(1) Estimated at 33% of rental expense as a reasonable approximation of the interest factor.

Exhibit 21

List of Subsidiaries

Absolute Total Care, Inc. a South Carolina corporation
Access Health Solutions, LLC, a Florida LLC
AECC Total Vision Health Plan of Texas, Inc., a Texas corporation
Bankers Reserve Life Insurance Company of Wisconsin, a Wisconsin corporation
Bridgeway Health Solutions of Arizona LLC, an Arizona LLC
Bridgeway Health Solutions, LLC, a Delaware LLC
Buckeye Community Health Plan, Inc., an Ohio corporation
Casenet, LLC, a Delaware LLC
CBHSP Arizona, Inc., an Arizona corporation
CCTX Holdings, LLC, a Delaware LLC
Celtic Group, Inc., a Delaware corporation
Celtic Insurance Company, an Illinois corporation
CeltiCare Health Plan Holdings LLC, a Delaware LLC
CeltiCare Health Plan of Massachusetts, Inc., a Massachusetts corporation
CenCorp Health Solutions, Inc., a Delaware corporation
Cenpatico Behavioral Health of Arizona, LLC, an Arizona LLC
Cenpatico Behavioral Health of Maricopa LLC, an Arizona LLC
Cenpatico Behavioral Health of Texas, Inc., a Texas corporation
Cenpatico Behavioral Health of Wisconsin, LLC, a Wisconsin LLC
Cenpatico Behavioral Health, LLC, a California LLC
Cenpatico CeltiCare Integrated Services, Inc., a Massachusetts corporation
Cenpatico of Florida, Inc., a Florida corporation
Cenpatico of Louisiana, Inc., a Louisiana corporation
Cenphiny Management, LLC, a Delaware LLC
Centene Center LLC, a Delaware LLC
Centene Company of Texas, LP, a Texas limited partnership
Centene Corporation, a Delaware corporation
Centene Holdings, LLC, a Delaware LLC
Centene Management Company, LLC, a Wisconsin LLC
CMC Real Estate Company, LLC, a Delaware LLC
Coordinated Care Corporation, Inc., d/b/a Managed Health Services, an Indiana corporation
Family Care & Workforce Diversity Consultants LLC, d/b/a Worklife Innovations, a Connecticut LLC
Hallmark Life Insurance Company, an Arizona corporation
Healthy Louisiana Holdings LLC, a Delaware LLC
IlliniCare Health Plan, Inc., an Illinois corporation
Integrated Mental Health Management, LLC, a Texas LLC
Integrated Mental Health Services, a Texas corporation
Kentucky Spirit Health Plan, Inc, a Kentucky corporation
LBB Industries, Inc., a Texas corporation
Louisiana Health Care Connections, Inc., a Louisiana corporation
Magnolia Health Plan Inc., a Mississippi corporation
Managed Health Services Illinois, Inc., an Illinois corporation
Managed Health Services Insurance Corporation, a Wisconsin corporation
Novasys Health , Inc., a Delaware corporation
Nurse Response, Inc., a Delaware corporation
NurseWise Holdings, LLC, a Delaware LLC
NurseWise, LP, a Delaware limited partnership
Nurtur Health, Inc., a Delaware corporation
Ocucare Systems, Inc., a Florida corporation
OptiCare IPA of New York, Inc., a New York corporation
OptiCare Managed Vision, Inc., a Delaware corporation
OptiCare Vision Company, Inc., a Delaware corporation
OptiCare Vision Insurance Company, Inc., a South Carolina corporation
Peach State Health Plan, Inc., a Georgia corporation
Physicians Choice LLC, d/b/a Palmetto Administrative Services, a South Carolina LLC
Phytrust of South Carolina LLC, a Florida LLC
RX Direct, Inc., a Texas corporation
Sunshine Consulting Services, Inc., a Delaware corporation
Sunshine Health Holding Company, a Florida corporation
Sunshine State Health Plan, Inc., a Florida corporation
Superior HealthPlan, Inc., a Texas corporation
Total Vision, Inc., a Delaware corporation
U.S. Script, Inc., a Delaware corporation
University Health Plans, Inc., a New Jersey corporation
Wellness By Choice, LLC, a New York limited liability company

Exhibit 23

Consent of Independent Registered Public Accounting Firm

The Board of Directors

Centene Corporation:

We consent to the incorporation by reference in the registration statement on Form S-8 (Nos. 333-108467, 333-90976, and 333-83190) and in the registration statement on Form S-3 (Nos. 333-164390 and 333-174164) of Centene Corporation of our reports dated February 20, 2012, with respect to the consolidated balance sheets of Centene Corporation as of December 31, 2011 and 2010, and the related consolidated statements of operations, stockholders' equity, and cash flows for each of the years in the three-year period ended December 31, 2011, and the effectiveness of internal control over financial reporting as of December 31, 2011, which reports appear in the December 31, 2011 annual report on Form 10-K of Centene Corporation.

/s/ KPMG, LLP

St. Louis, Missouri
February 20, 2012

EXHIBIT 31.1

CERTIFICATION

I, Michael F. Neidorff, certify that:

1. I have reviewed this Annual Report on Form 10-K 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)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's fourth 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 functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 21, 2012

/s/ MICHAEL F. NEIDORFF
Michael F. Neidorff
Chairman and Chief Executive Officer
(principal executive officer)

EXHIBIT 31.2

CERTIFICATION

I, William N. Scheffel, certify that:

1. I have reviewed this Annual Report on Form 10-K 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)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:

   a. Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;

   b. Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;

   c. Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and

   d. Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's fourth 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 functions):

   a. All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and

   b. Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Dated: February 21, 2012

/s/ WILLIAM N. SCHEFFEL

William N. Scheffel
Executive Vice President and Chief Financial Officer *(principal financial officer)*

EXHIBIT 32.1

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2011, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, Michael F. Neidorff, Chairman and Chief Executive Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 21, 2012

/s/ MICHAEL F. NEIDORFF
Michael F. Neidorff
Chairman and Chief Executive Officer
(principal executive officer)

EXHIBIT 32.2

CERTIFICATION PURSUANT TO 18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO
SECTION 906 OF THE SARBANES-OXLEY ACT OF 2002

In connection with the annual report on Form 10-K of Centene Corporation (the Company) for the period ended December 31, 2011, as filed with the Securities and Exchange Commission on the date hereof (the Report), the undersigned, William N. Scheffel, Executive Vice President and Chief Financial Officer of the Company, hereby certifies, pursuant to 18 U.S.C. Section 1350, that:

(1) the Report fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and

(2) the information contained in the Report fairly presents, in all material respects, the financial condition and results of operations of the Company.

Dated: February 21, 2012

/s/ WILLIAM N. SCHEFFEL
William N. Scheffel
Executive Vice President and Chief Financial Officer *(principal financial officer)*