CENPATICO
behavioral health
A CenCorp Health Solution™

Volume 1 - Administrative and Organizational

Proposal For Behavioral Health Services For Greater Arizona

October 2004

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a. Attachment A – Offer and Acceptance Form

	OFFER AND ACCEPTANCE SOLICITATION NUMBER: **HP532003**	ARIZONA DEPARTMENT OF HEALTH SERVICES 1740 West Adams Street Phoenix, Arizona 85007 (602) 542-1040 (602) 542-1741 Fax

Attachment A: Offer And Acceptance

Submit this form with an original signature to the:

Arizona Department of Health Services
Office of Procurement
1740 West Adams, Room 303
Phoenix, Arizona 85007

The Undersigned hereby offers and agrees to furnish the material, service or construction in compliance with all terms, conditions, specifications and amendments in the solicitation.

Arizona Transaction (Sales) Privilege Tax License No:

Federal Employer Identification No:
20-1624120

Greater Arizona Behavioral Health Authority LLC
Company Name

c/o CT Corporation System
3225 North Central Avenue
Address

Phoenix, AZ 85012
City, State, ZIP Code

For Clarification of this Offer, Contact:

Name: Andrew Sekel, Ph.D.
Telephone: 512-736-3845
FAX: 512-480-0574

Signature of Person Authorized to Sign Offer

Samuel A. Donaldson Ph.D.
Printed Name

Vice President, GREABHA
Title

OFFER ACCEPTANCE AND CONTRACT AWARD (For state of Arizona Use Only)

Your Offer is hereby accepted as described in the Notice of Award. The Contractor is now bound to perform based upon the Solicitation and the Contractor's Offer as accepted by the State, including if applicable, the Best and Final Offer.

This Contract shall henceforth be referred to as Contract Number: _____

The Contractor is hereby awarded the following Geographic Service Area(s):

- ☐ GSA 1 -Apache, Coconino, Mohave, Navajo and Yavapai Counties
- ☐ GSA 2 - La Paz and Yuma Counties
- ☐ GSA 3 - Cochise, Graham, Greenlee and Santa Cruz Counties
- ☐ GSA 4 - Gila and Pinal Counties
- ☐ GSA 5 - Pima County

The Contractor is hereby cautioned not to commence any billable work or provide any material, service or construction under this contract until the Contractor receives an executed purchase order or contract release document or written notice to proceed, if applicable.

State of Arizona Awarded this _____ day of _____, 20_____

_____
PROCUREMENT OFFICER

b. Cover Letter

October 14, 2004

Jon Medwin, MBA, C.P.M., CPPO, CGFM
Arizona Department of Health Services
Office of Procurement
1740 West Adams Street, Room 303
Phoenix, AZ 85007

Re: Request for Proposal (RFP) #HP532003

Dear Mr. Medwin:

This proposal is being submitted by Greater Arizona Behavioral Health Authority, LLC (GREABHA), which has been established by Cenpatico Behavioral Health™ LLC (CBH), a managed behavioral health subsidiary of Centene Corporation® (Centene), whose sole purpose is to administer the services described in the Request for Proposal (RFP) #HP532003 issued by the Arizona Department of Health Services, Department of Behavioral Health Services (ADHS/DBHS). GREABHA will be the administrative home of the key personnel and operations responsible for services delivered under this RFP, and will maintain local control of all operations, which is in concert with Centene's approach to management.

GREABHA proposes offering integrated managed behavioral health delivery systems in the following Geographic Service Areas (GSAs) of Greater Arizona:

- GSA 1: Counties of Apache, Coconino, Mohave, Navajo and Yavapai
- GSA 2: Counties of La Paz and Yuma
- GSA 4: Counties of Gila and Pinal

GREABHA wholeheartedly embraces the Arizona System Principles, the Arizona Children's Vision and Principles, and Principles for Persons with Serious Mental Illness (Arizona principles), which express the ADHS/DBHS commitment to build a consumer-driven system that is responsive to the needs of behavioral health recipients, families, stakeholders and communities. GREABHA and the Centene family of companies are committed to assisting ADHS/DBHS in meeting their goals through:

- Improving consumer "voice and choice"
- Providing timely access to consumer-driven services
- Fully engaging behavioral health recipients and their family members
- Providing consumer and family focused services
- Collaborating with the local communities and natural supports
- Providing effective innovation in service delivery and technical support services
- Ensuring the delivery of culturally competent services and provider organizations
- Encouraging service excellence through the implementation of best practices
- Ensuring accurate and accessible data, information and reporting
- Reducing cumulative administrative costs and reinvesting savings into supportive services in local communities

The Centene family of companies possesses a long and successful track record of assisting underserved populations by providing comprehensive, quality health care programs for the Medicaid population in five states. Our programs have consistently resulted in high levels of behavioral health recipient satisfaction:

- In Indiana in 2003, 93% of consumers rated the quality of care provided by Centene as good/very good and 95% say that they received adequate information on how to access care.

- In New Jersey, 100% of consumers reported that they received well childcare as soon as they wanted.

- In Wisconsin, 94% of consumers are satisfied with the overall care that they receive from Centene and 92% said that they would recommend the Centene to others.

These figures demonstrate Centene's successful ability to meet the needs of consumers with regard to providing timely and appropriate access to care. GREABHA is confident that we will provide the same high level of care to behavioral health recipients in Arizona.

The Centene family of companies is also recognized for the implementation of innovative programs that address the specific needs of the behavioral health recipients we serve. For example, our unique *Script*Assist program, which has been proven to increase medication regimen compliance, achieves success by developing personal relationships with recipients in order to improve the effectiveness of medication regimens and to strengthen partnerships with providers. The *Script*Assist program is designed to help behavioral health recipients, families, physicians and pharmaceutical companies avoid the negative consequences of the ineffective use of medications. GREABHA will make this innovative program available to Arizona consumers. The core *Script*Assist product is a telephone outreach program staffed by behavioral health nurses who assess behavioral health recipients' comfort with medications and regimen compliance. The nurses work in conjunction with recipients and providers to reduce side effects and to ensure that the medications are working effectively. The nurses seek to determine the root causes of non-compliance, with the goal of assisting consumers and providers to find the medication that they deem to be most beneficial. When the right medication is found in collaboration with the recipient and his/her Treatment Team, compliance improves, and the recipient's satisfaction with the results increases.

GREABHA's proposal is designed to meet the behavioral health needs of program recipients in Arizona, even as those needs change. While the services we provide may appear to be similar to those delivered by other vendors, our delivery model is distinguished by our comprehensive approach to operational design and execution:

GREABHA will:

- Work closely with our provider agencies through mentoring and coaching activities that help our providers ensure behavioral health recipients, family members, and other service providers feel welcome as collaborators in the service planning and implementation process.
- Provide culturally relevant care that addresses and respects language, customs, and values.
- Be responsive to each behavioral health recipient's unique needs, family, culture, traditions, strengths, age, and gender.
- Ensure that our behavioral health providers adopt a holistic approach to serving our behavioral health recipients, and that care is coordinated with all relevant collateral contacts as desired by the recipient, such as family members, local natural supports, stakeholders, Primary Care Providers (PCPs), and community and governmental agencies.

GREABHA is more than just a behavioral health vendor. The degree to which we pursue excellence in service delivery is a direct reflection of the quality of people that we have brought together within our organization. Very few mental health or substance abuse conditions occur without co-occurring medical or other behavioral health conditions. This is well understood in our industry and in the health care arena at large. With the support of Centene, GREABHA has assembled the top talent in the country to continuously evaluate, develop and deliver our services. We solicit feedback from national advisory groups in child welfare, social services, court services, mental health and addictions to enable us to stay abreast of developments in service delivery, treatments and community resources. We are attentive to the areas of service excellence and quality improvement in the development and refinement of our programs, and we always include behavioral health recipients and stakeholders in the decision making process. These principles are the cornerstone of our organization.

Key features of our program include:

- Local control
- Recipient-centered and recipient-driven approaches to care
- A targeted network that includes many non-traditional providers
- Efficient and effective methods of monitoring the system
- A comprehensive mentoring program for provider agencies designed to institutionalize the Arizona principles in Greater Arizona
- Integrated systems and technology
- Comprehensive service facilitation, including the consistent use of Clinical Liaisons and Child and Family Teams

GREABHA is committed to assisting behavioral health recipients in improving their quality of life and assisting them in achieving the highest level of functioning possible. GREABHA's proposal demonstrates our commitment to addressing the ADHS/DBHS requirement for a contractor that will deliver a managed care delivery system and provide services that are both individual- and family-centered, as well as culturally relevant to both Medicaid and non-Medicaid behavioral health recipients.

We recognize the need to improve:

- System Accountability
- Provider Competition
- Innovation
- Access to natural supports
- Proactive responsiveness to recipient needs
- Recipient "voice and choice"
- Availability of supportive services
- Increased flexibility

Our organization is experienced in implementing delivery systems that address these needs. We are eager to make a difference in the lives of Arizona consumers with behavioral health needs. Moreover, our financial model will help ADHS/DBHS provide the best possible care within the resources available. The system of payment that we propose implementing features self-monitors and creates attractive incentives for both payers and providers.

Our proposal meets all of the requirements set forth by ADHS/DBHS in its solicitation. In addition to the services detailed in our proposal, we also welcome the opportunity to partner with the ADHS/DBHS on other initiatives aimed at improving the overall health and well-being of Greater Arizona's behavioral health recipients and their families. We look forward to engaging in further discussions with ADHS/DBHS regarding how our program will be developed and enhanced to meet Arizona's program goals, and ultimately the needs of behavioral health recipients and their families.

If you have any questions regarding our proposal, please contact Andrew Sekel, Ph.D., Vice President of Business Development by telephone at 512-736-3845, or through e-mail at ASekel@Centene.com.

Very truly yours,

Samuel A. Donaldson, Ph.D.
Vice President
GREABHA

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c. Signed Solicitation Amendments

SOLICITATION AMENDMENT

Solicitation No. **HP532003**

Amendment No. 1

Page 1

Solicitation Due Date: October 14, 2004 3:00 P.M. MST

ARIZONA DEPARTMENT OF HEALTH SERVICES
1740 West Adams, Room 303
Phoenix, AZ 85007
(602) 542-1040
(602) 542-1741 fax

Contact: Jon Medwin

A signed copy of this amendment must be submitted with your Solicitation Response. This Solicitation is amended as follows:

Page 61, item 13, "Grievance and Appeals Administrator…Contractor shall not use its in-house legal counsel, corporate attorney or risk management attorney as Contractor's Grievance and Appeals Administrator." shall be amended to read, "Grievance and Appeals Administrator…Contractor shall not use its in-house legal counsel, corporate attorney or risk management attorney as Contractor's Grievance and Appeals Administrator, nor supervise grievance and appeals staff or function."

Page 109, item b, "…All pages of the proposal shall be line numbered, re-starting each page with Line 1." shall be amended to read, "All text documents of the proposal shall be line numbered down the left side of the page, restarting each page with Line 1. Documents that contain graphs, tables and/or any other imported object that is not in a text document (e.g. Microsoft Word) do not need to be line numbered."

Vendor hereby acknowledges receipt and understanding of above amendment

Signature Date 10/5/04

Name and Title: Samuel A. Donaldson, Ph.D. Vice President

Name of Company: GREABHA

The above referenced Solicitation Amendment is hereby executed this _____ day of _____, 2004 in Phoenix, Arizona.

Signature /S/

Name: Jon Medwin, MBA, C.P.M, CPPO, CGFM

Title: Procurement Administrator

SOLICITATION AMENDMENT

Solicitation No. HP532003

Amendment No. 2

Page 1

Solicitation Due Date: October 14, 2004 3:00 P.M. MST

ARIZONA DEPARTMENT OF HEALTH SERVICES
1740 West Adams, Room 303
Phoenix, AZ 85007
(602) 542-1040
(602) 542-1741 fax

Contact: **Jon Medwin**

A signed copy of this amendment must be submitted with your Solicitation Response. This Solicitation is amended as follows:

1. Page 77, item F.3.a., Title XIX Profit and Loss Corridors, second sentence "Service revenue equals ninety-two point five percent (92.5%) of total DHS revenue adjusted for accrued payables and receivables as a result of estimated profit corridor payments to or from DHS." is amended to read, "Service revenue equals ninety-two point five percent (92.5%) of total DHS revenue paid to the contractor."

2. Page 77, item F.3.b., Title XXI Profit and Loss Corridors, second sentence "Service revenue equals ninety-two point five percent (92.5%) of total DHS revenue adjusted for accrued payables and receivables as a result of estimated profit corridor payments to or from DHS." is amended to read, "Service revenue equals ninety-two point five percent (92.5%) of total DHS revenue paid to the contractor."

3. Page 77, item F.3.c., Non-Title XIX/XXI Profit Limit, third sentence "Service revenue equals ninety-two point five percent (92.5%) of total DHS revenue adjusted for accrued payables and receivables as a result of estimated profit corridor payments to or from DHS." is amended to read, "Service revenue equals ninety-two point five percent (92.5%) of total DHS revenue paid to the contractor."

Vendor hereby acknowledges receipt and understanding of above amendment.

Signature 10/5/04 Date

Name and Title: Samuel A. Donaldson, Ph.D.

Name of Company: Vice President GRENBHA

The above referenced Solicitation Amendment is hereby executed this _____day of _____, 2004 in Phoenix, Arizona.

/ S /

Jon Medwin, MBA, C.P.M., CPPO, CGFM

Procurement Administrator

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d. Attachment B – Offeror Business Info

Offeror's Name:

This proposal is being submitted by Greater Arizona Behavioral Health Authority, LLC (GREABHA), which has been established by Cenpatico Behavioral HealthTM LLC (CBH), a managed behavioral health subsidiary of Centene Corporation® (Centene), to administer the contract in Arizona.

OFFEROR GENERAL INFORMATION

1. **Type of Organization** (Check one and provide requested information)

(x) Corporation:

When & where incorporated: **GREABHA was incorporated on Sept. 2, 2004 in Phoenix, Arizona.**

Has corporation done business in Arizona? Yes ( ) No (**X**)

If yes, when and where?

CBH has been operating in Arizona since 2000, managing a behavioral health provider organization, called Desert Springs Professionals, and a specialized school-based program for children with behavioral conditions, called Academic Behavioral Accommodations (ABA).

Federal I.D. No.: **GREABHA's Federal I.D. No. is 20-1624120**

Primary nature of business: **Behavioral Health Managed Care**

Annual Gross: **None.**

The SEC Filing Form-10K for Centene Corporation is included in Section C of Volume 6.

Number of employees: **None.**

( ) Partnership:

Date of organization:

General Partnership ( ) Limited Partnership ( )

Has partnership done business in Arizona? Yes ( ) No ( )

If yes, when and where?

Social Security No.:

Primary nature of business:

Annual Gross: $

Number of employees:

( ) Joint Venture:

Date of organization:

Has the joint venture done business in Arizona? Yes ( ) No ( )

If yes, when and where?

Names and addresses of joint venture members:

NAME ADDRESS

Federal I.D. No.:

Primary nature of business:

Annual Gross: $

Number of employees: **( ) Sole Proprietorship:**

Name in full:

Address:

Has sole proprietorship done business in Arizona? Yes ( ) No ( )

If yes, when and where?

Social Security No.:

Primary nature of business:

Annual Gross: $

Number of employees:

2. **Type of Status** (Check one)

(**X**) For profit

( ) Not for profit

( ) Government

3. **License/Certification:** List all licenses and certifications (e.g. federal HMO status or State certifications) your organization maintains, including the license requirement and the renewal dates.

Upon contract award, GREABHA will apply for all applicable licenses and certifications as well as a Behavioral Health Service Agency license with the Arizona Department of Health Services, Division of Licensing Services.

Have any licenses been denied revoked or suspended within the past 10 years?

Yes_____ No___**X**____. If yes, please explain.

4. **Civil Rights Compliance Data:** Has any federal or state agency ever made finding of noncompliance with any civil rights requirements with respect to your program?

Yes_____ No__**X**_____

If yes, please explain.

5. **Accessibility Assurance:** Does your organization provide assurance that no qualified person with a disability will be denied benefits of, or excluded from, participation in a program or activity because the Offeror facilities (including subcontractors) are inaccessible to, or unusable by, persons with disabilities? (Note: Check local zoning ordinances for accessibility requirements).
Yes___**X**____ No_____

If yes, describe how such assurance is provided or how your organization is taking affirmative steps to provide assurance.

All Centene companies have corporate Policies and Procedures in place, and local staff to implement such requirements, to ensure that all of our facilities, programs and activities are accessible to persons with disabilities. We require our subcontractors and providers to be in compliance with all applicable state and federal laws in this regard. Additionally, we conduct site visits to high volume providers to ensure that their facilities are accessible to persons with disabilities or, in cases where they are not, that such providers agree to accommodate the consumers they serve in alternative locations that are accessible to persons with disabilities. Alternative accommodations include consumers' homes and other provider locations. We also provide transportation services and assistance to and from providers' offices.

6. **Prior Convictions:** List all felony convictions within the past 15 years of any key personnel (i.e., CEO, Medical Director, financial officers, major stockholders or those with controlling interest, etc.). Failure to make full and complete disclosure shall result in the rejection of your proposal.

None.

7. **Federal Government Suspensions/Exclusion:** Has the Offeror been suspended or excluded from any federal government programs for any reasons?

Yes_____ No___**X**_____

If yes, please explain.

8. Did a firm, organization, or individual contractor, provide the Offeror with any assistance in preparing this proposal? Yes__**X**___ No_____.

If yes, what is the name of this firm, organization or individual?

Doretha E. Owens – Director, Service Division, Market Strategies Inc

As well as the following independent contractors:

Julie Bigelow
Lori Ashcraft
Ron Copeland
Ilene Dode
Addam Gross
Terry Stevens
Mary Ellen Brown

8. Provide at least three (3) references for work, similar in scope and complexity to this RFP, performed during the last three (3) years.

The following references are for subsidiaries of Centene Corporation for which CBH provides contracted behavioral health services:

a. **Client Name**: State of Texas, Health and Human Services Commission
Address: 4900 N. Lamar Blvd, Austin, TX 78751-2316
Telephone: (512) 491 - 1311
Contact person: Robin Deary, Managed Care Director
Description of services provided: Superior Health Plan (100% owned subsidiary of Centene Corporation) – Service Area specific managed Medicaid program, fully capitated HMO product - All Medicaid covered services TANF & CHIP
Contract Start/End Dates: Medicaid 12/1/99- present /CHIP 9/01/02-present
Contract Value: $211 million (2003 Revenue)

b. **Client Name**: State of Wisconsin Department of Health and Family Services
Address: 1 West Wilson Street PO Box 309 Madison WI, 53701-0309
Telephone: (512) 491 - 1311
Contact person: Angela Dombrowicki, Director Bureau of Managed Care
Description of services provided: Managed Health Services of Wisconsin (100% owned subsidiary of Centene Corporation) – Service Area specific managed Medicaid program, fully capitated HMO product - All Medicaid covered services except chiropractic; dental covered in 4 counties ,TANF & SOBRA Women & Children, SSI and CHIP
Contract Start/End Dates: Medicaid 12/1/99- present /CHIP 9/01/02-present
Contract Value: $252 million (2003 Revenue)

c. **Client Name**: State of Ohio, Ohio Department of Jobs and Family Services
Address: 30 East Broad Street, Columbus, OH 43215
Telephone: 614-466-4693
Contact person: Laurel Smith, ODJFS
Description of services provided: Buckeye Community Health Plan, Ohio, Franklin, Hamilton and Lucas Counties (100% owned subsidiary of Centene Corporation) – Service Area specific managed Medicaid program, fully capitated HMO product - All Medicaid covered medical services for Healthy Start and Healthy Family programs
Contract Start/End Dates: November 2003 to present, through 2004
Contract Value: $48 Million

FINANCIAL DISCLOSURE STATEMENT

The Offeror must provide the following information as required by 42 CFR 455.103. This Financial Disclosure Statement shall be prepared as of 8/31/04.

1. **Ownership:** List the name and address of each person with an ownership or controlling interest, as defined by 42 CFR 455.101, in the entity submitting this offer:

Name	Address	Percent of Ownership or Control
Greater Arizona Behavioral Health Authority, LLC (GREABHA)	**c/o CT Corporation System 3225 North Central Ave. Phoenix, Arizona 85012**	**100% wholly owned by Cenpatico Behavioral Health LLC**
Cenpatico Behavioral Health LLC	**823 Congress Ave. Ste. 600 Austin, TX 78701**	**100% wholly owned by CenCorp Consulting Company, Inc.**
CenCorp Health Solution LLC	**7711 Carondelet Ave. Suite 800 St. Louis, MO 63105**	**100% wholly owned by Centene Corporation**
Centene Corporation	**7711 Carondelet Ave. Suite 800 St. Louis, MO 63105**	**Publicly traded entity on the NYSE under the symbol CNC**

2. **Subcontractor Ownership:** List the name and address of each person with an ownership or control interest in any subcontractor in which the disclosing entity has direct or indirect ownership of 5% or more:

Name	Address	Percent of Ownership or Control
NurseWise LP	**7711 Carondelet Ave. Ste 800** **St. Louis , MO 63105**	**100% wholly owned by CenCorp Consulting Company**

Names of above persons who are related to one another as spouse, parent, child or sibling: **None**

3. **Ownership in Other Entities:** List the name of any other entity in which a person with an ownership or control interest in the Offeror entity also has an ownership or control interest:

Name	Address	Percent of Ownership or Control
Cenpatico Behavioral Health Northern California, LLC	2485 High School Avenue, Suite 301 Concord, CA 94520-1819	99% Cenpatico Behavioral Health, LLC 1% owned by Hill Physicians Medical Group
Cenpatico Behavioral Health Wisconsin, LLC	1205 South 70th Street, Suite 500 West Allis, WI 53214	100% Cenpatico Behavioral Health, LLC
Cenpatico Behavioral Health Arizona, Inc.	11223 North 28th Drive, Suite F100 Phoenix, AZ 85029	100% Cenpatico Behavioral Health, LLC
Cenpatico Behavioral Health, LLC	823 Congress Avenue, Suite 600 Austin, TX 78701	100% CenCorp Consulting Company
Desert Springs Professionals	11223 North 28th Drive, Suite F100 Phoenix, AZ 85029	100% - Cenpatico Behavioral Health LLC
Integrated Mental Health Management, LLC	1600 West 38th Street, Suite 320 Austin, TX 78731	100% - Cenpatico Behavioral Health LLC
Integrated Mental Health Services	1600 West 38th Street, Suite 320 Austin, TX 78731	100% - Integrated Mental Health Management, LLC
MHS Behavioral Health Services of Texas, Inc.	1600 West 38th Street, Suite 320 Austin, TX 78731	100% - Cenpatico Behavioral Health LLC
NurseWise Holdings, LLC - Delaware	3773 Cherry Creek North Drive, Suite 1050 Denver, CO 80209	100% CenCorp Consulting Company
NurseWise LP - Delaware	3733 Cherry Creek North Drive, Suite 1050 Denver, CO 80209	CenCorp Consulting Company – General Partner
CenCorp Consulting Company	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Corporation

Name	Address	Percent of Ownership or Control
Managed Health Services Illinois, Inc.	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Corporation
Centene Management Company, LLC – Wisconsin	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Corporation
Centene Corporation of Texas	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Corporation
CMC Real Estate Company, LLC – Delaware	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Management Company, LLC
Centene Finance Corporation – Delaware	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% – Centene Corporation
The Centene Charitable Foundation – Missouri	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Corporation
The Centene Foundation for Quality Health Care – Missouri	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Corporation
Coordinated Care Corporation Indiana, Inc. – (d/b/a Managed Health Services, Inc.)	1099 N. Meridian St., Suite 400 Indianapolis, IN 46204-1041	100% Centene Corporation
University Health Plan, Inc. – New Jersey	550 Broad Street, 17th floor Newark, NJ 07102	100% - Centene Corporation
Buckeye Community Health Plan, Inc. – Ohio	U.S. Bank Bldg, Suite 1200 175 South 3rd Street Columbus, OH 43215	100% - Centene Corporation
Superior Health Plan, Inc. – Texas	The Regency Building, Suite 202 2100 South IH-35	100% - Centene Corporation
Managed Health Services Insurance Corp. – Wisconsin	1205 South 70th St, Ste 500 West Allis, WI 53214	100% - Centene Corporation
MHS Consulting Corporation – Wisconsin	1205 South 70th St, Ste 500 West Allis, WI 53214	100% - Centene Corporation
Banker's Reserve Insurance Co. of Wisconsin – Wisconsin	7711 Carondelet Avenue, Suite 800 St. Louis, MO 63105	100% - Centene Corporation

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4. **Long-Term Business Transactions:** List any significant business transactions, as defined in 42 CFR 455.101, between the Offeror and any wholly-owned supplier or between the Offeror and any subcontractor during the five-year period ending on the Contractor's most recent fiscal year end:

Describe Ownership of Subcontractors	Type of Business Transaction with Provider	Dollar Amount of Transaction
None		

5. **Criminal Offenses:** List the name of any person who has ownership or control interest in the Offeror, or is an agent or managing employee of the Offeror and has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid or State Children's Health Insurance Program since the inception of those programs:

Name	Address	Title
None		

6. **Creditors:** List name and address of each creditor whose loans or mortgages exceed 5% of total Offeror equity and are secured by assets of the Offeror company.

Name	Address	Description of Debts	Amount of Security
None			

RELATED PARTY TRANSACTIONS

1. **Board of Directors:** List the name and address for each member of the Board of Directors of the Offeror:

Managers of GREABHA	
Name/Title	**Address**
Michael F. Neidorff, President, CEO and Director, Centene Karey Witty, Chief Financial Officer, Secretary and Treasurer, Centene	7711 Carondelet Ave. Suite 800 St. Louis, MO 63105

Managers of GREABHA	
Name/Title	**Address**
John D. Tadich, Senior Vice President, CenCorp Health Solutions and President, GREABHA Brian Butts, Treasurer and Chief Financial Officer, GREABHA	

Officers of GREABHA	
Name/Title	**Address**
John Tadich, President, GREABHA Brian Butts, Treasurer and Chief Financial Officer, GREABHA Samuel A. Donaldson, Vice President, GREABHA Jennifer Spears, Secretary	7711 Carondelet Ave. Suite 800 St. Louis, MO 63105

Managers of Cenpatico Behavioral Health	
Name/Title	**Address**
Michael F. Neidorff, President, CEO and Director, Centene Karey Witty, Chief Financial Officer, Secretary and Treasurer, Centene John D. Tadich, Senior Vice President, CenCorp Health Solutions and President, GREABHA	7711 Carondelet Ave. Suite 800 St. Louis, MO 63105

Officers of Cenpatico Behavioral Health	
Name/Title	**Address**
Samuel A. Donaldson, Ph.D., Chief Executive Officer Brian Butts, Treasurer Jennifer Spears, Secretary	823 Congress Avenue, Suite 600 Austin, TX 78701

2. **Highest-Compensated Management:** List names and titles of the 10 highest compensated management personnel including but not limited to the Chief Executive Officer, the Chief Financial Officer, Board Chairman, Board Secretary, and Board Treasurer:

Name/Title	Address
Michael F. Neidorff, President, CEO and Director, Centene	7711 Carondelet Ave.Suite 800 St. Louis, MO 63105
Karey Witty, Chief Financial Officer, Secretary and Treasurer, Centene	11223 North 28th Drive, Suite F100
John D. Tadich, Senior Vice President, CenCorp Health Solutions and President, GREABHA	Phoenix, AZ 85029
Brian Butts, Treasurer and Chief Financial Officer, GREABHA	
Rosa M. Cotayo, CEO, GREABHA	
Aron Halfin, Chief Medical Officer, GREABHA	
Children's Medical Administrator, GREABHA (to be named)	
Chief Officer of Community & Consumer Affairs, GREABHA	
Clinical Operations Administrator, GREABHA	
Corporate Compliance Officer, GREABHA	
Quality Management Administrator, GREABHA	

3. **Related Party Transactions:** Describe transactions between the Offeror and any related party in which a transaction or series of transactions during any one fiscal year exceeds the lesser of $10,000 or 2% of the total operating expenses of the disclosing entity. List property, goods, services and facilities in detail noting dollar amounts or other consideration for each transaction and the date thereof. Include a justification as to the reasonableness of the transaction, its potential adverse impact on the fiscal soundness of the disclosing entity, and that the transaction is without conflict of interest:

a) The sale, exchange or leasing of any property:

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period
None.		

Justification:

b) The furnishing of goods, services or facilities for consideration:

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period
None.		

Justification:

c) Describe all transactions between Offeror and any related party which includes the lending of money, extensions of credit or any investment in a related party:

Description of Transaction	Name of Related Party and Relationship	Dollar Amount for Reporting Period
None.		

Justification:

d) List the name and address of any individual who owns or controls more than 10% of stock or that has a controlling interest (i.e., formulates, determines or vetoes business policy decisions):

Name	Address	Owner or Controller	Has Controlling Interest? Yes/No
None.			No

OFFSHORE PERFORMANCE OF WORK PROHIBITED

Due to security and identity protection concerns, all services under this contract shall be performed within the borders of the United States. All storage and processing of information shall be performed within the borders of the United States. This provision applies to work performed by subcontractors at all tiers. Offeror shall declare all anticipated offshore services in the proposal.

None.

e. Offeror Experience

This proposal is being submitted by Greater Arizona Behavioral Health Authority, LLC (GREABHA), which has been established by Cenpatico Behavioral Health™, LLC (CBH), a managed behavioral health subsidiary of Centene Corporation® (Centene). Centene's experience and extensive knowledge enhances GREABHA's ability to implement the systems and principles outlined in this RFP. Centene's success stems from our practice of implementing customized systems and principles in each of the states we serve.

In choosing GREABHA, the Arizona Department of Health Services/Division of Behavioral Health Services (ADHS/DBHS) is choosing a Behavioral Health Services Administrator that embraces the Arizona System Principles, Arizona Children's System Vision and Principles, Principles for Persons with a Serious Mental Illness (the Arizona principles) and that honors the uniqueness and diversity of each of the behavioral health recipients and families it serves. In choosing GREABHA, ADHS/DBHS will benefit from the resources of an innovative national behavioral and medical healthcare company dedicated and practiced in customizing behavioral health care with government payers, Medicaid health plans, Health Maintenance Organizations (HMOs), Participating Provider Organizations (PPOs), Integrated Physician Associations (IPAs), and employers.

GREABHA's knowledge and philosophy are well aligned with the Arizona principles for behavioral healthcare

Centene is a publicly held (NYSE: CNC), multi-tiered managed healthcare organization, with a total market capitalization (7/29/04) of $801.7 million and no debt. Our financials are publicly available and are posted on the Internet at www.centene.com. Since 1984, Centene has provided managed care programs and related services to individuals receiving benefits under Medicaid, including Supplemental Security Income (SSI), family and children's Medicaid programs, including chronic/disabled populations. Centene's local approach to behavioral health management includes emphasis on behavioral health recipient outreach and services customized within the local market, which enables Centene to provide accessible, high quality, culturally sensitive healthcare services, ensuring implementation of the Culturally and Linguistically Appropriate Services in Health Care (CLAS). Centene has developed specialized Medicaid expertise, which has helped to establish and maintain strong relationships with behavioral health recipients and the providers that serve them.

Experience, Knowledge and Philosophy

CBH, the managed behavioral health subsidiary of Centene, provides behavioral health services in California, Ohio, Texas, Wisconsin and Indiana. Our experience includes providing behavioral health care benefits, provider services and training, customer services, and clinical services through a regional administration model, including integrating and analyzing data from diverse data sources in order to provide centralized and efficient management of behavioral health services. In 2003, CBH, formerly known as Group Practice Affiliates (GPA), joined CenCorp Health Solutions™, a division of Centene. This alliance enabled CBH to begin providing all of the managed behavioral health services for Centene's Medicaid health plans in Indiana, Ohio, Texas and Wisconsin. CBH completed all four of these successful implementations within aggressive timeframes during the past year.

GREABHA is dedicated to being the market leader in promoting innovative care delivered by passionate employees with unique behavioral health expertise, to enhance the quality of life in our communities, one person at a time.

Since 1996, CBH has successfully provided services to large, rural, and culturally diverse Medicaid behavioral health populations. In Texas, for example, CBH uses *Promotoras* to help the underserved Latino population understand the services available through CBH's behavioral health program. These *Promotoras* work in the community assisting consumers in accessing services available through the program or from community resources. *Promotoras* are all bi-lingual

and trained to understand the cultural preferences that may be prevalent with this population.

GREABHA will use the knowledge gained from utilizing the *Promotoras* in Texas to support providers in providing outreach and engagement activities to enroll and retain Title XIX and Title XXI eligible persons in the diverse communities of Greater Arizona. These efforts will be focused on the Latino population, but will also be expanded to employ consumers from Native American communities who are located in the service areas.

Centene has a successful track record of reducing administrative costs for state Medicaid health plans. In Greater Arizona, we will reduce administrative costs by providing core administrative services out of a central office located in one of the awarded GSAs. These core administrative services will support each of the awarded GSAs, thereby gaining economies of scale and reducing overall administrative costs.

Experience in Arizona

CBH has been operating as a behavioral health provider organization in Arizona since 2000. This experience has enabled us to develop an intimate knowledge and understanding of the Arizona principles for behavioral healthcare, first-hand knowledge of the challenges involved in helping provider agencies to effectively implement these principles, an inside understanding of local trends and the diverse cultural populations in Arizona, and a clear vision for meeting the ADHS/DBHS requirements set forth in this RFP.

CBH currently manages Desert Springs Professionals (DSP), which has provided a full array of individual, couples, family and group outpatient therapy, psychological testing and medication assessment, education, and management through a staff of psychiatrists, psychologists, social workers, marriage and family therapists and professional counselors. DSP has also developed Family Resource Centers (FRC) to bridge the gap between educational and behavioral health systems, offering families a complete continuum of outpatient behavioral health resources. Services offered have included counseling and medication management, as well as nontraditional services, such as case management, behavior coaching, peer support, job coaching and supervised day programs at select locations. The FRC serves as a conduit to help families receive entitlements and to enroll in behavioral health systems. These experiences will assist GREABHA in working with local providers and school systems to supplement and extend existing community and school resources to better meet the needs of children with behavioral health issues. The knowledge gained from the FMCs will be made available to provider agencies in Greater Arizona to assist them in expanding the array of supportive services available to families.

CBH also manages a specialized, school-based program called Academic Behavioral Accommodations (ABA), which serves Medicaid-enrolled emotionally/behaviorally challenged and learning disabled children and adolescents. The ABA schools assist students with special needs and enable them to learn to their fullest potential. The primary goal of this program is to enable our students to return to regular classrooms.

GREABHA will work closely with our behavioral health recipients and providers to ensure the most appropriate and least restrictive levels of care.

Our network will encompass numerous types of providers, including:

- Peer support
- Home based
- Natural supports
- Natural healers and traditional licensed behavioral health providers

Behavioral health support services will be provided by trained and supervised consumers and non-licensed staff. GREABHA will provide trained Telephonic Consumer Outreach Representatives through NurseWise®, a provider agency that is part of the Centene family of companies.

GREABHA is committed to significantly expanding peer, family and natural support services to create additional options for behavioral health recipients

1 The following table provides an overview of CBH's experience:

Contract Venue	Date CBH began Offering Services	Current Number of Behavioral Health Recipients Served	Service Area	Population Served	Type of Service Provided
Texas	1996	150,000 (Superior Health Plan) 90,000	Austin, El Paso, and Lubbock/Amarillo 170 predominantly rural counties	Title XIX, Medicaid & SSI Medicaid CHIP members	Full continuum of Behavioral Health Care services
Arizona	2000	120 students	Tempe, Chandler, Laveen, Avondale, Phoenix	Medicaid-enrolled special education students	Behavioral health provider organization and a specialized school-based program for children with behavioral conditions
Northern California	2000	333,046 (MHN) 80,191 (Hill Physicians Group)	10 counties in Northern California	Commercial and Medicare	Full continuum of Behavioral Health Care services
Arizona	2002	40 participants	Tuscon (CPSA)	Medicaid-enrolled youths, at-risk for out-of-home placement	Community-based after-school, Saturday and summer social and recreational programming
Wisconsin	July 2003	165,414	Milwaukee (22 counties)	Title XIX, Medicaid & CHIP members	Inpatient & Outpatient Services
Indiana	Nov 2003	121,383 (MHS Indiana)	Statewide	Title XIX, Medicaid, SSI Medicaid & CHIP members	Inpatient UM
Ohio	April 2004	25,000 (Buckeye Community Health Plan (BCHP)	Lucas County	Healthy Family, Healthy Start	Inpatient & "exception" outpatient services (when not available through Community Health Plan)

2

Following is a brief summary of the elements that characterize our operational philosophy and some of the initiatives in which we are currently engaged that are designed to put this philosophy into practice.

Philosophy	Initiatives
Easy and Timely Access to Care	Implementing initiatives across all markets aimed at improving behavioral health recipients' access to services. Telephone response rates are 30 seconds or less in all markets, with abandonment rates of 5% or less. Conducting network expansion initiatives in Texas and Wisconsin to increase the availability of specialty providers in behavioral health recipients' local communities
Behavioral Health Recipient and Family Engagement	Helping consumers understand the services available to them through educational efforts and intensive consumer outreach programs Maximizing consumers "voice and choice"
Collaboration with Each Local Community	Actively involving behavioral health providers, behavioral health recipients, consumer advocacy groups, state agencies, and other stakeholders in the design and implementation of the behavioral health service delivery system through Community Advisory Councils Designing programs that actively engage behavioral health recipients in their treatment and inspire hope for recovery
Effective Innovation	Promoting best practices and holding providers accountable for results Ensuring that all behavioral health recipients have a clinical liaison and service plan and that all children have a service plan developed by their child and family team Treatment compliance tools and programs Ensuring that all behavioral health recipients be screened for co-occurring substance use Promoting collaboration among behavioral health providers, Primary Care Physicians (PCPs), behavioral health recipients, support systems, and Arizona state agencies
Expectation for Improvement	Identifying information regarding demonstrated efficacy of service options; making this information readily available to recipients and providers, and encouraging the least restrictive level of care to achieve consumers' treatment goals Collaborating with community organizations that offer innovative community-based and home based services. For example, in Texas, CBH contracts with behavioral health service providers to offer Assertive Community Treatment (ACT) teams, which deliver services to behavioral health recipients in community settings with a focus on recovery, self-sufficiency, and achievement of meaningful goals. Identifying natural supports and expanding their use
Cultural Competency	Training and monitoring all employees regarding cultural competency to ensure that effective, understandable, and respectful care is provided in a manner compatible with our consumers' cultural beliefs, practices and preferred languages Regularly auditing our system to ensure cultural competency Providing specialized services to promote behavioral health recipients' access to care, include community outreach activities, "welcome calls" to all new enrollees, retention calls to help behavioral health recipients maintain their Medicaid eligibility (automatically flagged by our customer service software), transportation services, and translators that are available to accompany non-English-speaking behavioral health recipients to their healthcare appointments

Achieving Systems and Principles Similar to Those in the RFP

CBH has successfully implemented Medicaid behavioral health programs with requirements similar to those of Arizona. Of the many programs that demonstrate CBH's ability to meet the ADHS/DBHS's contract requirements, the Texas program is an especially relevant example of systems and principles similar to those outlined in this RFP. In both Texas and Arizona, many enrollees have difficult and complex challenges, such as serious mental illness, chemical dependency, co-occurring substance abuse, other dual diagnoses, involvement with the juvenile justice and/or child welfare systems, significant medical complications and physical disabilities, and serious emotional disturbances in children.

In Texas, as is expected in Arizona, CBH:

- Engages behavioral health recipients and family members across the organization's structure
- Offers an extensive range of covered services
- Ensures coordination of services with primary health care, behavioral health organizations, inpatient and outpatient care, child and adult mental health delivery systems, and other public sector programs and services
- Provides a similar range of clinical, network, provider relations, quality improvement, reporting, accounting, fiscal management, claims, and information management functions
- Is accountable for contract performance standards and behavioral health recipient outcomes
- Carries financial risk through use of a capitated payment methodology
- Collaborates with agencies to effectively address the needs of multi-system-involved consumers; including Child Welfare, Juvenile Justice System, Long Term Care and other state agencies

Our Commitment to Arizona

GREABHA will work collaboratively with ADHS/DBHS and other community partners to effectively implement the Arizona principles for the behavioral health system to Greater Arizona. We look forward to using innovative programs and our family of companies to build a fully integrated and behavioral health recipient-centered system of care. The support and engagement of behavioral health recipients, families, and community partners will be used to implement systems of care that are responsive to their needs. **The financial strength of the Centene family of companies assures ADHS/DBHS of the solvency and necessary resources to build an effective Arizona-based behavioral health infrastructure.** GREABHA proposes managing behavioral health services in multiple GSAs, which will ensure consistency and accountability through a single managed behavioral health vendor for multiple regions of the state. This will reduce administrative costs and allow for re-investment in services to behavioral health recipients.

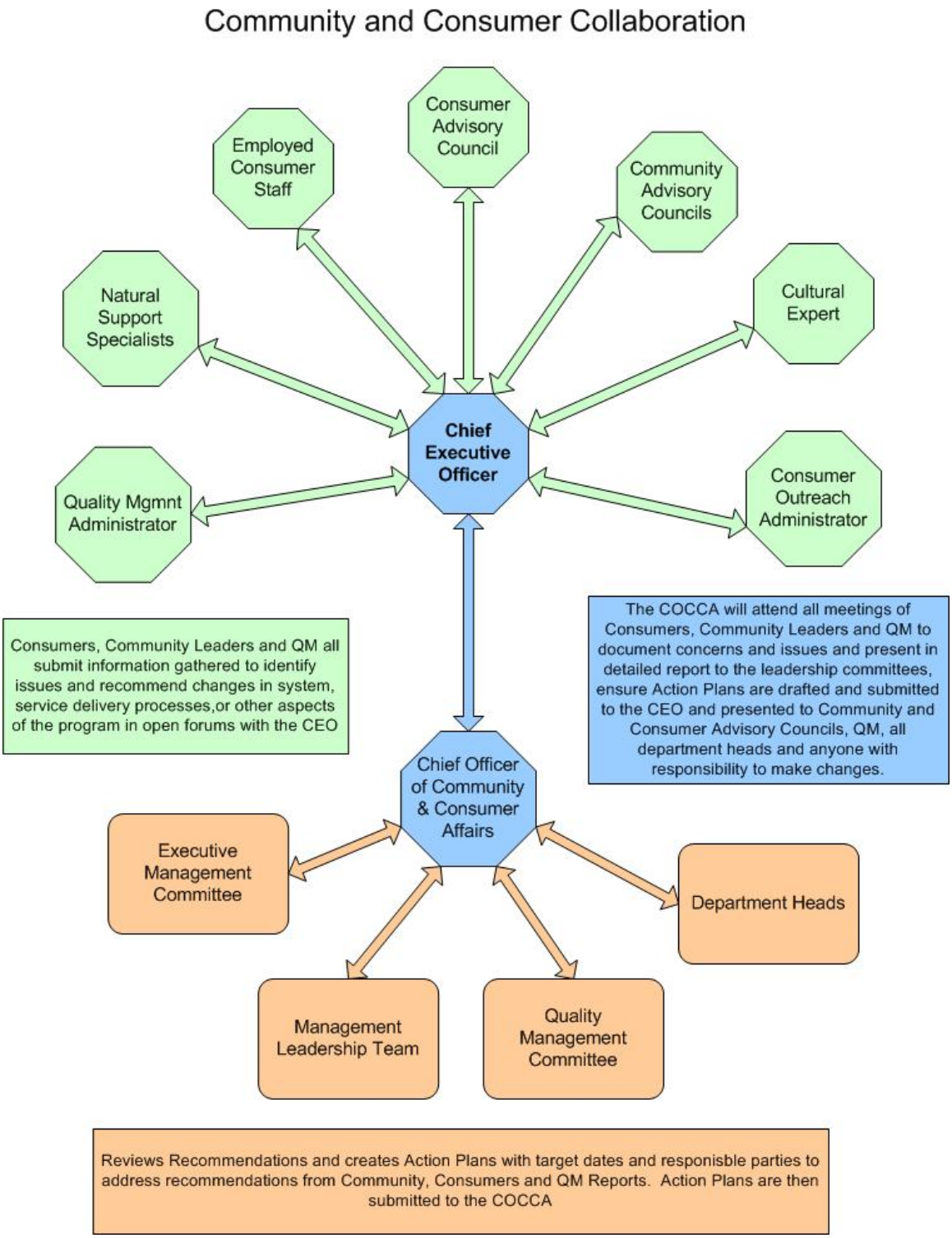
As part of this implementation, GREABHA will use our existing data system as the foundation on which to build a system-wide data infrastructure to support and track service delivery, compliance, and encounter system performance reporting. GREABHA will work with community provider agencies and ADHS/DBHS to develop a centralized data repository that will track each individual behavioral health recipient's current service plan, treatment team membership, and assigned Clinical Liaison.

GREABHA will work with providers and behavioral health recipients to continuously monitor and coordinate services, and will intervene when necessary to help behavioral health recipients access needed services and offer provider agencies mentoring, coaching, and technical support in implementing the Arizona principles. In addition, GREABHA measures key performance indicators, as prescribed by ADHS/DBHS.

f. Organizational Chart

The following organizational and flow charts illustrate the structure, down to the supervisor level, that GREABHA will use to fulfill the requirements of the RFP. Please note that the number of Full Time Equivalents (FTEs) listed in these charts assumes that GREABHA will be awarded all of the three GSAs for which we are bidding. FTE numbers will be adjusted based on the number of GSAs awarded.

Community and Consumer Collaboration



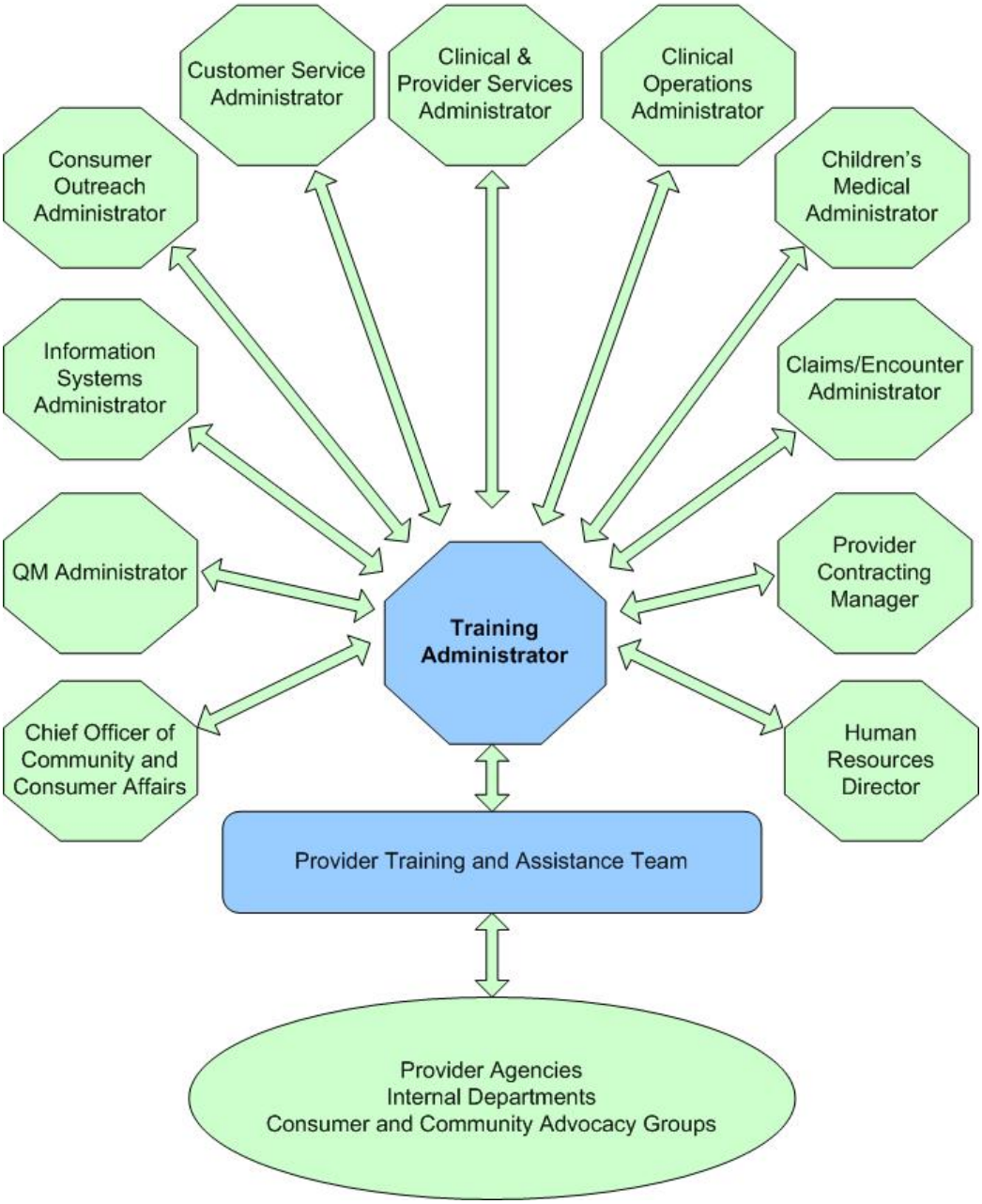
Quality Management Structure

In GREABHA, Quality Management (QM) is not limited to the QM department, but extends across all departments and functions. The QM Administrator is responsible for oversight of all quality measures and coordinating review of department key indicators. The QM Administrator presents for review required standards and benchmarks to the QM Committee (QMC), identifies key indicators for all areas associated with the Arizona principles, collects and interprets data, facilitates the QMC to make recommendations for improvements in GREABHA and in the provider system. The QMC will also draft quality improvement action plans based on the stakeholders' recommendations.

Training Team Structure

The Training information exchanges between internal and external staff and stakeholders takes many forms: reports indicating training needs and requests for information or assistance in sharing information across departments or with providers agencies. The Training Administrator identifies training needs by reviewing key indicator and trending reports and requests for training or assistance. The Training Administrator will then coordinate the appropriate resources to provide the training or assistance needed, either within the organization or for the provider network agencies with the primary goal of ensuring compliance with the Arizona principles.

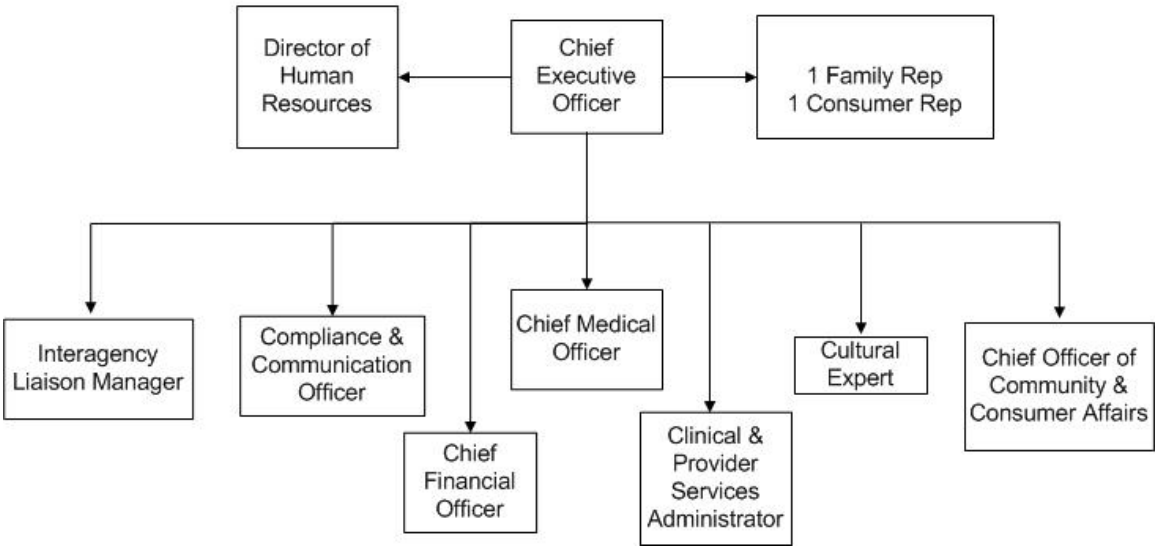
Training Team Structure



Executive Management Team

The Executive Management Team is responsible for designing and approving the strategic plan, decision making, ensuring compliance with the AZ principles, managing the organization; making all policy decisions; reviewing Quality Management and system data; identification of key areas of improvement; approving action plans; overseeing the operations; ensuring maximum behavioral health recipient and family engagement in the system and in decision-making; ensuring cultural competency throughout the system; and ensuring policies and processes are in compliance with the Arizona principles. The CEO leads the following Team Members:

Executive Management Team



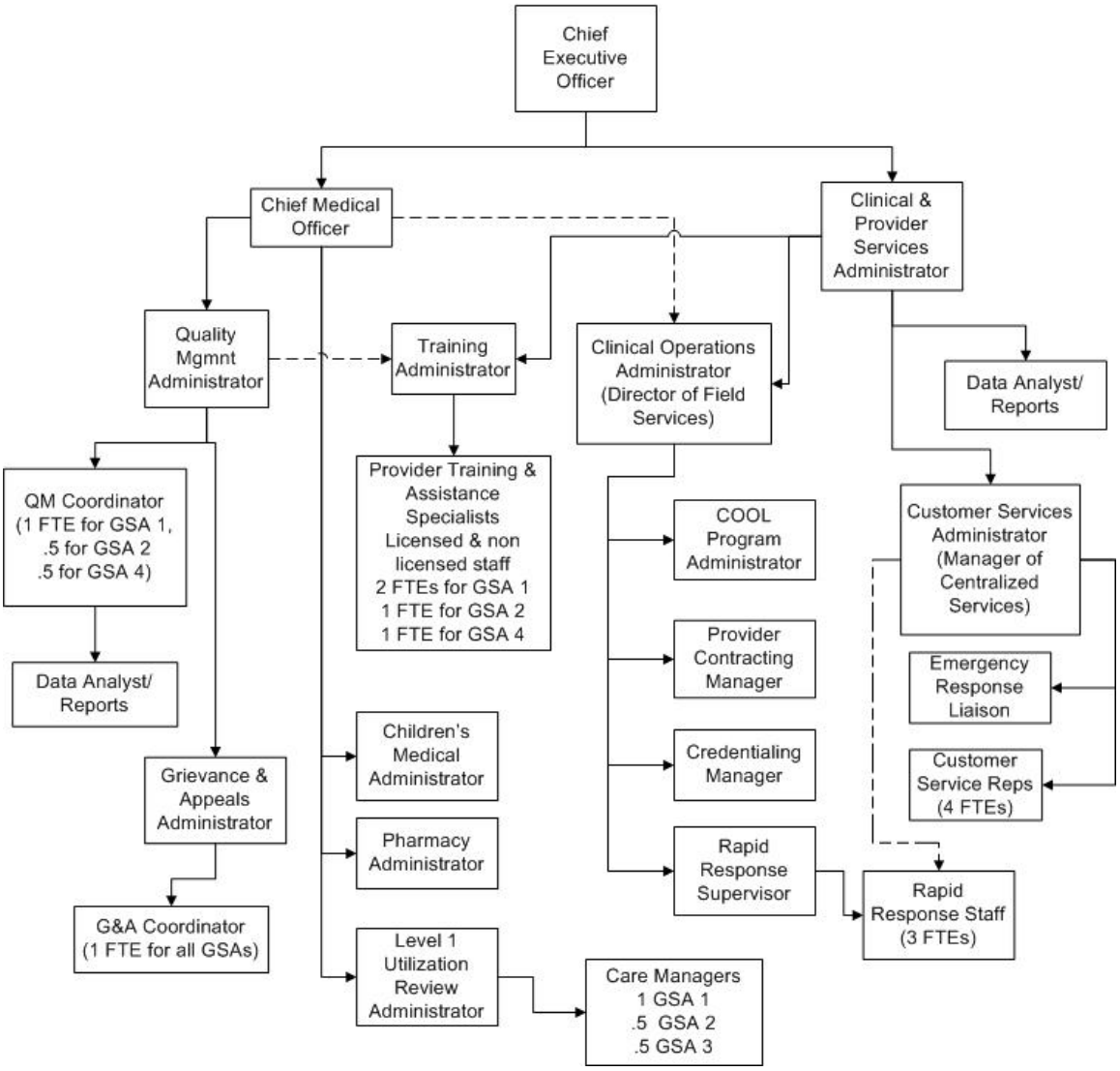
Management Leadership Team

Implements strategic plan, reviews operations, identifies problems and opportunities for improvement and system enhancements.

Clinical Operations

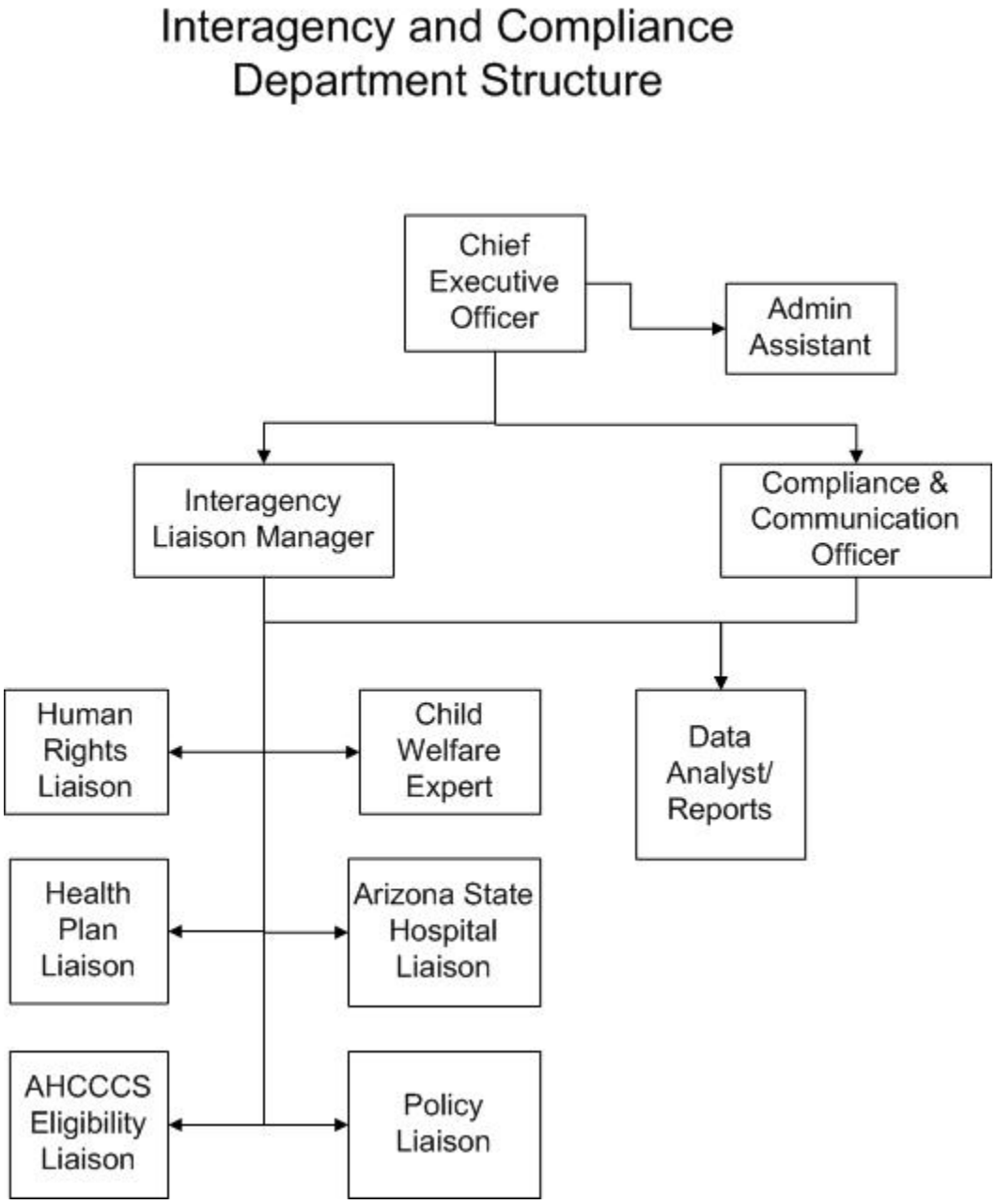
Our Clinical Operations department encompasses all clinical functions, Quality Management and Training. This structure ensures a cohesive, communicative approach to service delivery and guarantees quality and adherence to the Arizona principles.

Clinical Operations



Interagency and Compliance Department Structure

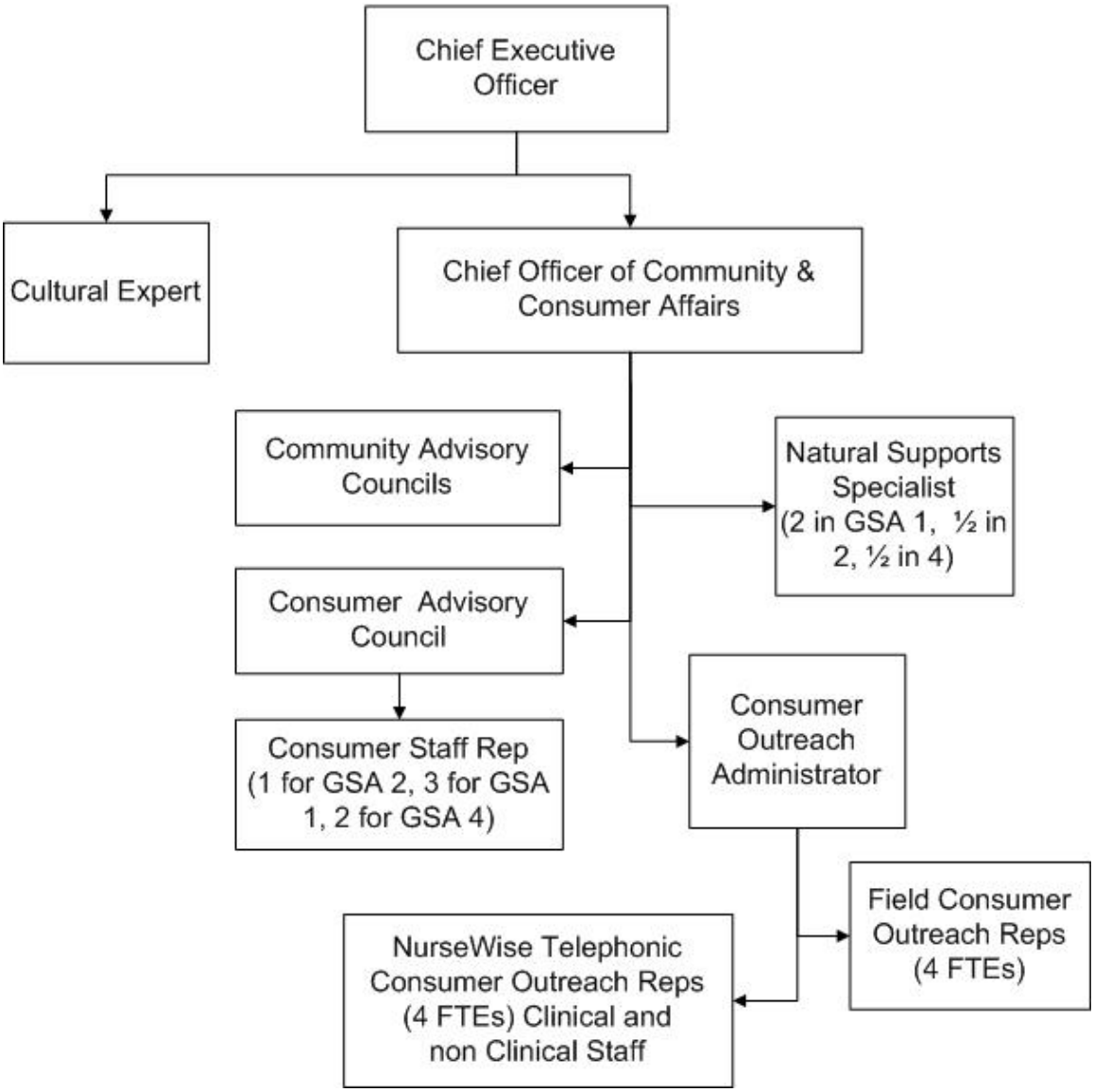
The Interagency staff works closely with all state agencies to identify service gaps, system issues, and opportunities for collaboration; measure effectiveness in working with behavioral health recipients; and share information within agencies. Our Compliance and Communication Officer ensures the organization is meeting the requirements of the Arizona principles, is following Policies and Procedures (P&Ps), and that P&Ps are compliant with ADHS/DBHS regulations. This position is also responsible for the review and approval of all external communications, coordinates review and recommendations before finalizing and sending to ADBH/DBHS for approval as needed.



Cultural, Consumer and Community Affairs Departments

The Cultural, Consumer and Community Affairs Departments work closely together to identify opportunities and make recommendations for system improvements. Our Cultural Expert leads a team of interdepartmental staff to review programs addressing cultural competency and recommends the addition of programs to improve communication among various minority groups, addressing specific geographic areas and counties, and considerations for cultural mix in each service area. The Chief Officer of Community and Consumer Affairs (COCCA) organizes the Consumer Advisory Council and Community Advisory Councils (one in each county). The COCCA will compile all concerns and issues with system and provider network/access, brainstorm with consumers and family members, provider agencies and community stakeholders and makes recommendations for change and improvement. The Councils also address crisis management issues and recommend prevention programs.

Cultural, Consumer and Community Affairs Departments



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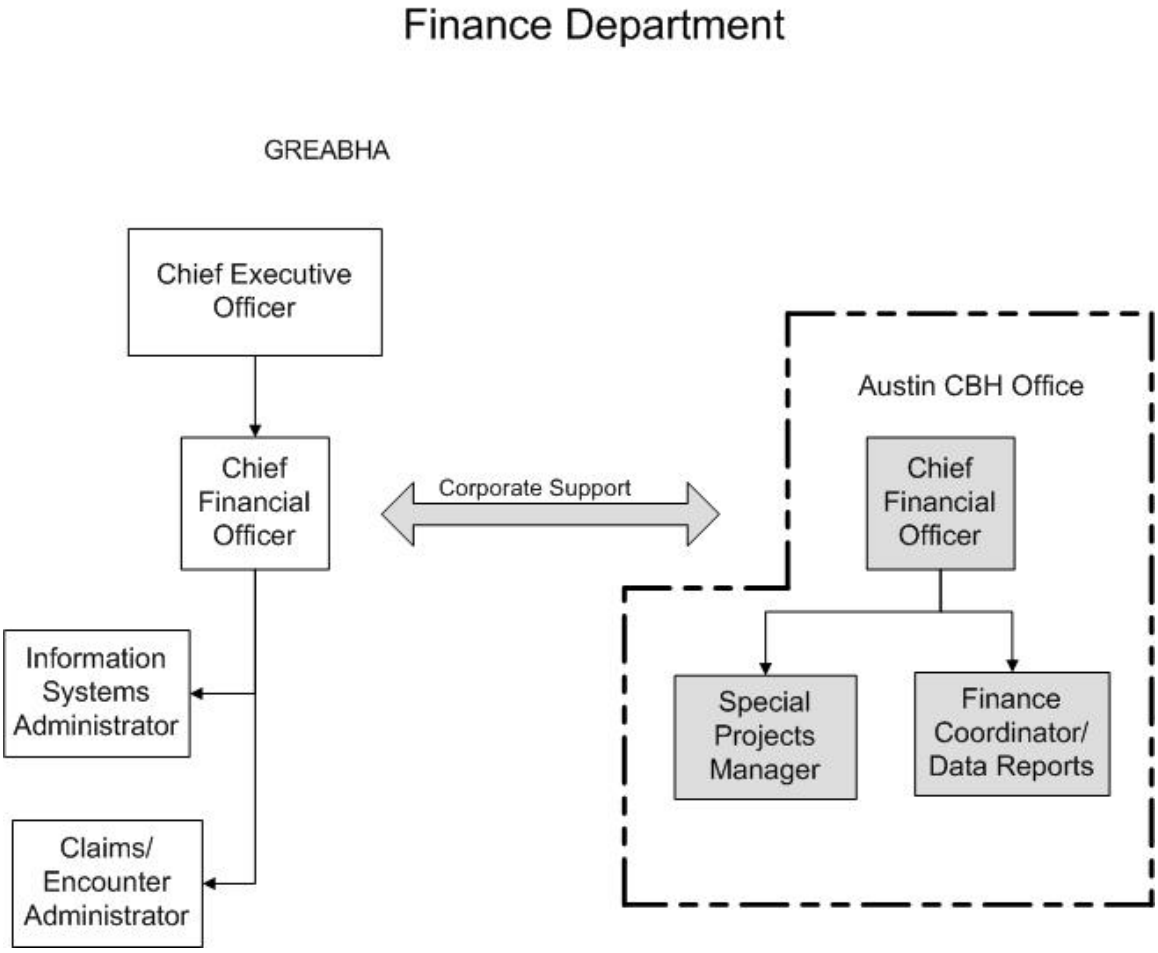
Finance Department

All financial management for this contract will be handled locally by the GREABHA Finance Department. This department is responsible for all finance activities, claims and encounter reporting and financial reporting. The local Finance Department will receive support from the CBH Finance Department as needed.



g. Organizational Structure

Organizational Structure for Arizona – GREABHA

GREABHA's focus is to administer the provision of exceptionally high-quality behavioral health services to behavioral health recipients; thereby, meeting and exceeding our customer's expectations. GREABHA believes the best way to provide service to behavioral health recipients is through local control and decision-making. GREABHA's parent company, Centene, has established this as a critical core element of how we do business. The corporate office provides extensive resources in the areas of finances, leadership management experience, Management Information Services (MIS), Quality Improvement and compliance -- all at a level not available from smaller organizations. GREABHA's resources include soliciting national expertise, including outside behavioral health experts in various disciplines and various specialty areas (child and adolescent treatment, recovery, Wrap Around, addictions, etc.). CBH's Clinical Subcommittee provides expert collaboration with clinical activities, policies, and guidelines. Our local business model allows GREABHA to be responsive to individual clients' needs, while also leveraging the expertise and resources of a national behavioral health organization.

Centene's family of companies provides exceptional expertise in the following functional areas:

- Service Facilitation/Behavioral health recipient outreach
- Network Management/Provider Relations (with state-of-the-art mentoring and technical assistance)
- Quality Improvement (Quality Improvement initiatives tied to the Arizona principles)
- Customer Service (with rapid resolution training and monitoring for all staff)
- Telephonic 24/7 Crisis Management, with Clinical and Nurse Triage
- Expedited Credentialing is standard
- Management of the Delivery System (with provider incentives to effectively implement the Arizona principles)
- Claims Payment (using state of the art claims processing and data reporting system)
- State Relationships **(Since its establishment in 1984, Centene has never lost a contract.)**
- Community relationships (GREABHA is building Community Advisory Councils to ensure local feedback and recommendations are obtained and to assess if the system is meeting all behavioral health recipient and community needs.)

Customer Service

GREABHA will structure our service center in Arizona to meet the specialized needs of Greater Arizona and the Arizona principles through the implementation of cross-departmental teams. Recognizing the critical role of accurate and effective communication, each team has a clearly defined role, function and reporting structure. External and internal communication is managed through a centralized communication team.

The heart of the GREABHA service center structure is the **Quality Management Committee (QMC).** The QMC is responsible for the collection and dissemination of dashboard performance indicators of the health and success of the delivery system. A critical element monitored by the QMC is the engagement of consumers in the analysis of all levels of the system.

The **Consumer Engagement Committee (CEC)** reviews policies and procedures, processes, access to care data, service delivery data, consumer satisfaction, provider agency profiling data, and Arizona principles service delivery data.

GREABHA understands that training, mentoring and coaching are the most effective methods for implementing system change, and we will achieve this through the establishment of the Provider Training and Assistance Team. Training may include Web-based training, mentoring and

coaching. The cross departmental **Training Committee** oversees all aspects of provider, staff, consumer and stakeholder training.

Communication is the key element to successfully improving the behavioral health system in Greater Arizona. GREABHA's organizational structure in Arizona is built around the goals of maximizing the role of communication and engagement of behavioral health recipients and their families in decision making and responding appropriately to their needs. To this end, we rely on the **Consumer Advisory Council** to review and provide feedback regarding consumer communications prior to their development and dissemination to consumers.

The **Management Leadership Team (MLT)** is responsible for identifying operational issues and solutions, and for implementing appropriate action plans.

The **Executive Management Team (EMT)** is responsible for establishing the vision, mission, goals and strategic plan for the company. The EMT reviews recommendations from the QMC, CEC, the Training Committee, the Consumer Advisory Council, the Community Advisory Councils, the MLT and all department heads. The EMT designs strategic plans based on this input.

There are several noteworthy positions in the organizational structure:

- The **Clinical and Provider Services Administrator (CPSA)** oversees all clinical operations within GREABHA and within the provider community including technical assistance, problem resolution, customer service program administration and provider contracting. This individual is responsible for effectively integrating contracting, training, technical assistance and monitoring into one department, to uniformly maximize compliance with the Arizona principles. The CPSA has the authority to act upon recommendations to improve the system.

- The **Chief Officer of Community and Consumer Affairs (COCCA)** reports directly to the CEO to maximize collaboration and feedback from behavioral health recipients, family members and stakeholders in the community. This is accomplished through the employment of local behavioral health recipients to provide a rapid and responsive communication loop between GREABHA and the behavioral health recipients and community. The employment of behavioral health recipients with a direct connection to the CEO and Executive Management Team will maximize collaboration and feedback from behavioral health recipients into the system. The COCCA is responsible for ensuring maximum behavioral health recipient collaboration, behavioral health recipient, family and community awareness of the system, and, with the assistance of the Cultural Expert, promoting a culturally effective process to meet behavioral health recipient needs.

- **The Cultural Expert** reports directly to the CEO and is responsible for identifying and implementing programs to more effectively meet behavioral health recipients needs in an effective, understandable, and respectful manner, compatible with their cultural health beliefs and practices and preferred language. This position will also make recommendations to the EMT on how to best employ, retain and recruit diverse staff and leadership that are representative of the demographic characteristics of the service area and meet all 14 CLAS standards of cultural competency.

- **The Compliance and Communication Officer (CCO)** has the authority and responsibility to monitor adherence to HIPAA guidelines, compliance to contract requirements and all applicable state and federal statutes, and reporting of all issues of fraud and abuse within the organization and in the provider community. The CCO is responsible for the review and approval of all public communication.

- **The Chief Medical Officer (CMO)** has the authority and responsibility for administration of pharmacy, UR of Level 1 services, and Quality Management. The CMO is responsible for the

success of Quality Improvement initiatives tied to the Arizona principles and reporting the results of QM monitoring to the EMT.

- **The Chief Financial Officer** has authority and responsibility for implementing all information and data systems, claims and encounter administration, financial reporting, and ensuring the integrity of all data to effectively report on compliance with the Arizona principles in our provision of services to include community, home-based and natural support services.

How GREABHA will Support the Arizona Principles

The organizational and committee structures have been established for maximizing behavioral health recipient and family engagement in decision-making and compliance with the Arizona principles. All committees will be given a charter that clearly outlines their responsibilities and roles are structured to maximize behavioral health recipient and family and stakeholder input, streamline the process of identifying problems and creating effective resolution while effectively using stakeholder staff resources.

The following is a list of committees, teams and meetings that will provide critical input into decision making with GREABHA. All committees will have clearly defined charters and scopes of responsibilities. The job positions used in the following table are as follows:

CEO = Chief Executive Officer
CFO = Chief Financial Officer
CMO = Chief Medical Officer
COCCA = Chief Officer of Community and Consumer Affairs
CPSA = Clinical and Provider Services Administrator
ILM = Inter-agency Liaison Manager
CCO = Compliance and Communications Officer
QMA = Quality Management Administrator
URA = Utilization Review Administrator
ISA = Information Systems Administrator
CSA = Customer Service Administrator
CEA = Claims Encounter Administrator
G&AA = Grievance & Appeals Administrator
COA = Consumer Outreach Administrator
CMA = Children's Medical Administrator
PCM = Provider Contracting Manager

Committee Name	Members	Scope of Responsibility	Authority
Executive Management Team (EMT)	CEO (chair); CMO; CFO; COCCA; CPSA; Consumer Advisor; Family Member Advisor; ILM; COO	Designing and approving strategic plan, decision making, ensuring compliance with the AZ principles, managing the organization; making all policy decisions; reviewing Quality Management and system data; identification of key areas of improvement; approving action plans; overseeing the operations; ensuring maximum behavioral health recipient and family engagement in the system and in decision-making; ensuring cultural competency throughout the system; and ensuring policies and processes are in compliance with the Arizona principles.	Final decision maker
Management Leadership Team (MLT)	CEO (chair); CMO; CPSA; CCO; COCCA; CFO; ILM; URA ; PCM CEA; Cultural Expert; QMA; Training Administrator;G&AA; COA, CMA	Implementing strategic plan, reviewing operations, identify problems and recommend solutions, identify opportunities for improvement and system enhancements	Recommendation and execution of approved action plans
Consumer Engagement Committee (CEC)	COCCA, Cultural Expert, Interagency Liaison, Consumer Staff Reps, Behavioral Health Recipients	Special team to review ideas and ways to engage consumers and family members in their care and recovery.	Recommend new programs and processes to EMT
Training Committee	Training Administrator, Provider Training and Assistance Specialists, all department heads and high volume provider agency reps.	Assesses training needs in the system by reviewing data generated by the Quality Management Team; Identifies training needs in the system and establishes training goals. Clearly defines outcomes; Reviews the training plan and submits the training plan to the Executive Management Team for final approval. Identifies the appropriate method of training based upon the training needs.	Recommend training programs and audits to MLT and EMT
Credentialing Committee	Credentialing Manager (chair), Network providers, QMA, CMO, UMA, G&AA	Processing provider applications, peer review, access and availability monitoring	Recommendations for provider inclusion in network
Meeting with CEOs	CEO (chair), CFO, CPSA, CEO and Provider Agencies CEOs	Direct Communication link with GREABHA CEO and providers, identification of key problems, effective communication regarding initiatives and expectations, upcoming system changes, provider feedback to GREABHA	Recommend problem resolutions
Quality Management Committee	CMO (chair), QMA, URA, Child Welfare Expert, Pharmacy Administrator, CPSA, COCCA, CCO, CFO	Oversight of all department key indicators, review of required standards and benchmarks, identification of key indicators for all areas associated with the Arizona principles, collecting and interpreting data, recommendations for system, provider system, quality improvement action plans, review of clinical	

Committee Name	Members	Scope of Responsibility	Authority
		system, provider system, quality improvement action plans, review of clinical guidelines and medical necessity criteria, service mix for AZ principles (support vs. clinical), formulary review. Provides weekly, monthly and quarterly reports on the "state of the delivery system" and report to the Executive Management Team for further interpretation, analysis, and action planning.	Recommendations, measure, audit, reporting, problem identification
Consumer & Family Advisory Council	COCCA (chair), Consumer Staff Rep, CEO, Behavioral health recipients (50 %), Community Advocates	Voice concerns and issues with system and provider network/access, brainstorm about ideas for improvement, make recommendations for change and improvement	Recommend changes, develop action plans
Cultural Advisory Council	Cultural Expert (chair), COCCA, Consumer Staff Rep, CEO, Behavioral health recipients, Community Advocates, Stakeholders	Review programs addressing cultural competency and recommend addition of programs and improve communication to various minority groups, addressing specific geographic areas and counties, considerations for cultural mix in service area	Recommend changes, develop action plans
Community Advisory Councils	COCCA (chair), Consumer Staff Rep, CEO, Behavioral health recipients (50 %), Community Advocates, Provider Agencies, Stakeholders	Address crises management issues, recommend prevention programs, recommendation and oversight of behavioral health recipient access and delivery system	Recommend programs and action plans
Compliance Committee	CCO (chair), CEO, CFO, CMO, CPSA, COCCA, QM Administrator	Ensure organization is meeting the requirements of the AZ Model, ensure organization is following P&Ps, ensure P&Ps are compliant with ADHS/DBHS regulations	Recommend changes in process, P&Ps and develop action plans
Intergovern-mental Affairs Committee	CCO (chair), CPS, Dept of Education, AZ officer of the court, Juvenile corrections, Dept of Corrections, Dept of Developmental Disabilities, ACYF, AHCCCS and health plans, AZ ADHS/DBHS Policy Dept.	Identify Service gaps, systems, issues, opportunities for collaboration, measure effectiveness in working with behavioral health recipients, share info within agencies	Recommend changes to improve system and meet requirements for AZ principles
Network Management Committee	CPSA (chair), CEA, PCM CMO, Training Administrator, Credentialing Manager, Network Providers	Reviews access and Availability Reports (GeoAccess); provider Selection criteria; complaints and data regarding access; Provider Newsletter	

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h. Resumes and Job Descriptions

Following please find resumes and job descriptions for key positions in the organizational structure that GREABHA has proposed. Some of these individuals currently hold positions at CBH and/or Centene. Other individuals are currently not employed by the Centene family of companies. GREABHA has entered into initial discussions with these individuals, as they are targeted candidates for certain key positions in GREABHA. At the time of this submission, no job offers have been extended, although both parties have expressed interest in further employment discussions upon contract award.

1

Rosa M. Cotayo, Psy.D.

Chief Executive Officer

Greater Arizona Behavioral Health Authority, LLC.

Dr. Cotayo has extensive experience in managing service delivery systems to be in compliance with state and federal contract expectations. She has particular expertise in the implementation of behavioral health services to diverse cultures and in large geographic areas. She is keenly knowledgeable about the interface between culturally sensitive services and enculturation. She has over 29 years experience working in the Behavioral Health Care System in Arizona. She has extensive experience in implementing special programs involving key training components. Her advocacy and intimate knowledge of bilingual education will be invaluable to this contract. Her experience as a provider, director of training and clinical director give her the wide reaching experience to project our company to the leader in meeting the goals of the Arizona principles for all populations.

Responsibilities and Accomplishments

- Responsible for the clinical leadership and direction of Magellan's CHAMPUS/TRICARE Central Region Program, managing care for over 1 million TRICARE beneficiaries and active duty service members spanning 16 states.
- Maintained close, productive business relationship with all vested parties on behalf of TRICARE: the federal government, Lead Agency, Military Treatment Facilities and TriWest.
- Managed care for over 1 million TRICARE beneficiaries and active duty service members spanning 16 states.
- Responsible for developing best practices in care management/case coordination and intensive case management outcome studies for Magellan.
- Responsible for the clinical performance of MBC's ten (10) Regional Service Centers in the Western Region.
- Responsible for designing, implementing and overseeing clinical staff and network development programs for theTRICARE Western Region.
- Responsible for annual evaluation of the clinical operations in the Western Region.
- Responsible for directing MBC's disaster relief efforts in Florida in the aftermath of Hurricane Andrew.
- Served as consultant to the following MBC national clinical operations for start-ups of new programs, staff and network development, program evaluation: Florida, Massachusetts, Vermont, New Hampshire.
- Implemented state policy in bilingual higher education for the State of New Jersey.
- Coordinated the establishment of bilingual higher education programs in New Jersey colleges and universities.
- Developed a comprehensive plan to evaluate bilingual higher education programs.
- Assisted in the implementation of bilingual teacher certification policies.
- Coordinated the establishment of a Task Force to develop a Master Plan for Bilingual Higher Education for the decade of the 1980s.
- Co-developed and implemented a model competency-based, field-oriented bilingual teacher education program.
- Coordinated the school-community relations component of the bilingual program.
- Adapted the New York City Board of Education Mathematics curriculum for use in the bilingual program.
- Evaluated Teachers College Doctoral Program in Bilingual Education (E.S.E.A. Title VII); developed instrumentation and prepared the final reports.

Rosa M. Cotayo, Psy.D.

Professional Work History

MBH TRICARE Central Region Program
Phoenix, Arizona
VP Clinical Services *1996 - Present*

Merit Behavioral Care (Magellan's legacy company)
Phoenix, Arizona
Regional Clinical Director *2002*

MBC (Magellan's legacy company)
Tucson, Arizona
Clinical Manager (6 years) *1998*

La Frontera Center, Inc. Community Mental Health Center (CMHC)
Tucson, Arizona
Staff Psychologist (2 years):

La Frontera Center, Inc. Community Mental Health Center (CMHC)
Tuscon, AZ
Pre-Doctoral Psychology Intern (1 Year):
University of Arizona, College of Medicine - Department of Psychiatry
Tucson, Arizona
Psychologist in Private Practice *10/84 - 1/97*

New Jersey Department of Higher Education
Trenton, New Jersey
Assistant Clinical Lecturer: *7/86 - 7/90*

Hunter College of the City University of New York
New York, New York
Coordinator, Office of Bilingual Higher Education: *2/77 - 8/80*

New York City Board of Education, Community School District I
New York, New York
Instructor/Curriculum Specialist: *7/74 - 1/77*

Columbia University-Teachers College
Bilingual Teacher: *9/72 - 6/74*

Education and Accreditation

Yeshiva University, New York, NY
Hunter College of CUNY, NY, NY
St. Peter's College, Jersey City, New Jersey Educational Consultant *9/74 - 6/82*

Psy.D., Clinical Psychology
M.A., Clinical Psychology
M.S., Education
B.A., Spanish Literature; Minors: Education, English

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Melinda Vasquez

Chief Officer of Community & Consumer Affairs

Greater Arizona Behavioral Health Authority, LLC.

Ms. Vasquez has extensive experience with various Medicaid, Medicare, and Commercial Health Plans with a wide spectrum of responsibilities. Ms. Vasquez is responsible for the implementation of new business for CBH, and project management of large, cross-departmental projects. Prior to joining CBH, Ms. Vasquez worked with NurseWise ® to design and coordinate the development of a centralized call center for the corporate office of several Medicaid plans. Additionally, Ms. Vasquez was key in filing the expansion application to take a Medicare plan from a few metro counties, to being the first to cover the entire state of Arizona

Responsibilities and Accomplishments:

- Directs project teams to implement new behavioral health contracts with various states
- Oversight of process improvement initiatives across multi-departmental, divisional and corporate areas of responsibility
- Expertise in call center set up and management, health plan compliance with state and federal regulatory agencies such as Dept of Insurance, HCFA and State Medicaid, and system conversions
- Experience with health plan member services, telephonic case management, telephonic triage services and drug compliance programs
- Implementation and design of software for tracking calls, triage protocols and surveys
- Establishment of client service operations, new product development and process improvement programs
- Moved 5 health plan customer service departments into a centralized Phoenix Call Center and ran the center while the centralization project was completed
- Coordinated the building of the workspace, designed the phone routing and reporting system, developed the training program for each site as it rolled in, hired and trained representatives to take on the new business as needed
- Reduced FTEs by 29% across the board, saving approximately $360,000 annually in representative salaries, plus the savings incurred in real estate, equipment costs, and management salaries
- Drafted and directed the provider education and coordinated the implementation of the IVR (Integrated Voice Response) System and increased automated information to provider network. Implemented multiple process redesigns to reduce costs and increase efficiencies by working with IS&T to design a call tracking system, automate call trends reports and propose policy changes to state regulators to work more effectively in contacting our members for our outreach programs
- Responsible for all Medicare Appeals and Grievances. Reviewed regulations and modified processes to bring the Medicare files into compliance. Managed an average of 25-50 open files daily. Brought Intergroup's record from over 30 non-compliant files per quarter to only 1 in the last quarter employed
- Liaison to several major medical groups

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Professional Work History

Cenpatico Behavioral Health
Austin, TX

Director of Business Implementations *11/2003 - Present*

OPTIMUM PROJECT SOLUTIONS
Chandler AZ

Owner/Consultant *9/2002 – 11/2003*

EVERCARE
Phoenix AZ

Director, Customer Care Center *1/2000 – 9/2002*

PREMIER HEALTHCARE OF ARIZONA
Phoenix AZ

Compliance Officer *3/1996 - 1/2000*

INTERGROUP OF ARIZONA
Grievance and Appeals Coordinator *1/1994 - 3/1996*

INTERGROUP OF ARIZONA
Member Services Representative

Education and Accreditation

Pasadena City College, Pasadena, CA *Bachelors, Economics*

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Cultural Expert

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Chief Executive Officer
Purpose:
Responsible for overall management, implementation and oversight of the organization's Cultural Competency Plan

- Capable of modeling behavior that is culturally responsive; facilitating cross-cultural communications; and identifying and bridging cultural gaps in both staff development and client service delivery
- Responsible for assuring that cultural proficiency is valued throughout the organization
- Serves as a conduit for wide-ranging information on creative/innovative models of cultural competency being used in other parts of the country. Reviews provider agency cultural competency plans and provides feedback and technical assistance
- Reviews compliance with cultural competency plans
- Instructs the Executive Management Team regarding Cultural Competency

Responsibilities:

- Maintain a continuous examination process for bias in policies, practices, and personal philosophies required to implement and sustain culturally relevant program efforts to support cultural responsiveness
- Create staff development and training programs to enhance the capacity to deliver culturally proficient clinical services, which include principles that support the organization's strategies that expand the knowledge base on culture and managing diversity
- Establish effective working relationships with local academic institutions for the purpose of enhancing the workforce through innovative and jointly developed training opportunities
- Surveys research literature and collects information on innovative operating program models
- Develop evaluation and treatment outcome measures in respect to culturally competent services
- Establish procedures for monitoring, evaluating, and addressing diversity issues in the organization
- Act as a liaison with other agencies and institutions providing services to the organization's consumer groups. Expand supervisors' knowledge base on culture and managing diversity and being assertive and direct in facilitating culturally responsive behavior among staff
- Leads the Executive staff, in establishing the cultural competency plan and oversees implementation of the plan
- Represents the organization's interest on various internal and external committees
- Works closely with Arizona Department of Health Services/Division of Behavioral Health Services, stakeholders, State agencies, and community to ensure that all standards and procedures are being met

Qualifications:
Knowledge/Experience:

- Minimum five years experience in program development, research, publication and consultation on cross-cultural issues in healthcare/behavioral health
- Minimum of five years experience in behavioral health with focus on issues related to cultural competence
- Bachelors degree in behavioral health, cultural studies, communications, business management or similar degree with intimate personal knowledge of cultural issues

Skills:

- Proficiency in Microsoft Office; consulting and influencing skills; ability to lead and advise on complex issues; ability to listen without judging in helping to resolve problems and/or clarify performance expectations; ability to assess and implement culturally sound programs; excellent planning and organizational skills; professional interpersonal skills; problem-solving orientation and skills; good analytical and mathematical skills; strong team player; exercise tact and diplomacy, maintain confidential information; detail orientation; excellent follow-through behavior; high level of accuracy; ability to interact with employees at all levels of the organization; ability to interact with people of various cultural backgrounds and impart this knowledge to fellow employees and the organization; ability to thrive in a fast-paced environment and travel.

Licensure: None Required

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Arthur L. Blinick LCSW CPHQ

Quality Management Administrator

Greater Arizona Behavioral Health Authority, LLC.

Skilled behavioral healthcare professional with extensive background in quality improvement, principles of total quality management/continuous quality improvement, project management, clinical operations, risk management, program development, training, and policy and procedure development. Able to see the "big picture", but also able to understand the "details" and operational requirements. Excellent project management, analytical, presentation, time management, matrix management and communication skills. Successfully managed accreditation reviews for CARF, NCQA, JCAHO, URAC, and represented agencies in State and other entity oversight reviews. Assisted delegated agencies in developing their own QI Programs and then audited them for compliance.

Responsibilities and Accomplishments:

- Created and directed a comprehensive Quality Improvement Program, including accreditation and oversight audit preparation and response. Managed CARF accreditation survey that resulted in increase in accreditation from one year to three years
- Significant responsibility for the design, implementation, and management of the Company's Quality Improvement Program. Provided leadership, guidance, direction and oversight to implement the Program and support the accreditation efforts of the HMOs for whom the Company served as a delegated behavioral health entity. Represented the Company in Accrediting agency (NCQA, JCAHO, Medicare, Medicaid), State oversight agencies, and outside consultant surveys, interviews, and audits. Provided extensive training for Company staff.
- Provided leadership and direction for the oversight of the Behavioral Health entities to which the Company delegated Quality Improvement. Conducted pre-delegation and annual oversight audits. Provided extensive training and consultative services to these delegated entities to help them build Quality Improvement Programs.
- Provided leadership on a national level to design, implement and manage the Company's Quality Improvement Program, which included commercial, and Employee Assistance accounts. Served on the Company's National Clinical Quality Improvement Committee.
- Developed, implemented, managed, and provided oversight of National Quality Improvement Projects such as appointment access sampling, including contract negotiation with outside vendors.
- Developed National Risk Management training manual used by the entire company.
- Managed the administrative, clinical and physical operation of several behavioral care offices.
- Risk Manager for Phoenix operations.
- Chaired and facilitated Continuous Quality Improvement Groups.
- Provided training to Clinical and Management staff on Risk Management, and Quality Improvement matters.

Arthur L. Blinick LCSW CPHQ

- Co-founder, and Administrative and Clinical Coordinator for a multi-disciplinary Chronic Pain Program for CIGNA Healthcare of Arizona, serving 300,000 members.
- Provided the full spectrum of clinical services to a varied patient population, including children, adults, families, and couples. Provided Employee Assistance Services to employees of a local School District.
- Provided the full spectrum of clinical services to a varied patient population, including children, adults, families, and couples. Regional Supervisor for Parent's Anonymous. I also provided administrative and supervisory services, including grant writing, and was extensively involved in community activities, especially with regard to children's services.

Professional Work History

EMPACT-SPC
Mesa, AZ

Vice President and Director of Organizational Advancement — *May 2002-Present*

EMPACT-SPC
Mesa, AZ

June 2001-May 2002 — *June 2001-May 2002*

CIGNA Behavioral Health-Phoenix AZ (formerly known as MCC Behavioral Care)
Phoenix, AZ

Asst. Director of Quality Improvement — *November 1995-November 2000*

CIGNA Healthcare of Arizona/MCC Behavioral Care/ CIGNA Behavioral Health
Phoenix, Arizona

Clinical Administrator — *October 1987-November 1995*

CIGNA Healthcare of Arizona

Clinical Social Worker — *December 1983-October 1987*

Community Counseling Centers
Holbrook Arizona
Clinical Social Worker — *September 1991-December 1983*

Education and Accreditation

University of Illinois, Urbana Illinois. The Jane Addams Graduate School of Social Work — *Master of Social Work*

The Ohio State University, Columbus Ohio. — *B.A. Sociology*

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Lori Adler

Q M C o o r d i n a t o r

Greater Arizona Behavioral Health Authority, LLC.

Extensive experience in oversight and development of Quality Improvement Plans, provider audits for compliance management of utilization review and service authorization for agencies providing services to adults and children receiving mental health services. Skilled in ensuring compliance with licensure and contract indicators and meeting regulatory requirements and performance improvement activities.

Responsibilities and Accomplishments:

- Over all responsibility and oversight for Public Sector Operations
- Oversight and responsibility for Case Management Operations
- Attendance at MDT meetings and IEP meetings as needed on high profile cases
- Oversight and responsibility for Utilization Management Program
- Served as HIPPA Privacy Officer
- Responsible for Licensure and contract indicator compliance
- Coordination of Policy and Procedure Manual
- Responsible for regulatory requirements and Performance Improvement Activities
- Responsible for all Risk Management Activities•
- Development and Implementation of Quality Improvement Plan
- School and community coordination of care for Emotionally Handicapped children
- Responsible for JCAHO, Licensure and contract indicator compliance
- Perform Audits as required by ADHS for Arnold vs. Sarn
- Performance Audits as required by ADHS for Jason K. – involving Special Education, State agencies and RBHA staff
- Serve as ADHS/DBHS customer service liaison
- Serve as member advocate and liaison for providers and state agencies (i.e., CPS, Probation, Parole, DDD, Dept of Education)
- Manage group home for developmentally disabled girls
- Supervise group home staff, schedule activities, risk management activities, provide training and educations for staff members
- Manage five group homes and a 32 bed RTC for children with Behavioral and Mental Health Problems
- Assistant Teacher Devereux Day School

Professional Work History

Phoenix Interfaith Counseling
Phoenix, AZ

Director of Public Sector Operations *December 2002 to Present*

Phoenix Interfaith Counseling
Phoenix, AZ

August 2002 to December 2002 *August 2002 to December 2002*

Devereux Arizona, Richard L. Raskin Treatment Network

Director of Quality Improvement and Compliance *February 2000 – August 2002*

ValueOptions
Phoenix, AZ

Quality Management Analyst *July 1999 to February 2000*

Lori Adler

ValueOptions
Phoenix, AZ
Provider Relations Coordinator/Network Manager — *February 1999 – July 1999*

ComCare
Phoenix, AZ
Assistant Manager (Phase IV) — *November 1995 - January 1999*

Bethpage Mission West
Phoenix, AZ
Group Home Manager (DDD Clients) — *October 1991 – July 1992*

Devereux Center Arizona
Scottsdale, AZ
Milieu Manager — *October 1991 – October 1990*

Devereux Center Arizona
Scottsdale, AZ
Assistant Teacher Devereux Day School — *July 1987 – October 1990*

Education and Accreditation

Northern Arizona University, Flagstaff Arizona — *Bachelor of Arts, Psychology*

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Addam Gross, MC, CPC, NCC

Training Administrator

Greater Arizona Behavioral Health Authority, LLC.

Addam has over 11 years experience in the Arizona Medicaid Behavioral Health Care System, with 4 of those years specifically focused on development, implementation and improvement of a training program to meet the requirements of the Arizona principles. His program knowledge, training implementation experience and years in the industry will take GREABHA right to the forefront of implementation with no learning curve, as we are hiring an expert to take us there.

Responsibilities and Accomplishments:

- Developed and directed training program on behalf of Maricopa County RBHA. Developed curriculum, assessed program effectiveness and participated in Quality Improvement Planning. Managed all aspects of the training program.
- Provided technical assistance, training and mentoring to provider agencies.
- Developed policies and procedures.
- Served as team leader for financial coordination with the specialty company entities and corporate functions.
- Managed all operational aspects of an outpatient mental heath clinic. Assured effective compliance with financial and staffing budgets. Facilitated coordination of clinical and case management services with multi-systems. Supervised a variety of employees ranging from front office staff to psychiatrists (60 employees). Coordinated projects with community/state organizations. Implemented and monitored compliance with policies and procedure. Worked in collaboration with treatment teams to develop and maintain program philosophy and pursued goals and objectives that were congruent with the program mission. Provided overall leadership and management for the site that emphasized high quality consumer care.
- Provided individual, group, family therapy, and intake assessments to persons requiring inpatient hospitalization. Samaritan specializes in the treatment of SMI, CD, Eating Disorders, Geriatrics, and Child/Adolescents. In addition to counseling, assisted with adult education within the hospital setting.
- Coordinated and developed treatment plans with a clinical team for the seriously mentally ill. Other responsibilities included crisis intervention, assessment, discharge planning, and referral/coordination with providers. In addition, assisted in training new hire orientation in clinical topics including the outreach and engagement of clientele and rapport building.
- Provided group/individual counseling to clients with serious mental illnesses. Other responsibilities were behavioral health documentation, crisis intervention, treatment planning, coordination of care, and discharge planning.
- Planned and facilitated community based recreational groups and activities with developmentally disabled adults and adolescents. Developed treatment goals for clients and supervised/trained residential counselors in the implementation of treatment strategies.
- Facilitated therapeutic activities with the children in a shelter setting. In addition, educated battered women on various domestic violence issues.
- Assisted developmentally disabled, chronically mentally ill, and/or traumatic brain injured adults in a 24 hour residential treatment setting (ACT). Focused on meaningful daily activity, personal care skills, community integration, and other rehabilitation goals. Supervised and provided on the job training, coaching, and mentoring for shift employees.

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Professional Work History

Independent Private Practice

Mental Health Counselor — *3/01 to Present*

ValueOptions - Maricopa County Regional Behavioral Health Authority
Phoenix, Arizona — 8/00 to 1/04

Alternative Behavioral Services/ValueOptions
Mesa, Arizona

Site Manager — *7/98 to 8/00*

Samaritan Behavioral Health Center
Scottsdale, Arizona

Intern Therapist — *7/98 to 7/99*

Alternative Behavioral Health Services/ComCare
Phoenix, Arizona
Integrated Service Coordinator/Case Manager — *2/97 to 7/98*

Friendship Partial Hospitalization Program
Phoenix, Arizona
Counselor — *5/96 to 2/97*

Kids first Domestic Violence Program
Janesville, Wisconsin
Intern/Educator — *9/95 to 9/96*

Brotoloc Health Care Systems: Residential Center
Whitewater, Wisconsin
Recreational Counselor — *1/93 to 1/94*

Education and Accreditation

University of Phoenix — *Masters, Counseling*

University of Wisconsin — *Bachelors, Psychology*

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Tom Valenti

Provider Training & Assistance Specialist

Greater Arizona Behavioral Health Authority, LLC.

Developed training program for a 40 seat call center, which included Customer Service and Care Coordination staff to ensure they understood benefits available to members of 4 different state Medicaid plans with several benefit levels within each state. Monitored and provided feedback on customer service techniques and knowledge. Identified training needs and set up re-training programs specific to the needs of the representative, scheduling retraining and retesting schedules as needed. Audited electronic entries of calls to ensure the staff understood the documentation requirements. Over 9 years experience with the Boys Town *behaviorally based treatment in a residential treatment facility in Michigan*

Responsibilities and Accomplishments:

- Managed daily operations of 10,000 calls per day inbound customer care center. Annual departmental budget forecast and compliance. Oversight of all human relations issues for over 55 staff, oversight of symposium call handling application to include periodic adjustment to assure prompt call handling, manage call center reporting and call data analysis, primary liaison with internal and external customer base. General floor management as needed.
- Improved Customer Service and Corporate Client Services though monitoring outcome data. Trained and supervised customer care representatives. Provided performance reviews, report telephone statistics on all departments, and work with project manager to develop Policies and Procedures for state compliance. Assessed and gave formal performance reviews to all call center staff. Assessed all training manuals for providers and set goals for customer service representatives in all areas of responsibility. Developed customer service evaluation model.
- Coordinated and oversaw all evaluation and training functions in the call center including planning, development, and facilitation of Pre-Service and ongoing training needs within the Call Center. Evaluated and coached Call Center staff performance through weekly monitoring tools within specified timeframes. Work with supervision team in maintaining Quarterly Reviews, supervision feedback, 6 month performance evaluations, annual performance reviews, and substandard performance worksheets. Maintained training and evaluation records of all Call Center staff.
- Coordinated patient care needs for assigned members in the HMO Blue Star Plus program for Texas. Telephonic case management including assessments, identification and coordination of community resources, and authorizations per level of authority. Advocated for members and facilitate problem resolution. Developed, implemented, and maintained an individual care plan for members. Coordinated transition of members. Coordinated outpatient and discharge services with concurrent review nurses. Monitored emergency room utilization and hospital admissions.
- Coordination of Evaluation, Training, and Quality Assurance activities. Developed, scheduled, and presented agency training. Scheduled, administered, and general oversight of evaluation policy and procedures. Full marketing, account oversight, scheduling, and presentation of community training. Establishment of quality assurance standards and procedures including facilitation of committee meetings, issue identification, monitoring and evaluation of resolution plan, creation and implementation of reporting guidelines. Assisting with first COA site accreditation.

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Professional Work History

United Health Group
Manager of Customer Care Center — *February 2002 to September 2003*
United Health Group
Supervisor of Customer Care Center — *August 2001 to Present*
Lifemark Corporation (merger with United Health Group 2/01)
Training & Evaluations Coordinator — *October 2000 to August 2001*
Lifemark Corporation
Care Coordinator Level 1 — *May 2000 to August 2001*
Teaching Family Homes of Upper Michigan
Quality Assurance Director — *September 1997 to November 1999*
Teaching Family Homes of Upper Michigan
Consultant — *September 1993 to September 1997*
Teaching Family Homes of Upper Michigan
Family Teacher — *September 1990 to September 1993*

Education and Accreditation

LaSalle University, Mandeville, LA — *Bachelors, Social Work*

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Terry Stevens

Clinical & Provider Services Administrator
(Provider Services Administrator)

Greater Arizona Behavioral Health Authority, LLC.

Dedicated healthcare management professional with extensive local Arizona experience in systems and operations management. Ms. Stevens is intimately knowledgeable of all aspects of the Arizona Medicaid service delivery system. Adept at analyzing situations, developing and implementing strategic plans. Ability to lead and effect change. Strong matrix management and communication skills with emphasis on multi-functional team management, coaching and mentoring, account management, project management and customer service.

Responsibilities and Accomplishments:

- Provided oversight and direction for an organizational change project which included the development and implementation of a new therapeutic program at a psychiatric inpatient facility. Other projects included the development of two new units: from proposal to implementation and a performance improvement team working on the reduction of seclusion and restraint. The development of a monthly training program for all staff to support the new therapeutic programming and the seclusion and restraint reduction process was also a key objective in this position. At the end of the first year the facility had reduced seclusion by 38 % and restraint by 43%. Training of psychiatric residents is also a key role, providing orientation to the system and customer service as well as to teach the family therapy class.
- Managed the implementation and startup of a six-agency, $33 million network operation. This included setting up workflows and systems to manage all aspects of this rapidly growing organization including policies and procedures, levels of care guidelines, utilization and clinical management plans. Directed team building efforts within the network and built relationships with key customers and stakeholders.
- Provided clinical and administrative oversight for three behavioral care offices, with thirty staff members including physicians, therapists, clinical supervisors, receptionists, record clerks and office managers. Responsible for managing a budget of $8 million. Administered and tracked quality management activities, team building, and strategic planning. Provided liaison to CIGNA Healthplan and account management to major employer groups. Assisted provider relations with network development and the training and quality monitoring of contracted providers and facilities.
- Provided court-ordered divorce mediation as well as marriage, family and divorce counseling.
- Performed custody evaluations and testimony as ordered by the court.
- Completed certification in mediation and advanced negotiation strategies.
- Developed and delivered stress management seminar for over 100 court employees offered at a daylong wellness program.
- Developed educational materials for parents on how to divorce with children. These materials were used during the mandatory orientation that started the mediation process
- Provided assessments and therapy to adult, adolescents and children. Supervised staff of 10 in the child and family therapy program. Taught family therapy skills to family practice and psychiatric residents through live family therapy clinic.
- Provided individual, group and family therapy. Supervised children's program outpatient and day treatment staff. Consulted with school district personnel and Department of Family Service staff around specific cases and shared programming.
- Developed day treatment program for elementary school age children.

Terry Stevens

Professional Work History

Medical Professionals of Arizona Department of Psychiatry
Mesa, AZ

Operations Manager *2001-Present*

Medical Professionals of Arizona Department of Psychiatry
Mesa, AZ

Clinical Services Director *1999-2001*

ANOTHER DIRECTION LLC; Phoenix, AZ, Another Direction Plus, LLC
Phoenix, AZ

Chief Operating Officer (2000-present) Clinical Director (1999-2000) *1999-Present*

CIGNA BEHAVIORAL HEALTH
Tempe, Arizona

Clinical Administrator (1993-1999) Lead Clinician (1989-1993)
Crisis Therapist (1988-1989) *1988-1999*

SUPERIOR COURT OF ARIZONA-CONCILIATION SERVICES
Phoenix, AZ
Family Counselor *1985-1988*

PSYCHIATRIC WALK-IN CLINIC, U. OF ALBERTA HOSPITAL
Edmonton, Alberta
Child and Family Coordinator *1982-1985*

Education and Accreditation

University of Illinois-Sangamon State Campus
Springfield, Illinois *MA, Clinical Psychology*

University of Missouri, Columbia MO

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Aron Halfin, M.D.

Chief Medical Officer

Greater Arizona Behavioral Health Authority, LLC.

Dr. Halfin grew up in Latin America and is fully bilingual. He graduated from the University of Costa Rica School of Medicine and is licensed to practice in Arizona. His cultural experience coupled with his rich managed behavioral health experience make him uniquely prepared to be the Chief Medical Officer for GREABHA.

Responsibilities and Accomplishments:

- Served as liaison to the corporate finance department. Monitored business processes and systems to assure integrity in health plan information and systems in compliance with Company policies and standards.
- Developed & coordinated the operating and capital budget for a $726 million corporation (made up of 4 Medicaid plans).
- Responsible for all medical operations of over 50 million lives in 36 Regional Service Centers.
- Served as key contributor in major 'right-sizing' initiative, resulting in 20% reduction in administrative expenses while maintaining or improving cost of care services to customers, members, and providers.
- Developed and built solid working customer relationships, resulting in improved satisfaction and contract renewals.
- Hired, trained and supervised 32 regional Medical Directors.
- Responsible for all clinical and medical operations for over 2.8 million lives in 15 Regional Service Centers. Managed full spectrum of products ranging from PPO/Indemnity to full risk HMO/POS. Managed responsibility for medical policy implementation
- Reorganized utilization management program resulting in a 60% decrease in inpatient utilization over an 8-month period, which attained a medical loss ratio of 62% and returned business unit to profitability. Decreased Physician Advisor budget by 50%. Supervised and retrained 40 case managers and 12 Physician Advisors. Co-developed information system to more accurately track all utilization review activities in real time.
- Chaired both Quality Improvement and Professional Provider Review Committees.
- Spearheaded NCQA Accreditation initiative for the Region, resulting in the first full (3 year) NCQA MBHO accreditation in the nation.
- Actively involved in managing and contracting a provider network of over 2500 providers and over 250 facilities throughout the southeast.
- Instituted outpatient case rate system, resulting in 50% decrease in outpatient cost of care.
- Had full clinical operations responsibility for 90-bed adult and geriatric unit in private for-profit hospital.
- Developed Psychiatric ICU and created consultation Liaison Services

Professional Work History

Centene Corporation
St. Louis, MO
Vice President of Clinical Operations *April 2004- Present*

Centene Corporation, Specialty Division
St. Louis, MO
Medical Director *October 2003- April 2004*

Magellan Behavioral Health, Health Plan Solutions Group & PUBLIC SOLUTIONS group

Aron Halfin, M.D.

Senior Vice-President and Chief Medical Officer	*2002-2003*
Magellan Behavioral Health, Health Plan Solutions Group	
Senior Vice-President and Chief Medical Officer	*1999- 2002*
Magellan Behavioral Health, Health Plan Solutions Group Northeast & Atlantic Midwest Divison	
Divisional Vice-President for Medical Services	*1998-1999*
Magellan Behavioral Health, Georgia Regional Service Center (Formerly Green Spring of Georgia)	
Vice-President Medical Services - Medical Director	*1996- 1998*
Greenleaf Center Inc. Ft. Oglethorpe, Georgia Medical Director, Adult Psychiatric Services	*1987-1995*
Private Practice, Adult Psychiatry Chattanooga, Tennessee Psychotherapist	*1985-1996*

Education and Accreditation

The University of Costa Rica School of Medicine	*M.D. Psychiatry*
Columbia University College of Physicians and Surgeons. New York, NY,	*Psychopharmacology Research Fellowship*

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Brian Butts

Chief Financial Officer

Greater Arizona Behavioral Health Authority, LLC.

Over 15 years healthcare experience in corporate finance, planning and development, seven years of which have been with Centene Corporation. He has a rich background in the financial analysis of Medicaid HMO services.

Responsibilities and Accomplishments:

- Supervision of three staff analysts, ensure staff is properly trained in all facets of healthcare finance, service excellence skills are enhanced, and professional development is grown.
- Development & coordination of the operating and capital budget for the BJC West/South region (region includes 5 hospitals). Work included development of budget schedules, forecasting actuals into new budget, coordination with hospital staff, and upload of budget into general ledger.
- Database management of region patient population, demographics, psychographics, and physician trends, payor information and employer information for use in the development of strategic plans for the region.
- Performance/ROI analysis on individual projects, and potential capital investments, Integrate customer knowledge with hospital/system objectives to develop or re-design products/programs.
- Analytical review of monthly/yearly hospital operations and investigation of budget variances, for MBMC and MB Sullivan.
- Production of business plans for Ambulatory Care Center and Outpatient Diagnostic Center. Work included preparation of board presentation outlining capital requirements, physician implications, community need and the financial impact of project on the hospital's bottom line.
- Preparation of the hospital's annual operating and capital budget both of which were done at a macro level for board presentations and at the micro level for individual managers. The budget was prepared using PC software and mainframe based software.
- Assisted in the implementation of the hospital's first cost accounting system. Work included intermediate product determination, standards building, establishing budgeting guidelines, and working with the clinical areas of the hospital to familiarize them with the system and its capabilities.
- Assisted in the development of the hospital MSO (management services organization). Project was developed to help primary care physicians start their practices without incurring huge debts.
- Assisted in the preparation of several bond proposals put forth by the hospital. Work included development of hospital financial statements, summary of operations, and executive summary.

2

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Brian Butts

Professional Work History

Centene Corporation
St. Louis, MO

VP of Finance Centene Speciatly Group *3/03- Present*

Centene Corporation
St. Louis, MO

9/97- 3/03 *9/97- 3/03*

Missouri Baptist Medical Center - BJC Health System
St. Louis, MO

Manager - Financial Planning & Analysis *10/95 – 8/97*

Missouri Baptist Medical Center - BJC Health System
St. Louis, MO

Manager of Strategic & Business Information *8/93 - 9/95*

Methodist Hospital
Indianapolis, IN
Senior Financial Analyst - Operations & Budgets *10/89 - 7/93*

Education and Accreditation

The Ohio State University, Columbus *BSBA in Finance*

Certified Public Accountant

2

1

Mary Sanchez

Director of Human Resources

Greater Arizona Behavioral Health Authority, LLC.

Mary Sanchez brings more than 18 years of experience in the field of human resources. Her expertise includes the areas of compensation, benefits, employee relations, recruitment and organizational development.

Responsibilities and Accomplishments:

- Served as a key member of the senior management teams for the Austin and Los Angeles offices. Local liaison for Training, Office Services and Payroll. Coordinated a formal design and roll out of employee recognition programs which focused on rewarding individual and team achievements
- Handled national and international recruitment of highly specialized and difficult-to-attract positions such as chemists, oncologists and other professionals with unique science backgrounds.
- Coordinated and planned staffing and retention programs with a focus on growing and developing the business
- Analyzed and developed an action plan for career fair assessment/recommendations; updated and redesigned all recruiting materials and conference recruiting display boards.
- Implemented contemporary recruiting methods
- Lead management towards maintaining a positive work environment as staff moved from ‘order takers’ to consultative/sales professionals
- Implemented new compensation structure to include incentives for rewarding sales achievements
- Incorporated a sexual harassment and workplace violence program
- Investigated and introduced a wellness program designed for call center staff
- Established the pilot for a company wide diversity focus
- Handled all national and local recruitment of allied health, management and support staff. Also served as an active leader on the hospital’s supervisory counsel.
- Researched and attended professional association recruiting opportunities, nation wide
- Established an applicant tracking system
- Implemented an applicant response process
- Instrumental in developing a community wide reference checking network
- HR Director
- Sr. HR Generalist

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Professional Work History

Millward Brown IntelliQuest
Austin, Texas

HR Director *2000 – Dec 2003*

ILEX Oncology
San Antonio, T1999 - 2000exas

New England Business Forms
Flagstaff, Arizona

HR Manager *1997 – 1999*

Flagstaff Medical Center
Flagstaff, Arizona

Health Care Recruiter *1995 – 1997*

South Austin Hospital
Austin, Texas *1989 – 1995*

National Oilwell
San Marcos, Texas *1985 – 1988*

Education and Accreditation

University of Texas, Austin *Bachelor of Business Administration - Business Management*

1

Andrew H. Miller

Natural Supports Specialist

Greater Arizona Behavioral Health Authority, LLC.

Mr. Miller has extensive personal knowledge of the Native American culture, growing up in a Native American community and attending a Native American school. His knowledge of local resources and experience with the Native American culture has prepared him to be an excellent natural support specialist.

Responsibilities and Accomplishments:

- Created programming and initiatives to engage Jewish students who would not otherwise be involved with Hillel or Jewish life on campus. Events were of a social, educational, religious, or political nature.
- Assisted in the development and fundraising initiatives of the city-wide Jewish Student center. Assisted in letter-writing campaigns, grant research and writing, and individual solicitations.
- Assisted in programming religious, social, and political events for Jewish university students in the San Francisco Metropolitan area.

Professional Work History

Fund Development Manager
Scottsdale, AZ

Fund Development Manager *2/04-Present*

Hillel at Kent State University
Kent, OH

8/02-6/03 *8/02-6/03*

San Francisco Hillel
San Francisco, CA

Development Intern *10/01-6/02*

San Francisco Hillel
San Francisco, CA

Programs Intern *10/01-6/02*

Education and Accreditation

University of San Francisco *B.A., Communication Studies, Emphasis: Public Relations and Journalism*

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1

Michelle Flatbush

Natural Supports Specialist

Greater Arizona Behavioral Health Authority, LLC.

Over 14 years of experience as a teacher and administrator for mentally handicapped children, working in residential facilities, public and private schools. Michele has personal experience with the Native American culture and the knowledge of what is needed in support services to help this population. Her experience in administration and working with multiple state agencies gives her the interpersonal skills to work with community service organizations to help coordinate the natural support services needed for our program.

Responsibilities and Accomplishments:

- Taught Severely Emotionally Disabled adolescents and adults at the Arizona State Hospital.
- Managed school operations; including the development and acquisition of curriculum and instructional materials for Teachers; marketed company services; developed educational assessments; conducted all IEP meetings, reviewed IEP's prior to meetings; assisted with development of the Policy & Procedure manual; grant writing; developed budget; tracked monthly expenditures; coordinate staff training, in-services, workshops and other staff development/educational activities for teachers and ancillary education staff; perform all performance reviews and administer staff supervision. Established and implemented an employee communication plan which achieved measurable positive results throughout all levels
- Supervised six teachers and nine teaching assistants in residential child and adolescent program. Responsible for Individual Education Plans for 75+ children from numerous school districts in Arizona and California. Duties also included marketing, curriculum development and grant writing.
- Oversaw a staff of two special education teachers and three teaching assistants in a private school setting . Duties included all administrative responsibilities associated with the administration of a private special education school.
- Taught Regular and Special Education students (grades 5-12) in an adolescent recovery center
- Taught Mild Mentally Retarded students in grades 2-4.
- Taught in a Seventh & Eighth grade Cross-Categorical classroom with students identified as Learning Disabled, Mildly and Moderately Mentally Retarded, and Severely Emotionally Handicapped.

Professional Work History

Academic Behavioral Alternatives
Phoenix, AZ

Campus Administrator/Principal *August 2002 to Present*

Devereux Arizona
Phoenix, AZ

August 2001 to August 2002 *August 2001 to August 2002*

Arizona Youth Academy
Phoenix, AZ

Site Coordinator *July 2000 – August 2001*

Michelle Flatbush

Maricopa County Regional Schools,
Teacher *1997 – 2000*

Maricopa County Regional Schools,
Teacher *1996 - 1997*

Copper Canyon Elementary School
Teacher *1995 – 1996*

Education and Accreditation

Bachelor of Arts, Education

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Erik Ryan

Natural Supports Specialist

Greater Arizona Behavioral Health Authority, LLC.

Mr. Ryan has extensive experience working with child and family teams in the recruiting and implementation of natural supports, His knowledge of the special education system has given him hands on experience collaborating with state agencies, community groups, boys and girls clubs, YMCAs, and advocacy groups. Mr. Ryan is fully bilingual with extensive graduate training in Latino cultural studies.

Responsibilities and Accomplishments:

- Developed, implemented, and marketed programs that address the academic, behavioral, and social challenges of children with special needs in Pima and Maricopa Counties
- Provided direct site, staff, and operational supervision of day, after-school, weekend, and summer programming
- Marketed services to school districts and children's behavioral health networks in order to initiate, implement, and maintain service contracts
- Oversight and management of an annual budget of $300,000-$400,000
- Developed and implemented Social Studies and Language Arts courses for at-risk and homeless secondary-aged children
- Developed and implemented a variety of elective courses for at-risk and homeless secondary-aged children
- Developed and implemented an academic and social/recreational summer program for at-risk and homeless secondary-aged children
- Developed and implemented home and community-based learning and socialization experiences for preschool-aged children. Provided outreach, identification, and enrollment services for eligible families for current and upcoming school year. Provided instructional assistance for children enrolled for pre-school services at local campus
- Provided mediation, advocacy, and community outreach to children and families receiving bilingual education services Provided direct support to bilingual education staff and students in the areas curriculum development and adaptation, translation of core content materials, sheltered and small group instruction in core content areas
- Provided technical assistance in the assessment and identification of English Language Learners
- Provided direct instruction and supervision of computers to elementary school-aged children
- Provided direct support to bilingual education staff and students in the areas of curriculum development and adaptation, translation of core content materials, sheltered and small group instruction in core content areas. Provided technical assistance in the assessment and identification of English Language Learners

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Erik Ryan

Professional Work History

CBH AZ/ABA Schools
Tucson, AZ

Campus and Programs Administrator/Marketing and Account Management *2001-Present*

Tucson Preparatory School
Tucson, AZ

Secondary School Teacher/Summer Program Administrator *1999-2001*

NACOG Head Start
Flagstaff, AZ

Grand Canyon Home-Based Teacher/Classroom Instructional Assistant (Sunnyside Campus) *1998-1999*

Albuquerque Public Schools/Valley HS
Albuquerque, NM

Community Liaison/Instructional Assistant for Bilingual Program *1996-1998*

Placentia-Linda Unified School District/Tynes Elementary
Placentia, CA
Computer Teacher/Instructional Assistant for Bilingual Program *1995-1996*

Education and Accreditation

University of New Mexico *MA: Comparative Literature and Cultural Studies*

Chapman University *BA: English and Spanish*

Fullerton College *AA: Liberal Studies*

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Brian D. Higgins

Field Consumer Outreach Representative

Greater Arizona Behavioral Health Authority, LLC.

Brian has over 7 years experience working with at-risk children and adults through various programs and shelters. His additional teaching background, and education and experience with the Native American and the Latino cultures, adds to his ability to reach out and engage consumers in their care and help inspire them with hope for recovery.

Responsibilities and Accomplishments:

- Coordinated and directed the operations of a shelter in the for families in conflict and a shelter for at-risk teens
- Hired, trained, scheduled and prepared staff evaluations.
- Supervised staff and clients, conducted staff meetings, managed budgetary affairs, and payroll, Facilitated individual and group activities, mediated conflicts and conducted referrals to other youth and family services; worked closely with Child
- Coordinated services with Child Protective Services and Pima County Juvenile Courts.
- Provided all end of month documentation, wrote reports and oversaw household buying and shelter maintenance.
- Taught various courses for the Departments of History and Near Eastern Studies
- Taught various historical survey courses in non-Western civilizations; developed two new courses for the PCC curriculum.
- Conducted phone and on-site surveys at local venues with regard to skin cancer, tobacco use among teens, and basic knowledge of diet and nutrition. Position involved record keeping, evaluation of data and utilized Spanish language skills.

Professional Work History

Desert Springs Professional/ABA
Tuscon, AZ

Lead Transportation Staff/Behavioral Health Staff *2002-Present*

Open Inn

Site Coordinator *2001-2002*

Homolovi Ruins State Park

Assistant Park Manager *2000*

Oracle State Park Arizona

Park Ranger *1996-2001*

University of Arizona
Adjunct Professor *1990-2000*

Pima Community College
Adjunct Professor of History *1993-1999*

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Brian D. Higgins

Education and Accreditation

University of Arizona — *M.A. History (Latin America & Modern Europe)*

B.A., History, University of Arizona,
following academic year spent at University of the Americas,
Cholula, Puebla, Mexico

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1

Candace Burnell

A Z State Hospital Liaison

Greater Arizona Behavioral Health Authority, LLC.

Over 10 years experience working with students,(Native American, Latino and Caucasian) both adult and children, with behavioral, learning or emotional disabilities in a variety of settings. She was director of a prison library, has taught community college courses in social skills, problem solving, anger management and breaking barriers. Skilled in development and implementation of Special Education programs.

Responsibilities and Accomplishments:

- Developed the Implementation Plan for an on-site program for Native American students with special needs and behavioral problems in the regular classroom setting. Served as the liason for the school district to facilitate the goals of the plan. Maintained ADE and IEP compliance. Hired, assigned, and supervised staff with demonstrated knowledge of HR policies and procedures. Exercised good judgment in making crisis intervention decisions. Directed and provided support and resources for a positive behavioral management program.
- Taught a self-contained classroom for 3rd through 8th grade students with emotional and learning disabilities. Taught to a variety of learning abilities and styles. Maintained IEPs in compliance with IDEA.
- Site Administrator for two classrooms serving students with special needs and behavioral problems in their regular classroom setting.
- Special Education Teacher in a self-contained classroom for 4th through 8th grade students with emotional and learning disabilities.
- Developed and acquired culturally sensitive curriculum and instructional materials for Native American students with emotional and learning disabilities.
- Taught community college level business English at a women's prison.
- Developed programming and instructed incarcerated women in conflict management, anger management, problem solving and life skills
- Managed the operations of a private school serving 30 students with special needs and behavioral problems in their regular school setting. Maintained State approval in compliance with IDEA, sound relationships with public school districts and support agencies.
- Hired and assigned staff with demonstrated knowledge of HR policies and procedures.
- Taught Jr. High self-contained ED classroom.
- Taught to a variety of learning abilities and styles.
- Maintained school documentation in accordance with State regulations.
- Successfully maintained appropriate classroom behaviors.
- Supervised delinquent and dependent youth in detention and shelter facilities.
- Developed, organized and supervised activities and programs.
- Adjunct Instructor and Librarian
- Taught community college level business English at a women's prison.
- Developed programming and instructed incarcerated women in conflict management, anger management, problem solving and life skills.
- Tutored GED and ABE students.

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Candace Burnell

Professional Work History

Academic Behavioral Alternatives (ABA) at Laveen Elementary School District
Laveen, AZ

Administrator and teacher *2003-2004*

Academic Behavioral Alternatives (ABA) at Gila Crossing Community School
Gila Crossing Indian Reservation *2002-2003*

Academic Behavioral Accommodations (ABA)
Tempe, AZ

Principal *2001-2002*

Academic Behavioral Accommodations (ABA)
Tempe, AZ

Teacher *2000-2001*

Polk County Youth Services
Des Moines, IA
Youth Services Worker *1998-1999*

Youth and Shelter Services
Des Moines, IA *1996-1998*

Education and Accreditation

University of Phoenix *Masters of Education Administration and Supervision*

Iowa State University *B.S. Applied Arts*

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Charles Fenigstein

C O O L P r o g r a m A d m i n i s t r a t o r

Greater Arizona Behavioral Health Authority, LLC.

Over 25 years of administrative, management and clinical experience in behavioral health care settings. Extensive work developing and overseeing chemical dependency and sexual offender programs for adults and juveniles.

Responsibilities and Accomplishments:

- Managed all aspects of an addictions treatment facility including maintaining a safe and effective therapeutic environment, supervision of personnel, development and training of staff, work with interdisciplinary team to develop psychiatric treatment plans, develop sexual offender and chemical dependency programs, interpret, enforce and develop departmental policies and procedures.
- Oversight of treatment provision for community based Juvenile Justice related treatment program. Supervised and trained staff. Maintained communication with community agencies. Assessed and interviewed for service eligibility. Provided individual, group and family counseling. Maintained compliance with Medicaid and Bureau of Prisons Standards. Prepared reports and maintained records.
- Developed and presented training on focus areas for state employees. Provided support and technical assistance for developing/restructuring programs related to children's residential services. Participated in relevant task forces and committees. Responsible for all pertinent records keeping, files and reports.
- Assisted Branch Manager in overseeing 12 residential treatment programs within the Juvenile Justice system. Interpreted, enforced and developed departmental policies and procedures. Supervised program effectiveness as related to American Correctional standards. Provided technical assistance in program development to residential facilities as needed. Strategic planning.
- Residential Facility Superintendent
- Conducted individual, group and family therapy. Developed and implemented court programs for chemically dependent clients. Community relations.
- Provided training for school systems, hospitals, and other organizations. These workshops include team building for both students and teachers, as well as providing technical support to meet organizational needs.
- Provided educational presentations for parents and youth in Santa Fe's school system as part of pilot program, "Releasing Anger Positively".
- Facilitated communications with probation and parole board and related community agencies. Maintained records, prepared reports. Conducted group therapy for substance abuse issues. Supervised and trained staff for local program.
- Provided individual and group counseling, assessment and evaluation of Job Corp program participants. Complies data regarding effectiveness of drug-use testing. Conducted staff training.
- Responsible for individual, group and family therapy for clients.
- Assisted in personnel supervision, public relations, statistics, budget and program development.
- Established and implemented contracts with the State Probation and Parole Board

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Charles Fenigstein

Chandler Valley Hope/R.T.C
Chandler, AZ

Program Director *1999 – Present*

Pinion Hills Hospital/R.T.C.
Velarde, NM *1997-1999*

Intermountain Centers For Human Development
Santa Fe, NM

Clinical Director *1996 - 1997*

Kentucky Cabinet For Human Resources, Program Development and Training Branch
Frankfort, KY

Family Services Program Specialist *1993 – 1996*

Kentucky Cabinet For Human Resources
Frankfort, KY
Assistant Branch Manager *1992 – 1993*

Kentucky Cabinet For Human Resources, Lincoln Village Treatment Center
Elizabethtown, KY
Bluegrass Comprehensive Care
George Town, KY *1978 –1979*

Independent Consultant
Arizona, NM
Trainer *1998 – Present*

New Mexico Center For Disppute Resolution
Santa Fe, NM
Trainer *1998 – Present*

Ultimate Care
Louisville, KY
Administrative Consultant/Group Facilitator *1993 – 1996*

Whitney M. Young Job Coprs Centers
Simpsonville, KY
Substance Abuse Services Consultant *1987 – 1992*

Education and Accreditation

University of Kentucky, Lexington, KY *M.S., Education*

University of Transylvania, Lexington, KY *B.A., Philosophy*
University of the Americas, Puebla, Mexico

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Jay A. Gray, Ph.D.

Interagency Liaison Manager

(Interagency Liaison)

Greater Arizona Behavioral Health Authority, LLC.

Dr. Jay Gray has more than 20 years of local Arizona experience developing and managing Medicaid behavioral health services and programs. As Executive Director of Desert Springs Professionals, LLC and Cenpatico Behavioral Health Arizona, Inc., he is responsible for managing the Arizona operations, which includes five private special education schools, supervised day program services and an outpatient clinic. He has experience working with all Arizona state agencies.

Responsibilities and Accomplishments:

- Managed five multidisciplinary behavioral health clinics
- Managed five private special education schools in Arizona.
- Collaborated with public school districts to implement private special education programs on public school district campuses
- Implemented community based socialization programs for youths at risk of out of home placement.
- Managed a resocialization program for persons with serious mental illnesses
- Orchestrated the delivery of Outpatient Case Management, Psychiatric, Nursing and Counseling Services for Value Options Enrolled Children & Adults with Serious Mental Illness
- Managed 800 Staff, 25 Clinic Sites, Facilitated & Monitored delivery of services to 12,000 Medicaid behavioral health recipients
- Developed and Implemented Philosophy of Care, Continuous Quality Improvement Processes, Risk Management and High Risk Situation Management
- Experience base: Policy and Procedure Development, System Development, Facilitate Delivery of Evaluation, Case Management and Physician Services
- Interfaced with Multiple Departments, State Agencies, Stakeholders and Service Providers to enhance and improve system. Developed and implemented system enhancements to improve the Service Delivery System.
- Facilitated development of “real time” client management reports. Ensured data integrity. Developed clinical outcome analyses.
- Orchestrated the delivery of Case Management, Utilization Management and Continued Stay Review Services for Medicaid Enrolled Youth and Adults enrolled in General Mental Health or Substance Abuse Services.
- Lead Inter-Departmental Project Teams. Established vision and facilitated product completion within established timelines.
- Managed the delivery of all Prevention, Counseling and Crisis Services involving multiple programs and 125 staff.
- Developed in-home family counseling program. Provided youth and family counseling.

Professional Work History

CBH Arizona, Inc. d/b/a Academic Behavioral Alternatives, Phoenix, AZ
Phoenix, Arizona

Executive Director & Chief Executive Officer *6/99 – Present*

ComCare/ABS of Arizona/Value Options
Phoenix, AZ
VP of Clinical Operations *12/98 – 5/99*

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Jay A. Gray, Ph.D.

ComCare
Phoenix, AZ

Director Child & Adolescent, General Mental Health & Substance Abuse Department — *11/96 – 12/98*

Empact-Suicide Prevention Center
Tempe, AZ

Clinical Director, Promoted to Vice President in 1994 — *6/90 – 11/96*

Interfaith Counseling Service
Scottsdale, AZ
Clinical Coordinator — *8/89 – 6/90*

Interfaith Counseling Service
Scottsdale, AZ
Clinical Coordinator — *8/89 – 6/90*

Arizona State University – Counseling and Consultation
Tempe, AZ
Faculty Associate-Predoctoral Internship (under supervision of Psychologist) — *7/87 – 7/88*

Irwin Army Hospital, Fort Riley, KS, and Kansas State University
Manhattan, KS
Counselor Intern — *8/85 – 6/86*

Thursday Evening Club (Program provides re-socialization and natural supports to Chronically Mentally Ill members of the Community and their families.)
Glen Ellyn, IL
Executive Director — *8/84 – 5/85*

Education and Accreditation

Kansas State University, Manhattan, KS — *Ph.D. -Counseling and Student Personnel Services (Department – Counseling and Educational Psychology) Outside Emphasis: Organizational Development*

Arizona State University, Tempe, AZ — *Professional Certificate - Professional Psychology Predoctoral Internship Counseling and Consultation*

George Williams College, Downers Grove, IL — *Professional Certificate – Organizational Development*
Bethany Theological Seminary, Oak Brook IL — *M.A.Th. – Counseling*
University of Wisconsin, Platteville, WI — *M.S. – Agricultural Industries*
Tabor College, Hillsboro, KS — *B.A. – Agri-Business*
Northeast Iowa Technical Institute, Calmar, Iowa — *A.A.S. – Farm Management Technology*

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John Pacey

Pharmacy Administrator

Greater Arizona Behavioral Health Authority, LLC.

John Pacey has over 15 years of successful experience in managing pharmacy benefits. Experience in drug utilization/cost control, formulary development/implementation, benefit design, finance/financial modeling, budgeting, marketin/sales, account management, rebate contracting, clinical pharmacy programs/disease management and CQI/patient outcomes.

Responsibilities and Accomplishments:

- Principal full-service regional PBM serving commercial, self funded, sales/marketing, pharmacy network, finance/accounting, customer service, contracting, administration and claims processing.
- Principal of managed care pharmacy consulting firm. Designed and implemented pharmaceutical marketing studies (Bayer, Kops, Parke-Davis) and designed/ implemented/hosed provider conferences: 87/89 - Presented "managed Care Providers "conference" - Bristol Myers Squibb - 12/98 - Presented "Pharmaceutical Trends in Managed Care" -Pfizer - 1998- Presented "Pharmacies", PBM's and MCO's" - Abbott, BMS, Novartis
- Director of Pharmacy services for 150,000 live regional group/IPA model HMO with commercial, Medicaid and Medicare plans. Provided clinical pharmacy support to seven subsidiary companies in three states. Implemented in -house PBM services including pharmacy network and rebate contracting and administration, clinical pharmacy programs, help des, prior authorization protocols and closed formulary. Responsible for shared-risk home health and sub-acute care contracts. Managed Clinical Pharmacy projects including: Design of Clinical Pharmacy components (Medication Management Clinics) of HCFA Social HMO Demonstration Project (SHMO) - 1997, Directed design and implementation of Anticoagulation and Hypertension clinics for commercial HMO populations - 1996-97, Pharmaceutical Care Study in Medicare Population for Robert Wood Johnson "Chronic Care Initiatives in HMO's" grant project - 1996
- Planned, designed and implemented centralized in-house pharmacy services at staff model HMO. Expanded pharmacy operations to three satellite clinic sites to support expanding enrollment. Developed all pharmacy policies and procedures. Completed BC/BS management training program. Provided pharmacy support to medical and related clinic staff.

Professional Work History

Pacific Healthcare Systems, LLC. (PHSI)
Las Vegas, NV
President *7/98-4/02*

Pharmadyne, Inc.
Las Vegas, NV *7/97-12/98*

Sierra Health Services
Las Vegas, NV
Director of Pharmacy Services *10/88-7/97*

Blue Cross/Blue Shield of Ohio
Cleveland, Ohio

Chain Pharmacist
Akron, Ohio
Pharmacy Manager *7/75-1/83*

John Pacey

Education and Accreditation

Kent State University	*Masters of Business Administration*
Duquesne University	*B.S. Pharmacy*
	B.S. Pharm.,R.Ph.

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Judy Martin

Policy Liaison

Greater Arizona Behavioral Health Authority, LLC.

Professional with over 9 years experience in account management for Medicaid health plan and large government accounts. Worked with high level staff at multiple health plan locations for Medicaid program coordination and large corporate accounts, keeping them informed of state requirements and reviewing and improving processes for enrollment and interaction of health plan staff with consumers to identify coverage needs and ensure they receive the coverage needed.

Responsibilities and Accomplishments:

- Sole contact for Samaritan's large accounts, including the Federal Government and Arizona Board of Regents.
- Conducted open enrollment presentations to provide information on new and current benefits to maximize employee participation.
- Responsible for rate negotiation, providing timely and thorough responses to service issues, assisting with eligibility, benefit and claim issues for my assigned accounts.
- Sole contact for Intergroup's Self-Funded accounts, Honeywell and BULL HN.
- Conducted open enrollment presentations to provide information on new and current benefits to maximize employee participation.
- Interpreted and evaluated benefit determination to expedite claims issues and implement payment adjustments.
- Pre-Certification and Prior Authorization knowledge as well as CPT and ICD-9 coding experience.

Professional Work History

SSC, Inc.
Regional Account Manager *February 2004-Present*

Aquatic Excellence, Inc.
Co-Owner/Operator *July 1996-Present*

Account Manager
Samaritan Health Plan *October 1995-October 1996*

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Kay Wheeler

Customer Services Administrator

Greater Arizona Behavioral Health Authority, LLC.

Over twenty years of diversified and successful experience within the healthcare industry, with 10 years overseeing Customer Service call centers managing calls for 13 states with multiple benefit levels. Worked with both Medicare and Medicaid, with oversight responsibility of up to 50+ associates.

Responsibilities and Accomplishments:

- Managed Medicare Advantage accounts with a membership of 503,000 plus members comprising of 50% of the company business; instrumental in recognized revenue gains of $31 million. Interfaced with health plan management and associates to coordinate the implementation of Medicare Savings Programs. Customer accountability through enrollment and revenue data. Spring of 2004; promoted to Senior Account Manager responsible for supervising and training 4 Regional Account Managers serving Medicare Advantage plans in 27 states throughout the country. Interface with Senior & Middle Management within each organization. Supervise the implementation of all new accounts, as well as ongoing maintenance & statistical data to existing accounts.
- Call Center Manager for Evercare/Evercare Choice. Responsible for 40+ employees, Supervisor, Trainer, and System Support Specialist in the Call Center. The Call Center serviced members, providers, and internal customers for 13 different Medicaid/Medicare health plans. Instrumental
- Began service with INTERGROUP as a Member Service Representative, providing customer service information to members, employers, providers and internal departments. 1994; promoted to Customer Service Supervisor, responsible for 26 associates. 1996; transferred to SeniorCare Marketing as Retention Specialist, assisted Seniors with difficult issues and instructed SeniorCare classes. 1998; promoted to Retention Supervisor, responsible for 6 associates in two regions. 1999; promoted to Retention Manager, 2001; promoted to Director of Medicare Services, responsible for 50+ associates and 2 managers in Medicare Enrollment, Appeals & Grievance, Telemarketing, and Medicare Sales & Retention.

Professional Work History

Social Service Coordinator's, Inc.

Senior Account Manager *2002-Present*

United HealthCare, Evercare

Manager, Call Center *2002*

HEALTHNET, formerly INTERGROUP

Director, Medicare Services *1992-2001*

Dr. David R. Fritz, DDS

Office Manager *1990-1992*

Dr. Steven H. Cooper, DDS
Dental Assistant *1979-1983*

Education and Accreditation

Gateway Community College / Phoenix, Arizona
Scott Community College / Pleasant Valley, Iowa
Albia Community High School / Albia, Iowa

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Keith Hibbard

Information Systems Administrator

Greater Arizona Behavioral Health Authority, LLC.

Keith Hibbard has extensive experience in IS, BH and healthcare systems. He has worked over 10 years in the IS arena for Behavioral Health Care companies. His extensive knowledge in claims systems, benefit plans and web based programs will give us the support to take GREABHA to the front lines of technology support for a diverse consumer population and provider network, giving us the structure to ensure care and claims payment is effective and accurate.

Responsibilities and Accomplishments:

- Responsible for all aspects of support, implementations and new product development for Centene's CenCorpHealth Solutions. This covered and included National Call Center, Claims administration and implementation for Behavioral Health, SSI implementation and integration, and pharmaceutical case management and administration.
- Managed day-to-day operations, research and development, client implementation, and government compliance for all Magellan systems.
- Major accomplishments were: 1) Met Federal Government requirements for HIPAA Transaction and Privacy; 2) Achieved 70% claims auto adjudication for batch and on-line entered claims and HIPAA 837 received claims; 3.) Legacy System Migration and new client implementation to support system and site consolidation.
- Claims Operations – Primary focus was to remove system obstacles from claims to allow for increased claims productivity and accuracy. These efficiencies included working with key clients to obtain and process benefit information electronically, increasing eligibility load accuracy by more than 45% to 98.5% pass rate, and decreasing authorization errors to less than 5%.
- Managed the day-to-day operations and projects for a fifty FTE information systems department. These include strategic system implementation/migrations, production application support, system quality control, as well as, system risk assessment and strategic system and business planning.
- Strategic Systems Implementation/Migrations: Planed and executed the legacy system migrations and new client implementation teams to successfully implement business on the AMISYS platform. Oversaw multiple teams implementing approximately 6 million members between 1996 and 1999. Each project consists of legacy data conversion, benefit and pricing analysis and configuration, import and export data conversions to client systems, unit and model office testing and system documentation.
- Strategic Planning and Business Assessment: Team lead for implementation of strategic corporate initiatives such as: Implementation of Claims EDI and Batch Processing; Development of Client Server AMISYS interfaces for Provider and Clinical Data systems; as well as, the release management and software integration.
- Planned, directed and executed the implementation of AMISYS®, a highly sophisticated managed care software system. Responsibilities included project plan development, resource coordination, budget management, and testing plan development and execution.
- In addition to the implementation, responsible for coordinating the efforts of the technical and client staffs to convert data from the customers existing legacy systems to AMISYS® as well as created interfaces for the communication of data between the client and third parties. This responsibility involved assisting with the creation of conversion specifications, data mapping, testing coordination and ensuring client acceptance of converted data.

Keith Hibbard

Professional Work History

Centene Corporation
St. Louis, MO

Director, Information Systems – CenCorp Division — *11/03 - Present*

Magellan Behavioral Health
St. Louis, MO

12/96 – 10/03 — *12/96 – 10/03*

Magellan Behavioral Health
St. Louis, MO

Director, Information Technology – AS400 CAPS — *08/00 – 01/01*

Magellan Behavioral Health
St. Louis, MO

Director, Information Technology – AMISYS — *12/96 – 08/00*

AMISYS Managed Care Systems, Computer Systems Co.
Rockville, MD
Senior Project Manager — *11/94 – 12/96*

Value Behavioral Health, Specialty Managed Care Co.
Falls Church, VA
Manager, Analytical Services & Quality Improvement — *1990 - 1994*

Value Behavioral Health, Specialty Managed Care Co.
Falls Church, VA
Records Information Manager — *05/90 - 04/91*

Education and Accreditation

Virginia Tech, Falls Church, VA — *Course taken toward M.B.A.*

University of Pittsburgh, Pittsburgh, PA — *B.S. in Health Information Management*

1

1

Laurel L. Rettle

Rapid Response Supervisor

Greater Arizona Behavioral Health Authority, LLC.

Over 15 years experience in the behavioral health field. Extensive experience in crisis intervention services providing counseling, crisis therapy assessments, critical incident debriefing and substance abuse assessments. Provided consultation services to assist companies in optimizing work performance of employees with psychological/personal issues. Experience providing crisis management services across large geographic areas.

Responsibilities and Accomplishments:

- Consulted with client company management, human resources, and medical departments on how to optimize work performance of employees who may have a variety of psychological and personal issues. Coordinated job performance referrals, fitness for duty assessments, and response to traumatic events.
- Consulted with managers for appropriate interventions in dysfunctional work groups, chemical dependency issues, and change in the work place.
- Individual and family therapy in a comprehensive staff model facility. Solution focused therapy to assist change.
- Background working with human resources and EAP Teams.
- Individual and family therapy as a network provider.
- EAP provider for over 30 valley companies.
- Public speaking and seminars for such places as Bank One and Mesa Public Schools
- In-home family therapy using systems approach.
- Presentations to schools and White Mountain Indian Reservation
- Public Relations work on the reservation.
- Provided brief strategic interventions for families.
- Training of staff and volunteers
- Substance Abuse assessments and referrals
- Responsible for the development and training of new staff and volunteers.
- Organized and networked with community resources.
- Supervised crisis mobile team, and lead supervision and team meetings. Also provided clinical services such as crisis therapy and assessments, and substance abuse assessments and referrals. Coordinated and supervised job performance of other staff.
- Provided counseling and assessment to persons experiencing mental health or substance abuse related problems.

Professional Work History

MHN
Mesa, AZ

Manager Consultant — *May 2001 to present*

MHN/Catalina Behavioral Health Services
Mesa, AZ

January 2000 to May 2001 — *January 2000 to May 2001*

Private Practice
Mesa, AZ

Private Practice, Certified Professional Counselor — *October 1997 to January 2003*

Laurel L. Rettle

EMPACT - SPC
Tempe, AZ

Family Therapist *April 1991 – January 2000*

EMPACT - SPC
Tempe, AZ
Crisis Therapist and Team Leader *February 1990 to April 1991*

Terros
Phoenix, AZ
Clinical Coordinator of Crisis Dept *September 1989-April 1990*

Terros
Phoenix, AZ
Crisis Counselor *October 1987-April 1988*

Education and Accreditation

Northern Arizona University, Flagstaff, AZ *Masters of Arts in Education in Counseling*

McKendree College, Lebanon, IL *Bachelor of Arts in Psychology*

1

Lynda S Long

Provider Contracting Manager

Greater Arizona Behavioral Health Authority, LLC.

Over 9 years of provider contracting experience for a Physician Hospital Organization. Experience as the Director of Operations, which included the negotiation of all high volume provider contracts and regular communication and problem solving with provider agency executives. Over 7 years experience as Director of Operations

Responsibilities and Accomplishments:

- Implemented Market Prominence relational database and ongoing database management.
- Developed and implemented QI programs to audit and ensure data integrity of member records, CMS payments, Member premium payments, Marketing leads, and Sales.
- Crystal Reports, Excel and Access used for database management, report development and data analysis.
- Access and Excel used for database management, report development and data analysis. Occasional SQL reading and writing used.
- Daily operations and managed staff for Member Services, Enrollment and Billing, Grievance and Appeals, and Database Management.
- Ensured compliance with State and Federal agencies for Medicare+ Choice and Medicare Supplemental plans.
- Developed and prepared month end department performance reports, Membership financial reconciliation and budget compliance.
- Prepared and participated in CMS, HEDIS and AZDOI audits.
- Implemented of Meridian relational database and ongoing database management.
- Assisted in preparation of budget, business plan and ensure compliance. Ensure compliance with Commercial (HMO, PPO, POS) and Medicare + Choice Health Plan contracts.
- Prepared and participated in CMS, HEDIS and AZDOI audits.
- Assist Receiver in group billing reconciliation, claims adjudication, contract compliance and audits for bankruptcy.
- Liaison to TPA for system design to ensure accurate claim administration and reporting.
- Produced quarterly physician and office staff training, as well as interface with offices on an as needed basis.
- Daily operations for claims, provider network, and interface with Health Plan administration.

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Professional Work History

Sun Health MediSun

Director Medicare Operations *2001–2004*

Premier HealthCare

Director Medicare Operations *1997–2001*

Rural Health Administrators

Director of Network Services *1995-1997*

St Joseph's PHO

Managed Care Operations Analyst *1989–1995*

Education and Accreditation

Glendale Community College

2

1

Mary T. Beardsley-King

A H C C C S E l i g i b i l i t y L i a i s o n

Greater Arizona Behavioral Health Authority, LLC.

Over 11 years of experience working in the AHCCCS/ALTCS health care setting. She possesses a strong understanding of behavioral health service delivery requirements from initial contracting to claims resolution, and extensive knowledge of service delivery across state agencies.

Responsibilities and Accomplishments:

- Recruited for ALTCS Provider Representative position, due to strong background in ALTCS service delivery.
- Currently performed contract and claims related services for all ALTCS provider types; increased behavioral health provider network over 300% since March of 2001 sole Provider Representative for ALTCS behavioral health services; strong understanding of behavioral health service delivery requirements from initial contracting to claims resolution stages; complete technical reports to AHCCCS as needed for ALTCS Provider Services area.
- Involved coordinating health care services between Arizona Physicians IPA, the Division of Developmental Disabilities, CRS, and private insurance coverage when necessary. Position demanded:
- High level of involvement with DES/DDD Case Managers statewide to ensure appropriate service delivery; extensive knowledge of service delivery across state agencies; highly effective working relationship with multiple company departments;strong understanding of the needs of the long term care population and their families.
- Conducted variety of member surveys and utilization studies for DD population because of analytical abilities and experience in research methods and statistical evaluation.
- Responsible for program and case management for transitional homeless families.
- Located HUD housing for homeless families; completed intake on homeless families and matched them with community sponsors;
- Responsible for overseeing career development and job placement of graduates.
- Taught interviewing skills, resume, and career development workshops;
- Designed entire curriculum for career development workshops specific to the air conditioning and electrical industry; this included development of lesson plans and class materials;
- Conducted graduate placement activities and maintained placement level at 90% or above.
- Chemical Dependency Counselor

Professional Work History

Mercy Care Plan
Phoenix, Arizona

ALTCS Provider Services Rep — *8/2000 to Present*

Arizona Physicians, IPA
Phoenix, Arizona

11/92 – 8/2000 — *11/92 – 8/2000*

Homeward Bound
Phoenix, Arizona

Program Development — *4/91 – 11/92*

Arizona State University
Tempe, Arizona

Teaching/Research Assistant — *1/88 – 5/91*

Mary T. Beardsley-King

The Refrigeration School
Phoenix, Arizona
Career Development Director *10/84 – 8/87*

Education and Accreditation

Arizona State University, Tempe, Arizona *Master of Science – Family Studies*

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1

Megan L. Engel

Health Plan Liaison

Greater Arizona Behavioral Health Authority, LLC.

Professional with 6 years experience in project management and process review and training for health plan staff. Instrumental in benefits review and filing, benefits training and Medicaid enrollment processes. Worked with high level staff at multiple health plans, informing them of state requirements and reviewing and improving processes for enrollment and interaction of health plan staff with consumers to identify coverage needs and ensure they receive the coverage needed.

Responsibilities and Accomplishments:

- Promoted to Sr. Account Manager after first year of employment. Act as primary liaison between SSC and 30% of the Medicare and Medicaid HMOs (customer). Responsibilities include: conducting implementation meetings with high level management staff within the HMO, providing face to face training to all applicable HMO staff, coordinate data transmissions in a HIPAA compliant format between both companies, work with HMO compliance department to create filing documents for the state. Work with SSC's internal departments to ensure communication regarding a new account, which includes 'go live date', specifics relating to each HMO and the state in which that HMO operates. Directly impacted over $2.5 million in revenue directly impacted the renewal of contracts for every customer upon contract renewal date.
- Instrumental in the setup of National Accounts custom plans, including creation of plan codes for system set up as well as all applicable marketing materials. Developed training documents and conducted classes on all new benefits for internal Customer Service, Claims, Sales and Medical Management.
- Successfully managed and completed process which resulted in a timely filing for the 2002 Benefits.
- Lead project manager to implement vendor in region which directly impacted over $2 million in revenue during the first year.

Professional Work History

Social Service Coordinators, Inc.

Senior Account Manager — *February 2003 - Present*

PacifiCare of Texas

Project Manager I / Project Manager II — *March 2000 – January 2003*

PhyCor IPA Management

Quality Management Coordinator promoted to Health Plan Analyst (Credentialing) — *February 1998 – March 2000*

Healthsouth Surgery Center of Dallas

Medical Records/Credentialing Coordinator — *July 1997 – February 1998*

Education and Accreditation

Southwest Texas State University, San Marcos, Texas — *Bachelor of Science in Health Information Management*

2

1

Nancy Mann

Chief Welfare Expert

Greater Arizona Behavioral Health Authority, LLC.

Dr. Mann is an Arizona licensed psychologist with extensive experience working with children and families. She is particularly skilled working with multi-challenged youths and in facilitating effective ways in which systems can work together to meet their needs.

Responsibilities and Accomplishments:

- Duties included individual and family psychotherapy and psychological assessment with children, adolescents, and adults. Areas of specialty include child and adolescent evaluation and therapy and treatment of ADHD and ODD. During a period of reorganization, I served as Site Supervisor from 9/02 – 9/03. Duties included direct supervision of clinical staff and front office staff
- Individual, group, and family psychotherapy with children, adolescents, and adults. Experience with children and adolescents and had involved assessment, diagnosis, and treatment of various childhood disorders. Approaches included both long-term and time-limited/crisis intervention methods.
- Doctoral dissertation research was in the area of ADHD. Worked closely with children and their families by teaching behavior modification techniques and implementing in-home behavioral treatment plans. Extensive experience presenting to groups of parents on the topics of identification and treatment of ADHD, behavior modification training, and school/classroom accommodations for children with ADHD. Group experience included conducting social skills groups with children with ADHD, ODD, and other conditions resulting in deficits in interpersonal interactions.
- Position also included maintaining staff privileges at Anacapa by the Sea, a psychiatric and substance abuse rehabilitation hospital in Port Hueneme, CA. Responsibilities included conducting diagnostic testing, including cognitive and personality assessments and neuropsychological screenings, with adults and adolescents to identify and clarify diagnosis and develop specific treatment recommendations. Experienced in conducting group psychotherapy with adolescents in this inpatient setting.
- Provided classroom instruction in educational and vocational training issues with high functioning developmentally disabled adults.
- Provided individual and group psychotherapy and psychological assessment/testing primarily with children and adolescents. Rotations included children's program, adolescent program, and neuropsychological assessment.
- Performed individual and couples psychotherapy and psychological assessment/testing.
- Conducted individual and group psychotherapy and psychological assessment/testing with children and adolescents.
- Assisted faculty members with research and preparation of class materials, compiled student newsletters, and tutored graduate students in various coursework including research statistics and methodology.
- Provided individual counseling and facilitated support groups for individuals with eating disorders.
- Assisted in therapy groups and coordinated recreational activities for chronically mentally ill adults in an outpatient program.

2

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Nancy Mann

Professional Work History

Catalina Behavioral
Mesa, AZ

Licensed Psychologist *10/93-9/00*

Ashley Children's Psychology Center
Northridge, CA

10/93-9/00 *10/93-9/00*

Association for Retarded Citizens
Camarillo, CA

Adult Education Instructor *10/92-10/93*

Camarillo State Hospital, Camarillo (APA accredited)
Camarillo, CA

Pre-doctoral Intern *9/91-9/92*

Pepperdine Psychology Clinic
Culver City, CA
Psychology Trainee *8/90-/91*

Camarillo State Hospital
Camarillo, CA
Psychology Trainee *5/89-8/91*

Step Up On Second
Santa Monica, CA
Program Coordinator *1/88-11/88*

Pepperdine University
Culver City, CA
Graduate Assistant *5/87-5/88*

University of Wisconsin-Eau Claire
Eau Claire, WI
Peer Counselor *9/84-5/85*

Tri-County Mental Health Hospital
Reedsburg, WI
Mental Health Volunteer *5/84-9/84*

Education and Accreditation

Pepperdine University *Psy.D. in Clinical Psychology*
University of Wisconsin-Eau Claire, Eau Claire, WI *M.A. in Psychology*
B.A. in Psychology

2

1

Patricia J. Weidman

Clinical Operations Administrator (Director of Field Services)

Greater Arizona Behavioral Health Authority, LLC.

Extensive background in business management , operations, nursing and legal. Self-motivated; able to set effective priorities to achieve immediate and long-term goals and meet operational deadlines; Project Management and Quality Control skills; Ability to drive change and influence individuals at all levels; Excellent verbal, written, and interpersonal skills; Analytical and well organized; Thorough in researching and analyzing data. Six years experience with UR oversight.

Responsibilities and Accomplishments:

- Fielded Specialty Company, health plan management and Corporate Finance's inquiries using standardized and currently operational managerial processes, measures, and reports. Manage budgets and forecast for strategic planning and key initiatives.
- Worked with Investment Bankers/Venture Capitalists/Banks for additional funding through the companies initial public offering.
- Medical Liaison for Health Services and Provider Relations for 24 insurance carriers including: PHOs, PPOs, HMOS, AHCCCS, ALTCS, and Provider Relations Specialist. Developed provider network for PHO, including: contracting/negotiations; network analysis,
- Developed provider reference manual, editor for monthly provider newsletter, developed prior authorization criteria and implementation strategies.
- Conducted medical claims; analyzed claims data and worked closely with case managers to ensure cost controls were implemented; served as the Liaison between other departments.
- Managed staff of 25 health care professionals and support staff for Managed Care Demonstration for the Department of Defense; strategic planning and development, budgeting and financial responsibilities; developed and maintained provider network, contract negotiations, credentialing files in compliance with NCQA requirements;
- Liaison between the Air Force and the community; established ongoing information and marketing programs to enhance participation; analyzed data to evaluate the effectiveness and cost savings to the government
- Conducted training seminars for staff, network providers, and the community; designed office procedures, developed policies to comply with Federal Regulations; coordinated managed care benefits for over 15,000 CHAMPUS beneficiaries.
- Worked directly with DOD to prepare for base closure and transition of care. Conducted town hall meetings with Congressional staff and Champus beneficiaries to answer questions and provide guidance on the transition.

Professional Work History

EverCare/United Health Group
Phoenix, Arizona

Operations Manager *1998-Present*

TriWest HealthCare Alliance
Phoenix, AZ

Contracting and Analysis Specialist *1997-1998*

Spectra Health Systems
Chandler, AZ

Medical Liaison *1994-1997*

Patricia J. Weidman

Samaritan Health Plan
Phoenix, AZ

Nurse Coordinator/Case Manager	*1992-1994*

Department of Defense- Williams Air Force Base, AZ

Assistant Director for Managed Care Demonstration	*1991-1992*

Education and Accreditation

University of Phoenix, Phoenix, AZ	*Bachelor of Science in Business Administration*
Glendale Community College - Glendale, AZ	*American Institute, Phoenix, AZ*
American Institute, Phoenix, AZ	*91C-Clinical Health Specialist/Practical Nurse*
U.S. Army, Presidio	**AZ Licensed Practical Nurse*

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1

Human Rights Liaison

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Interagency Liaison Manager
Purpose:

- Coordinates with ADHS/DBHS Office of Human Rights, facilitates dissemination of human rights information throughout the system, provides information to Human Rights Committees, and provides assistance to behavioral health recipients regarding human rights violations.

Responsibilities:

- Manages and maintains database and extracts monthly reports reflecting trends and patterns in reported incidents of human rights violations
- Reviews and processes incoming Incident/Accident Reports
- Makes recommendations for investigation, follow-up and/or corrective action
- Conducts interviews and site visits
- Researches and prepares Mortality Reports and Seclusion and Restraint Reports as required by the State
- Conducts investigations and chart reviews
- Prepares and revises policies as required to maintain compliance with local, state and federal regulatory requirements
- Prepares and processes motions as needed
- Reviews subpoenas and prepares responses

Answers general questions received regarding applicable policies, procedures, and statutes

Qualifications:
Knowledge/Experience:

- Bachelors Degree in Behavioral Health or Human Resources related field. Three years experience as consumer advocate. Knowledge of human rights. Excellent verbal and written communication skills.

Skills:

- Proficiency in Microsoft Office products; consulting and influencing skills; ability to advise on complex issues; ability to listen without judging in helping to resolve problems; excellent planning and organizational skills; professional interpersonal skills; problem-solving orientation and skills; strong team player; exercise tact and diplomacy, maintain confidential information; detail orientation; excellent follow-through behavior; high level of accuracy; ability to interact with employees at all levels of the organization; ability to thrive in a fast-paced environment and travel.

Licensure:
None Required.

2

1

Children's Medical Administrator

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Chief Medical Officer
Purpose:
Actively oversees all children's clinical programs and participates in children's QM/UM activities
Responsibilities:

- Ensure high quality, effective clinical care is accessible to all children and adolescents.
- Assist quality management, grievance and appeals, and customer service staff to promote collaborative relationships with all stakeholders
- Ensure that the AZ Children's Vision and Principles are integrated into all clinical functions
- Directs interdepartmental meetings of all staff in children's system within service center to coordinate efforts among clinical services, crisis services, networks, and utilization management
- Directs clinical audit of children's providers and monitors Comprehensive Service Provider quality management activities
- Provides clinical leadership regarding the effective implementation of the AZ Children's Vision and Principles

Qualifications:
Knowledge/Experience:

- Graduate of a medical school accredited by the Accreditation Council for Medical Education (ACME) or equivalent training in a foreign medical school with successful completion of the ECFMG and FLEX examinations. Full training in a residency program in the United States or Canada that is approved by the ACME. Compatibility with outpatient philosophy of treatment. Previous experience as a managed care Medical Administrator is desirable.

Skills:

- Proficiency in Microsoft Office; consulting and influencing skills; ability to lead and advise on complex issues; ability to listen without judging in helping to resolve problems and/or clarify performance expectations; ability to leverage the human assets of the assigned group through employee development, appropriate and timely feedback and logical career progression/succession planning; recognition of priority issues, quick response and execution of plans are key requirements; excellent planning and organizational skills; professional interpersonal skills; problem-solving orientation and skills; good analytical and mathematical skills; strong team player; exercise tact and diplomacy, maintain confidential information; detail orientation; excellent follow-through behavior; high level of accuracy; ability to interact with employees at all levels of the organization; ability to thrive in a fast-paced environment and travel.

Licensure:
Current Arizona physicians license, board certified in psychiatry; board certified in child psychiatry.

2

1

Claims/Encounter Administrator

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Chief Financial Officer

Purpose:

Responsible for the timely and accurate processing and adjudication of claims and encounters.

Responsibilities:

- Directs all operations of the Claims Department, including Claims Research, Eligibility and Enrollment/Disenrollment, and claims Fraud/Abuse.
- Develops and implements policies and procedures.
- Ensures compliance with applicable state and federal statutes and rules.
- Serves as a liaison to regulatory and funding agencies related to claims.
- Ensures timely electronic and manual claims adjudication.
- Trains internal customers.
- Participates in cross-departmental process improvement initiatives.
- Trains and mentors provider agencies regarding successful claims/encounter adjudication.
- Participates on the Training Committee.

Qualifications:

Knowledge/Experience:

- Demonstrates in-depth skills and knowledge of the industry and claims processing. Bachelors Degree in business administration, accounting, healthcare administration, or related field. Over 12 years of experience in overseeing and developing Medicaid claims operations and familiarity with the different elements that affect claims processing, preferably in a behavioral health setting, with 8 years of management experience.

Skills:

- Apply principles of logical and scientific thinking to define problems, collect data, establish facts, and draw valid conclusions. Proficient in use of Microsoft office suite products, including Word, Excel, and Access. Intimate knowledge of web-based and claims processing software. Interpret an extensive variety of technical instructions in mathematical or diagrammatic form. Deal with multiple abstract and concrete variables. Perform the basic functions of mathematics; all units of measure. Interpret data and present results in various formats. Able to communicate effectively, with ability to simplify complex concepts and train internal and external customers effectively. Perform reading, writing and speaking at a high level, demonstrating good oral and written communication skills, as well as attention to details. Ability to apply knowledge effectively in all interaction across the organization. Proficiency in negotiation skills – able to influence at all levels of the organization and with internal/external constituencies. Understand and navigate the organization to achieve results. Ability to achieve expectations on a consistent basis. Understand the link between one's own job responsibilities, team member's roles, and overall organizational goals and needs. Constantly look for improvements in work processes and results. Ability to travel

Licensure:

None required

2

1

Compliance & Communication Officer

(Corporate Compliance Officer)

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Chief Executive Officer
Purpose:
Responsible for monitoring adherence to HIPAA guidelines, compliance to contract requirements and all applicable state and federal statutes, and reporting of all issues of fraud and abuse within the organization and in the provider community. Responsible for the review and approval of all public communication.

Responsibilities:

- Administers and implements the Fraud and Abuse Program
- Monitors the RBHA system regarding compliance with state and federal regulations
- Provides technical assistance, and mentoring to provider agencies regarding regulations
- Analyzes encounter data and provider financial reports to identify outliers and potential fraud and abuse
- Implements the fraud and abuse policy and investigates fraud and abuse allegations
- Provides on-site presence for all employees to address compliance issues
- Has authority to access provider records and make independent referrals to ADHS/DBHS and AHCCCS Office of Program Integrity
- Oversees the review and approval process for all public communication to consumers, providers and community stakeholders to ensure communications comply with the strategic objectives of the RBHA, cultural competency plan, the Arizona principles and/or contractual agreements
- Reviews external communication with stakeholders and ADHS/DBHS as appropriate
- Reviews, edits and approves all external communication

Qualifications:
Knowledge/Experience:

- Bachelor's degree in business management, public policy, government affairs, communications, public relations. Advanced degree preferred. Ten (10) years of management, compliance and/or government affairs experience. Minimum of 5 years communications experience. Experience in a managed care or insurance environment preferred.

Skills:

- Superior communication, and analytical skills. Ability to work with diverse staff and clients. Able to apply principles of logical and scientific thinking to define problems, collect data, establish facts, and draw valid conclusions. Interpret multiple abstract and concrete variables. Perform advanced functions of mathematics, algebra and statistics. Apply mathematical operations to frequency distributions, reliability and validity of tests, normal curve, analysis of variance, correlation techniques and factor analysis. Perform reading, writing and speaking at an advanced level. Excellent professional writing skills. Excellent verbal communication skills. Strong clinical skills. Detail oriented and very strong organization skills.

Licensure:
None required

2

1

Emergency Response Liaison

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Customer Services Administrator
Purpose:
Facilitate effective coordination of services with First Responders and emergency rooms.
Oversees and implements disaster response plan.

Responsibilities

- Meets on a regular basis with First Responders, Emergency Room staff, and Emergency Room Doctor Associations to facilitate coordination of services
- Resolves system access problems to ensure effective treatment for behavioral health recipients
- Identifies service gaps and proposes solutions
- Attends Community Advisory Council meetings as appropriate to identify and resolve local service delivery issues
- Develops and maintains the company disaster response plan
- Coordinates the efforts of the disaster response team
- Makes recommendations for investigation, follow-up and/or corrective action
- Conducts interviews and site visits
- Prepares incident reports as required by the State
- Prepares and revises policies as required to maintain compliance with local, state and federal regulatory requirements
- Answers general questions received regarding applicable policies, procedures, and statutes

Qualifications:
Knowledge/Experience

- Bachelors Degree in Behavioral Health, Medical or Human Resources related field. Three years experience in emergency service delivery, crisis management and disaster recovery; experience in working with all levels of personnel. Excellent verbal and non-verbal communication skills.

Skills:

- Proficiency in Microsoft Office; consulting and influencing skills; ability to advise on complex issues; ability to listen without judging in helping to resolve problems; excellent planning and organizational skills; professional interpersonal skills; problem-solving orientation and skills; strong team player; exercise tact and diplomacy, maintain confidential information; detail orientation; excellent follow-through behavior; high level of accuracy; ability to interact with employees at all levels of the organization; ability to thrive in a fast-paced environment and travel.

Licensure:

None required

2

1

Grievance & Appeals Administrator

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Quality Management Administrator
Purpose:
Oversees and ensures appropriate processing of SMI grievances, member appeals, provider claim disputes, or requests for a State Fair Hearing Responsible for oversight of the Grievance and Appeals Department

Responsibilities:
- Ensures that the Grievance and Appeals department processes all appeals and grievances in accordance with required time frames and other contractual and legal requirements
- Monitors and trends appeals, grievances and sentinel events
- Provides senior management with monthly reports on any identified trends
- Ensures that all provider claim disputes are processed and investigated according to contract requirements
- Works with various external constituencies, i.e., state, local and federal governments, local community and the public related to grievances and appeals
- Integrates federal and state law changes into company's regulatory system related to grievances and appeals
- Recommends solutions and works with department and company staff to ensure problems are corrected and departments are advised of corrective measures to prevent recurrences
- May provide training and direction to agencies in developing procedures to comply with grievance and appeals requirements

Qualifications:
Knowledge/Experience:
- For attorney, Juris Doctor; For paralegal, A.A. in Paralegal studies preferred
- Two years practicing as an attorney or a paralegal
- Administrative Law experience preferred. Prior experience in mental health field preferred

Skills:
- Excellent customer service, communication, arbitration and conflict resolution skills. Apply principles of logical or scientific thinking to define problems, collect data, establish facts, and draw valid conclusions. Deal with multiple abstract and concrete variables. Ability to supervise others: determining or interpreting work procedures for a group of workers, assigning specific duties to them, maintaining harmonious relations among them, and promoting efficiency. Deal with system of real numbers; related algebraic solution of equations and inequalities; limits and continuity; and probability and statistical inference. Practical application of fractions, percentages, ratio and proportion, practical algebra, and geometric construction. Perform reading, writing and speaking at an advanced level, demonstrating good oral and written communication skills, as well as attention to details. Ability to use computer systems for the management, reporting and presentation of information, as well as correspondence. Ability to travel.

Licensure:
Arizona State Bar License in good standing or Certified Arizona Paralegal.

2

1

Level I Utilization Review Administrator

Greater Arizona Behavioral Health Authority, LLC.

Reports to: Chief Medical Officer
Purpose:
Responsible for oversight and compliance with Level 1 utilization management procedures.

Responsibilities:

- Ensures that all utilization management activities provided for Level 1 services are in compliance with the AZ principles, and medical necessity criteria
- Recruits, trains and supervises care managers
- Compiles routine reports and conduct special studies as required
- Interfaces with provider network on UM-related issues
- Interacts with physician advisors to discuss clinical and authorization decisions
- Participates in quality improvement committee meetings
- Ensures all timelines and reporting requirements are met
- Ensures all utilization review timelines and documentation requirements are met

Qualifications:
Knowledge/Experience:

- Master's degree and a minimum of eight years of appropriate behavioral health and substance abuse treatment experience; belong to an appropriate professional association; have at least two years of experience in managed care and crisis intervention.

Skills:

- Proficient knowledge of medical necessity criteria. Experienced with Microsoft Office products; consulting and influencing skills; ability to lead and advise on complex issues; ability to listen without judging in helping to resolve problems and/or clarify performance expectations; ability to leverage the human assets of the assigned group through employee development, appropriate and timely feedback and logical career progression/succession planning; recognition of priority issues, quick response and execution of plans are key requirements; excellent planning and organizational skills; professional interpersonal skills; problem-solving orientation and skills; good analytical and mathematical skills; strong team player; exercise tact and diplomacy, maintain confidential information; detail orientation; excellent follow-through behavior; high level of accuracy; ability to interact with employees at all levels of the organization; ability to thrive in a fast-paced environment and travel.

Licensure

Must hold and maintain an Arizona license as a psychologist or independent behavioral health professional

2

i. Management Services Subcontracts – GSA 1

To facilitate implementation and to fulfill the requirements in the Arizona RFP, GREABHA has contracted with four organizations:

- The Southwest Network
- META Services
- Caremark, Inc.
- Medical Verification Solutions, LLC (MVS)

The requested information regarding these three organizations is provided below.

1. The Southwest Network

The Southwest Network has a proven track record of leadership and innovation in the implementation of the Arizona principles.

Name of Subcontractor	The Southwest Network
Address	3707 N. 7th Street #200, Phoenix 85014
Telephone Number	602-266-8402
Ownership	Nonprofit
Specific Management Service (including Delegated Administrative Functions)	Training and coaching to providers in GSA 1
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Team of Mentoring and Training Staff 350 hours
Compensation Arrangement including expected Total Annual Compensation	Not to exceed $35,000
Plans for Monitoring	GREABHA will meet with The Southwest Network monthly to evaluate the needs of providers and to evaluate the effectiveness of the training and coaching.

09/28/2004 15:07 DESERT SPRINGS → 13147254658 NO.228 P002
09/28/2004 14:56 NO.486 P02

GPA
FOCUSED BEHAVIORAL SOLUTIONS

LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH GROUP PRACTICE AFFILIATES FOR PROVISION OF SERVICES TO ARIZONA MEDICAID MEMBERS

Group Practice Affiliates, "GPA" is proposing to become the Regional Behavioral Health Authority in one or more of the GSA Regions for which the State of Arizona is currently soliciting proposals. This Request for Proposals ("RFP"), Numbered HP532003, is issued by the Arizona Department of Health Services for provision of services to Title XIX and Title XXI Covered consumers, Developmentally Disabled Children and Adults, and Non-Title XIX and XXI Persons with a Serious Mental Illness.

If GPA is awarded the contract to become the Regional Behavioral Health Authority for GSA 1, GSA 2, or GSA 4, Southwest Network will provide training and coaching to the providers in those regions at the direction of GPA.

1. CONTRACTOR PRINTED NAME

The Southwest Network

2. ADDRESS (primary address if more than one location)

3707 N. 7th Street #200, Phoenix, AZ

3. ZIP CODE 85014 4. COUNTY Maricopa

5. TELEPHONE (602) 2610-8402 6. FAX (602) 264-0887

7. TAX ID# 86-0966400 8. AZ PROVIDER ID# 5452416

HOURS TO BE SUBCONTRACTED

GSA 1 350

GSA 2 175

GSA 4 175

COMPENSATION

Not to exceed $70,000

MONITORING

Southwest Network will meet with GPA monthly to evaluate the needs of providers and to evaluate the effectiveness of training and coaching.

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09/28/2004 15:07 DESERT SPRINGS → 13147254658 NO.228 P003
09/28/2004 14:56 NO.486 P03

GPA
FOCUSED BEHAVIORAL SOLUTIONS

ATTESTATION

Southwest Network has never been suspended or excluded from any Federal program.

9. PROVIDER'S SIGNATURE

10. DATE 9/28/04

11. PRINTED NAME OF SIGNER Jeff Jorde

12. TITLE President/CEO

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2. META Services, Inc.

META Services has a proven track record of leadership and innovation in the implementation of the Arizona principles.

Name of Subcontractor	META Services, Inc.
Address	2701 N. 16th Street #316, Phoenix 85006
Telephone Number	602-650-1212
Ownership	Nonprofit
Specific Management Service (including Delegated Administrative Functions)	Training and coaching to providers in GSA 1
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Team of Mentoring and Training Staff 300 hours
Compensation Arrangement including expected Total Annual Compensation	Not to exceed $21,400
Plans for Monitoring	GREABHA will meet with META Services monthly to evaluate the needs of providers and to evaluate the effectiveness of the training and coaching.

GPA

LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH
GROUP PRACTICE AFFILIATES
FOR PROVISION OF SERVICES TO ARIZONA MEDICAID MEMBERS

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If GPA is awarded the contract to become the Regional Behavioral Health Authority for GSA 1, GSA 2, or GSA 4, META Services, Inc. will provide training and coaching in the planning, development, and implementation of mental health recovery principles and practices to GREABHA staff and to the providers in those regions at the direction of GPA.

1. CONTRACTOR PRINTED NAME

   META Services, Inc.

2. ADDRESS (primary address if more than one location)

   2701 N. 16th Street #316
   Phoenix, AZ

3. ZIP CODE 85006
4. COUNTY Maricopa
5. TELEPHONE 602.650.1212
6. FAX 602.650.1616
7. TAX ID# 86 0671446
8. AZ PROVIDER ID# 1204014

HOURS TO BE SUBCONTRACTED

GSA 1 – not to exceed 300

GSA 2 – not to exceed 175

GSA 4 – not to exceed 225

COMPENSATION

Not to exceed $50,000.00

MONITORING

META Services, Inc. will meet with GPA monthly to evaluate the needs of providers and to evaluate the effectiveness of training and coaching.

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GPA

ATTESTATION

META Services, Inc. has never been suspended or excluded from any Federal program.

9. PROVIDER'S SIGNATURE _____

10. DATE September 28, 2004

11. PRINTED NAME OF SIGNER Eugene Johnson

12. TITLE President/CEO

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3. Caremark/PCS

To ensure continuity of care for Arizona behavioral health recipients, GREABHA provides Pharmacy Benefit Management (PBM) services through a contract with Caremark/PCS, the same PBM vendor that currently serves the majority of behavioral health recipients in GSA 1 and GSA 2. GREABHA's parent company, Centene, has experience working with Caremark to provide specialty pharmacy services such as self-injectables or therapies that require extensive monitoring or follow-up care.

Name of Subcontractor	Caremark/PCS
Address	9501 E. Shea Blvd., Scottsdale, AZ 85260
Telephone Number	(480) 391-4600
Ownership	Publicly traded NYSE symbol CMX
Specific Management Service (including Delegated Administrative Functions)	Pharmacy claims processing and payment, pharmacy network contracting and management, rebate contracting and administration, formulary administration, drug utilization review, pharmacy help desk
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	3 FTEs Customer Service 0.5 FTE Pharmacy Administrator 0.5 FTE Contracting Pharmacy program administration requires approximately 40 hours per week per 50,000 live both pharmacy and non-pharmacy
Compensation Arrangement including expected Total Annual Compensation	Discounted AWP plus dispensing fee per prescription. Per claim administration fee and rebate administration fee Total Annual Compensation: $7.1 million $2.84 per member per month
Plans for Monitoring	Annual delegated oversight audit including financial, operations, customer service, clinical, administrative and quality functional areas. Contract specifies deliverables from subcontractor.

CAREMARK
It all starts with care

October 6, 2004

Galit Lev-Harir
Centene Corporation

Dear Ms. Lev-Harir:

This letter is to inform you that Caremark and its Subsidiaries and facilities in the State of Arizona are all in good standing without any restriction, sanction or suspension within the scope of its business, as of this date.

Sincerely,

Richard J. Nagler
Vice President, Western Region

PHARMACY BENEFIT MANAGEMENT AGREEMENT

This **PHARMACY BENEFIT MANAGEMENT AGREEMENT** (this "Agreement") is made and entered into this _____ day of _____, 2004 by and between **CENPATICO BEHAVIORAL HEALTH**, a Delaware corporation ("HMO"), and **CAREMARK RX**, an Illinois corporation ("Manager").

RECITALS

WHEREAS, HMO is a managed care organization which arranges for the delivery of behavioral heath care services on behalf of Health Plans (as hereinafter defined), including state Medicaid and CHIP programs in the state of Wisconsin, and desires to contract with a pharmacy benefits management company for the management and delivery of pharmacy benefits to its Covered Persons (as hereinafter defined); and

WHEREAS, Manager is in the business of developing and administering systems for the delivery of pharmacy benefits and desires to contract with HMO to provide access to such systems and the management services related thereto.

NOW, THEREFORE, in consideration of the terms and conditions set forth in this Agreement, the parties hereto agree as follows:

I. DEFINITIONS

In addition to the capitalized terms defined elsewhere in this Agreement, the following terms shall have the following meanings:

1.1. **"Benefit Contracts"** means a health benefit plan that: (i) is sponsored, purchased, issued, or administered by Health Plans, (ii) contains the terms and conditions of a Covered Person's coverage, and (iii) provides pharmacy benefits either as part of the basic plan or through a rider to the plan. A Benefit Contract is also known as a certificate of coverage, summary plan description, evidence of coverage, or group services agreement.

1.2. **"Commencement Date"** the date on which Manager begins to provide services pursuant to the terms of this Agreement, which date shall be January 1, 2005, subject to State regulatory filing and/or prior approval requirements.

1.3. **"Copayment"** collectively means the charge, in addition to the premium, which a Covered Person is required to pay for certain covered services provided under the Benefit Contracts and includes copayments, coinsurance, deductibles, or other similar charges, which may be either a defined dollar amount or a percentage of eligible expenses. A Covered Person is responsible for the payment of any Copayment directly to a pharmacy at the time a prescription is dispensed.

1.4. **"Covered Person"** means an individual eligible to receive coverage for outpatient prescription pharmacy benefits as an enrollee under a Benefit Contract.

1.5. **"Covered Prescription Drug Services"** means those outpatient prescription drugs and pharmacy products, services, and supplies that are covered pursuant to the Benefit Contracts.

1.6. **"ADHS"** means the Arizona Department of Health Services.

1.7. **"Health Plans"** means any of the managed care health plans established and operated by HMO or its subsidiaries or affiliates, whether insured or self-insured, commercial or governmental program. This term includes behavioral health and state RBHA programs operated in the State of Arizona.

1.8. **"Intellectual Property"** means all patents, patents pending, trademarks, service marks, trade names, service names, slogans, registered copyrights, commercially significant unregistered copyrights, technology rights and licenses, computer software (including, without limitation, any source or object codes or related documentation), trade secrets, franchises, know-how, inventions, and all improvements to such intellectual property.

1.9. **"RBHA Management Contract"** means the written agreement entered into by Cenpatico and the Arizona Department of Health Services for the management of the Arizona Regiona Behavioral Health Association programs.

1.10. **"Medically Necessary"** shall mean the provision of a Covered Prescription Drug Service which a Covered Person requires as determined by one or more participating providers, in accordance with generally accepted medical practice standards in effect at the time of treatment and in conformity with the professional and technical standards adopted by the Quality Improvement and Utilization Management Committee(s) of HMO and its subsidiaries and not solely for the convenience of the Covered Persons.

1.11. **"Non-Covered Services"** shall mean those health care services that are not Covered Prescription Drug Services and are not benefits under the ADHS/RBHA Contract and are, therefore, the financial responsibility of the Covered Persons, or are to be paid by the ADHS fee-for-service programs.

1.12. **"Participating Pharmacy(ies)"** means a pharmacy, including a retail service pharmacy, or a pharmacist which/who has entered into an agreement with Manager under which pharmacy/pharmacist has agreed to provide Covered Prescription Drug Services to Covered Persons and to comply with (i) contractual requirements pursuant to this Agreement, and (ii) statutory and regulatory requirements.

1.13. **"Pharmacy & Therapeutics Committee"** or **"P&T Committee"** means the HMO committee that: (i) considers a prescription drug for inclusion on the HMO Preferred Drug List or other comparable formularies, and (ii) develops other criteria, procedures, and rules for the Program including, but not limited to, quantity levels and prior authorization issues.

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obligations under this Agreement, including, without limitation, a certificate of authority as a third party administrator. Manager shall promptly notify HMO of any and all licensing, administrative, or legal actions initiated against it by any government agency which has as a potential remedy the loss or limitation of any license or which is likely to result in the inability of Manager to fulfill and perform its duties under this Agreement. Manager shall be solely responsible for any fines, penalties, or other assessments imposed against it or against HMO by any state or federal regulatory authority which arise out of Manager's failure to comply with HMO's procedures for administering PBM Services. In the event a state or federal regulatory authority imposes a fine, penalty or other assessment against HMO for acts or omissions caused by Manager's failure to comply with this Agreement, Manager shall reimburse HMO in full for such fine, penalty or other assessment within ten (10) days of receiving written notice from HMO. Manager shall perform the PBM Services required under this Agreement in accordance with all applicable state and federal laws and regulations, including, without limitation, those relating to the activities of third party administrators.

2.1.4. No Conflict; Required Filings and Consents. Manager represents and warrants to HMO that the execution, delivery, and performance of this Agreement does not, and the provision of the services contemplated hereby will not: (a) conflict with the Articles of Incorporation or Bylaws or other corporate documents of Manager; (b) conflict with or violate any laws applicable to Manager or by which any of its properties is bound or affected; or (c) result in any breach of or constitute a default (or an event that with notice or lapse of time or both would become a default) under, or give to others any rights of termination, amendment, acceleration, or cancellation of, or result in the creation of a lien or encumbrance on any of the properties or assets of Manager pursuant to any note, bond, mortgage, indenture, contract, agreement, lease, license, permit, franchise, or other instrument or obligation to which Manager is a party, or by which Manager or any of its properties is bound or affected. The execution and delivery of this Agreement by Manager does not, and the performance of this Agreement by Manager and the provision of the services contemplated hereby by Manager will not, require any consent, approval, authorization or permit of, or filing with or notification to, any third party, except for certain filings required by certain state governmental entities.

2.1.5 Financial Viability. Manager represents and warrants that it has sufficient net worth and financial reserves to meet its reasonably foreseeable needs under the terms of this Agreement and the Cenpatico/ADHS Contract. Upon request by HMO, Manager shall provide HMO a copy of its most recent audited financial statements.

2.2. Representations and Warranties of HMO.

2.2.1. Organization and Qualification. HMO represents and warrants to Manager that it is a corporation duly incorporated, validly existing, and in good standing under the laws of Delaware. HMO has the corporate power and authority necessary to own and operate its properties and to carry on its business as now conducted. HMO is qualified to do business as a foreign corporation in

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every jurisdiction in which the nature of its business or its ownership of property requires it to be so qualified.

2.2.2. Corporate Authorization. HMO represents and warrants to Manager that the execution, delivery, and performance of this Agreement are within its corporate powers. All requisite authority necessary to enter into this Agreement has been obtained, and HMO has duly and validly executed and delivered this Agreement. Assuming this Agreement constitutes the valid and binding agreement of Manager, this Agreement constitutes a valid and binding agreement of HMO enforceable against HMO in accordance with its terms.

2.2.3. Regulatory Compliance. HMO represents and warrants that Health Plans are currently, and shall remain throughout the duration of this Agreement, duly licensed as required to enter into and provide benefits under the Benefit Contracts. HMO shall promptly notify Manager of any and all licensing, administrative, or legal actions initiated against it or Health Plans by any state or federal government agency which has as a potential remedy the loss or limitation of its licensure or which is likely to result in the inability of HMO to fulfill its obligations under this Agreement. HMO or Health Plans shall be solely responsible for any fines, penalties, or other assessments imposed against them by any state or federal regulatory authority which arise out of HMO's or Health Plans' acts or omissions in connection with the administration of the Benefit Contracts. HMO shall perform its duties under this Agreement in accordance with all applicable state and federal laws and regulations.

2.2.4. No Conflict; Required Filings and Consents. HMO represents and warrants to Manager that the execution, delivery, and performance of this Agreement does not, and the performance of this Agreement by HMO will not: (a) conflict with the Articles of Incorporation or Bylaws of HMO; (b) conflict with or violate any laws applicable to HMO or by which any of its properties is bound or affected; or (c) result in any breach of or constitute a default (or an event that with notice or lapse of time or both would become a default) under, or give to others any rights of termination, amendment, acceleration, or cancellation of, or result in the creation of a lien or encumbrance on any of the properties or assets of HMO pursuant to any note, bond, mortgage, indenture, contract, agreement, lease, license, permit, franchise, or other instrument or obligation to which HMO is a party, or by which HMO or any of its properties is bound or affected. The execution and delivery of this Agreement by HMO does not, and the performance of this Agreement by HMO will not, require any consent, approval, authorization or permit of, or filing with or notification to any third party, except for certain filings required by certain state governmental entities.

III. OBLIGATIONS OF MANAGER: PHARMACY BENEFIT MANAGEMENT AND SERVICES

3.1. General Manager Services. Manager shall provide to HMO the PBM Services described in this Agreement and in **Exhibit** B and C.

3.2. Retail Participating Pharmacy Network. Manager agrees to provide networks of retail Participating Pharmacies under contract with Manager to provide dispensing services to Covered Persons under the Retail Pharmacy Program. Manager agrees that HMO may

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require the termination of a specific retail pharmacy for good cause including quality of care issues. Manager shall notify HMO of any terminations in the Participating Pharmacy network. Manager shall send letters to Covered Persons who have utilized a Participating Pharmacy in the prior twelve months notifying them of the termination of such Participating Pharmacy, after receiving from HMO: (a) the addresses of the affected Covered Persons; and (b) the approval of the letters by HMO. HMO shall be responsible for the postage costs of any mailings to Covered Persons when a Participating Pharmacy is terminated at HMO's request. Manager shall be responsible for the postage costs of any mailings to Covered Persons when Participating Pharmacy is terminated at Manager's request. Manager agrees that during the term of this Agreement all Manager customized pharmacy provider agreements for such retail pharmacy network shall be assignable to HMO. Such assignment shall be made at HMO's sole discretion and at a time determined by HMO.

3.3. Pharmacy Network Information. Manager shall provide HMO with a complete list of the names, addresses, license numbers, and normal office hours of the Participating Pharmacies, together with the provider-specific information required by HMO, at the time this Agreement is signed and thereafter as such information becomes available. Manager shall provide at least ninety (90) calendar days prior written notice to HMO of the proposed termination of Participating Pharmacies if a group of 5 or more pharmacies is terminated at one time or if such termination of one or more pharmacies would result in the pharmacy network not meeting state access standards .

3.4. Consultation. Manager shall provide ongoing consultation and assistance to HMO with respect to the delivery of PBM Services to Covered Persons. The scope of such assistance shall include, without limitation, advice and recommendations regarding the PBM Services, provider network, and claims. Manager shall educate HMO's provider network regarding Manager's policies and procedures in a reasonably prudent manner.

3.5. HMO Policies. Manager shall perform the PBM Services in accordance with the standards, policies, procedures, and requirements established by HMO for such activities and in accordance with applicable state and federal law. Manager may utilize its own policies and procedures for the PBM Services, provided that such policies and procedures are consistent with the HMO standards and requirements and are provided to HMO for its review and approval.

3.6. Laws, Regulations and Licenses. Manager, at its own cost, shall: (a) maintain all federal, state, and local licenses that are materially necessary to provide PBM Services under this Agreement and the lack of which could adversely affect HMO; (b) shall comply with all applicable statutes and regulations in providing all PBM Services pursuant to this Agreement; and (c) require all Participating Pharmacies employed by or under contract with Manager to comply with (a) and (b).

3.7. Personnel and Other Resources. Manager shall provide sufficient, dedicated personnel, information systems support, and other resources, as reasonably required to successfully provide high-quality, cost-effective PBM Services for HMO pursuant to this Agreement.

3.8. Customized Installation Materials. Manager agrees to provide to HMO customized installation materials for HMO that are accurate and support the specific

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language in the Benefit Contracts. Manager is responsible for administering the Benefit Contracts accurately and in accordance with all regulatory requirements.

3.9. Communications. At HMO's option and approval, Manager shall produce brochures, and other materials for Covered Persons specific to Covered Prescription Drug Services. Manager agrees to provide an accompanying explanatory brochure and direct reimbursement claim forms for use by Covered Persons who have not received or who have lost their identification cards. Manager agrees that any materials sent to Covered Persons must be approved by HMO. HMO shall be responsible for all postage costs related to mailings to Covered Persons, except as otherwise provided in this Agreement. Manager agrees that all written communications sent to HMO Covered Persons, Participating Pharmacies, or facilities that relate in any way to HMO's Benefit Contracts must be reviewed and approved by HMO before such communications are sent out to any such individuals or groups. Manager agrees that all program communication protocols to be used with HMO Participating Pharmacies will be reviewed and approved by HMO prior to use. HMO shall approve or disapprove all such materials within a reasonable time after submission by Manager.

3.10. Eligibility and Claims Processing.

3.10.1. Eligibility. Manager shall administer the eligibility of Covered Persons according to eligibility information provided by HMO via tape or telecommunication or such other reasonably practicable method in a mutually agreeable acceptable format. Manager shall load eligibility tapes within one (1) business day and inform HMO upon completion. Manager agrees to provide toll-free access for network pharmacies to Manager's customer service department for claims processing assistance. Manager shall notify HMO immediately upon becoming aware of any discrepancies in the eligibility information.

3.10.2. Payment of Claims. Manager shall process Covered Persons' Covered Prescription Drug Services in accordance with the Benefit Contracts, Manager's standard operating procedure, and any applicable statutory and regulatory requirements governing third party administrators, including but not limited to any prompt payment of claims requirements. Claims adjudication includes, without limitation: (i) an explanation to a Covered Person of benefits describing any payment reduction or denial of the claim; (ii) a request for additional information to determine benefits; (iii) a notification that additional information is required from a provider; and (iv) payment for clean claims, as defined in any applicable law or regulation.

3.10.3. Disputes. Any disputes over claims shall be resolved prior to payment by Manager. If Manager makes an error or omission in claims processing, Manager shall be solely responsible for any related costs.

3.10.4. Postage. All postage costs related to payment or denial of direct reimbursement claims are the responsibility of Manager.

3.10.5. Claims Reports. Manager shall provide claims reports and written notice to HMO of the amount necessary to pay the fees due to Manager for claims processed, as set forth in **Exhibit A**. Manager will provide HMO with a claims

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processing fee statement pursuant to **Exhibit A**. Within 15 days after receipt of each statement from Manager, HMO shall remit payment of such fees.

3.10.6. Claims Auditing. Manager shall regularly audit its electronic and on-site claim processing activities and shall regularly audit its retail pharmacies, in accordance with Manager's standard audit procedures. Manager shall provide HMO with a report on such audits containing specific audit information and containing such other information as HMO reasonably requests. HMO shall receive one hundred percent of any such audit recoveries that were incorrectly paid pursuant to the HMO PBM Services. When any such overpayment was the result of errors or omissions by Manager, payment of such audit recovery shall include interest at the prevailing prime rate of interest for the period of time from the payment of the claim to receiving recovery from Manager.

3.10.7. Claim Appeals. In the event of a claim denial by Manager, Manager shall promptly communicate to the Covered Person the right to appeal according to the Covered Person's Benefit Contract and applicable law. Manager shall assist HMO in dealing with the Covered Person's appeal of Manager's decisions.

3.11. Covered Person Hold Harmless Provision. Manager agrees that it shall look only to the applicable Health Plan and agrees to hold Covered Persons harmless for compensation for all services provided to Covered Persons during the term of this Agreement. Under no circumstances, including but not limited to, nonpayment by Health Plan, Health Plan's insolvency or breach of this Agreement, shall Manager or any Participating Pharmacy bill, charge, collect a deposit or Surcharge from or seek compensation, remuneration, or reimbursement from, or have any recourse against, Covered Person or persons (other than Health Plan) acting on the Covered Person's behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or Copayments made in accordance with the terms of the applicable Benefit Contract, nor does this provision affect the right of Participating Pharmacy to collect fees for services to Covered Persons which do not constitute Covered Services or for which Covered Person has specifically assumed financial responsibility, in writing, prior to the time that services were rendered. Manager further agrees that this provision shall: (i) survive the termination of this Agreement, regardless of the reason for termination, and shall be for the benefit of the Covered Person; (ii) supersede any oral or written agreement now existing or hereafter entered into between Manager and a Covered Person or persons acting on the Covered Person's behalf; and (iii) be construed to inure to the benefit of Covered Persons and persons acting on the Covered Person's behalf. Any modifications, additions, or deletions to this provision shall be effective no earlier than fifteen (15) days after any applicable regulatory authority has received any required written notice of and has approved such changes.

3.12. Reports. Manager agrees to provide reports to HMO in a format and containing such information as HMO reasonably requests, including but not limited to, claims paid, claims denial, claims lag, coordination of benefits, and third-party liability reports. The reports shall contain the information set forth in **Exhibit C**. If a state fine or penalty is imposed upon HMO due to Manager's failure to provide reports on the required due date, then Manager shall reimburse HMO for the full amount of the fine and any incidental expenses.

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3.13. Coordination of Benefits. When HMO provides required information, Manager agrees to administer coordination of benefits in accordance with HMO's coordination of benefits rules and the Benefit Contracts.

3.14. Service Performance Standards. HMO and Manager shall each use good faith and reasonable commercial efforts to perform their respective duties and obligations under this Agreement in a diligent, professionally responsible, and efficient manner. The parties agree to cooperate with and assist each other as reasonably necessary in the performance of their respective duties and in developing timely responses to the needs of HMO's business. Manager shall perform the services for which it is responsible under this Agreement using the same degree of skill and care in such performance as a prudent person engaged in pharmacy benefit management services would use under substantially similar circumstances. Manager accepts the service performance standards set forth in **Exhibit** C hereto, including the fees which shall be at risk if the performance standards and guarantees are not met. Manager shall provide to HMO monthly or quarterly reports, as applicable with respect to Manager's performance, and annual statistics, within ninety (90) days of the end of the calendar year, demonstrating whether Manager met the service performance standards described in **Exhibit** C. At such time that Manager provides such reports to HMO, Manager shall reimburse HMO any monies owed because of Manager's failure to meet such service performance standards and guarantees.

3.15. Insurance. Manager shall procure by the Effective Date and shall maintain, at its own expense: (a) professional liability insurance in the amount of $5,000,000.00 per occurrence and $10,000,000.00 annual aggregate including coverage for errors and omissions; (b) general liability insurance in the amount of $1,000,000.00 per each occurrence and $3,000,000.00 annual aggregate; and (c) umbrella/excess liability insurance in the amount of $10,000,000.00 each occurrence and aggregate. HMO must be named as an "additional insured" on the policies referenced above for claims affecting HMO's interests.

3.15.1. Nature of Insurance. Manager's and its contractors' or subcontractors' insurance policies shall: (i) be issued by companies that are admitted insurers in the jurisdiction in which all or a majority of the services or products are being provided, that have an A.M. Best rating of not less than "A-", and are in a size category which is not lower than "VIII"; (ii) be primary and noncontributory with any of HMO's insurance or self-insurance; (iii) name HMO as an additional insured; and (iv) not be cancelable, non-renewable or materially changed except after not less than thirty (30) days written notice to HMO. Manager shall provide to HMO certificates of insurance evidencing the insurance coverage required by this Section.

3.15.2 Liability. None of the foregoing requirements as to the type and limits of insurance to be maintained by Manager are intended to and shall not in any manner limit or qualify the liabilities and obligations assumed by Manager under this Agreement.

3.16. Claims and Regulatory Inquiries. Manager shall, within ten (10) days, provide information to HMO regarding all non-routine inquiries by regulatory departments, pharmaceutical manufacturers, attorneys, Covered Persons, or other individuals or entities

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with respect to Manager's services pursuant to this Agreement, including, but not limited to, the denial of any claims or any causes of action.

3.17. Books and Records. Manager shall maintain adequate medical, financial, and administrative records related to PBM Services in a manner consistent with the standards of the community and in accordance with all applicable statutes and regulations, including, but not limited to, reasonable documentation of all the data of Covered Persons related to Manager's services under this Agreement to determine whether Manager is performing its obligations under the Agreement and correctly billing HMO. HMO shall have the right to review such data at reasonable times and upon reasonable notice. If any audit reveals an underpayment or overpayment by HMO to Manager, such discrepancy will be reported to Manager, and Manager will respond within forty-five (45) days. Any amounts deemed payable as a result thereof shall be promptly repaid to the appropriate party with accrued interest (whether or not this Agreement has terminated). If the parties disagree on the amount to be repaid, the matter shall be resolved in accordance with Section 11.5. This obligation shall survive the expiration or earlier termination of this Agreement.

3.18. Accreditation. Manager agrees to provide HMO with reasonable assistance and cooperation in meeting all accreditation standards, including but not limited to National Committee for Quality Assurance standards, applicable to the services provided pursuant to this Agreement.

3.19. Utilization Review. In accordance with the terms and conditions of the delegation standards attached hereto as **Exhibit C**, Manager shall, for and on behalf of HMO, establish and administer a utilization review program in connection with PBM Services provided or proposed to be provided to Members, utilizing the standards, criteria, protocols and procedures established by HMO and in accordance with the applicable requirements of state and federal law and NCQA standards. Manager agrees to abide by, and shall have each of its employees or contracted providers performing utilization review services under this Agreement sign a written statement agreeing to abide by, the following NCQA standards: (1) any and all utilization review decisions made under this Agreement shall be based only on the appropriateness of the proposed prescription drug services and the existence of coverage for such services; (2) neither contracted providers nor Manager's staff or other individuals conducting utilization review are rewarded for issuing denials of coverage; and (3) financial incentives provided to persons conducting utilization review are not used to encourage decision-making that results in under-utilization of Covered Prescription Drug Services.

3.20 Submission of Electronic Files. On a quarterly basis, Manager shall submit directly to HMO's database contractor electronic files of data maintained pursuant to this Agreement on a quarterly basis. The submission shall consist of electronic standard NCPDP claims payment files files.

IV. OBLIGATIONS OF HMO

4.1. General.

4.1.1. HMO will be the entity that contracts with Health Plans related to the services provided under this Agreement. Such agreements between HMO and Health Plans may provide for additional services by HMO and shall make

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provision for fees and other terms that HMO, in its discretion, determines to establish.

4.1.2. HMO agrees to provide information reasonably needed by Manager to administer its responsibilities under this Agreement including (a) Benefit Contracts documents; (b) timely eligibility and enrollment data on Covered Persons; (c) specific HMO customer information and needs; (d) Participating Pharmacy information when Manager's pharmacy network is not utilized or is used in addition to another participating pharmacy network; (e) patient identifiable prescription drug claims (including prescription drug claims from prior pharmacy benefit management vendors); and (f) patient identifiable medical claims reasonably necessary for Manager to implement and operate its clinical management programs for HMO. Information shall be provided in a mutually agreeable format.

4.1.3. HMO or Health Plans shall be solely responsible for drafting HMO's Benefit Contracts.

4.2. Payment to Manager. HMO shall compensate Manager for the PBM Services and the Covered Prescription Drug Services provided by Manager as described in Exhibit A to this Agreement. All payments to Manager shall be deemed final unless adjustment is requested within ninety (90) days of Manager's receipt of payment. HMO's request to recoup overpayments made to Manager, including overpayments made because of erroneous eligibility information, shall not be subject to such 90-day deadline. Except for fee-for-service (Billback) claims described in Section 2 of Exhibit A, HMO shall have no further obligation for payment related to the Covered Prescription Drug Services under its Benefit Contracts. Manager shall be at financial risk for the cost of covered prescription drug services as specified in a separate letter agreement executed by both parties hereto and which shall constitute a legally binding part of this agreement.

HMO shall remit payments to Manager on a monthly basis, by the 10th business day of each month. Payments shall be remitted via wire transfer to the account(s) designated by Manager or by other means as mutually agreed upon, provided such invoices contain all information necessary for HMO to determine its liability in the case of fee-for-service (Billback) claims and to determine the number of Covered Persons under this Agreement in the case of capitated fees. For each month for which payment is due, HMO shall be liable for payment of capitated fees to Manager for only those Covered Persons for whom HMO receives capitation from the State. Manager shall invoice such fees by the third business day of each calendar month and shall provide written detail for adjustments of fees assessed in prior months due to all eligibility status changes.

4.3. Regulatory. HMO shall (a) maintain all material federal, state, and local licenses that are reasonably required to operate its business; (b) comply with all material applicable statutes and regulations; and, (c) make reasonable commercial efforts to cause Health Plans to comply with (a) and (b).

4.4. Insurance. HMO agrees to maintain adequate insurance related to the operation of its business and its obligations under the Agreement.

4.5. Claims and Regulatory. HMO shall promptly provide information to Manager within ten (10) days about all non-routine inquiries by regulatory authorities,

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pharmaceutical manufacturers, or Covered Persons, with respect to the services provided by Manager under this Agreement.

4.6. Audits. HMO shall keep reasonable documentation of all Covered Persons related to this Agreement. Manager shall have the right to review such data at reasonable times upon reasonable notice.

V. PREFERRED DRUG LIST

5.1. Preferred Drug List. Beginning on the Commencement Date or on such later date designated by HMO and continuing through the term of this Agreement, Manager shall administer the HMO PDL or other formularies as developed by HMO from time to time pursuant to the Benefit Contracts.

5.1.1. HMO Preferred Drug List. The Preferred Drug List ("PDL") is a list that identifies those FDA approved prescription drug products that are preferred by HMO for dispensing to Covered Persons. HMO's PDL will at minimum contain the the medications listed on the ADHS/DBHS Medication listing that is in the ADHS/DBHS Provider manual and may contain additional covered medications.

5.1.1.1. HMO and its P&T Committee have complete control in deciding what prescription drugs are placed on the PDL from time to time.

5.1.1.2. Manager shall have the right to present clinical data and rationale to the P&T Committee in conjunction with its evaluation of prescription drugs, but shall not be a voting member of the P&T Committee.

5.1.2. Preferred Drug List Compliance. HMO has in effect certain Program features designed to promote prescribing of PDL drugs by participating providers, dispensing of PDL drugs by Participating Pharmacies, and awareness of the advantages of the PDL by Covered Persons. Such features include, but are not limited to, incented benefit plan designs and corresponding levels of Copayments. HMO shall notify Manager, in advance, of any proposed Program modifications that are reasonably anticipated to have a material effect on PDL compliance. Additionally, HMO shall, as its option, participate in Manager's formulary communications programs, which may include communications with HMO Covered Persons, Participating Pharmacies and/or physicians, and financial incentives to Participating Pharmacies for their participation in the PDL. Manager shall notify HMO, in advance, of all PDL communications programs. HMO shall approve and may make reasonable changes to the content of such PDL communication programs before they are provided to the above HMO groups and individuals.

5.2. PDL Rebate Program. Pursuant to agreements entered into between Manager and certain pharmaceutical manufacturers ("Manufacturer Agreements"), Manager receives PDL Rebates from certain drug manufacturers as a result of the inclusion of such manufacturer's branded products on the PDL ("PDL Rebates"). Manager also receives and retains additional rebates and/or fees from certain manufacturers which may take into account various factors, including the utilization of certain drugs within

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their respective therapeutic categories for Manager's business in aggregate as a result of various commitments, services, and programs including, but not limited to, formularies (e.g. cost effective, incentive, volume, and market-share rebates). Manager shall fully disclose to HMO all rebates that Manager receives on HMO's behalf.

5.2.1. Rebate Distribution. Manager shall in good faith calculate the portion of any such rebates received that are allocable to PBM Services provided pursuant to this Agreement. Any disagreements related to such allocation determination shall be resolved in accordance with **Section 11.5**.

5.2.2. Drug Formulary Only Administration. Manager shall, at HMO's request, provide drug formulary only rebate administration for no additional fee for pharmacy claims processed by other entities, if such business qualifies for PDL Rebates. Such entities shall comply with Manager's data format requirements and processes.

VI. CONFIDENTIALITY

6.1. Confidential and Proprietary Information. In fulfilling the objectives of this Agreement, HMO and Manager may provide to each other or learn (directly or indirectly) certain information which a party considers to be confidential or proprietary ("Confidential Information"). Confidential Information shall include, without limitation, information relating to Covered Person and provider identities; reimbursement procedures; claims adjudication procedures; software and financial systems; the specific financial sections and provisions, specific operational aspects, financial guarantees contained in this Agreement, and other information relating to each party's business which is not generally available to the public. Each party's Confidential Information shall also include confidential, proprietary information which a third party has disclosed to a party, and which such party is obligated to maintain as confidential. Notwithstanding the foregoing, Manager and HMO acknowledge the other party's obligation to provide its pharmaceutical manufacturers and customers with information generally regarding this Agreement and, consistent with the foregoing, agrees that such parties may disclose generally the terms of this Agreement.

6.1.1. Neither party shall have any obligation to disclose its Confidential Information to the other party, unless such an obligation is set forth elsewhere in this Agreement.

6.1.2. Each party agrees to maintain the secrecy of and not to use or disclose the other party's Confidential Information, except as required in order for a party to perform under this Agreement. A party may disclose the other party's Confidential Information only to the receiving party's directors, officer, employees, agents and representatives (collectively, the "Representatives"), but only if a Representative needs to know the Confidential Information in order for the receiving party to perform under this Agreement. The parties agree to inform their Representatives of the confidential nature of the disclosing party's Confidential Information, and each party shall require any Representative, who is not an employee of the receiving party to sign an appropriate confidentiality agreement to protect the disclosing party's Confidential Information from unauthorized use or disclosure. Each party shall direct its Representatives to

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treat the other party's Confidential Information confidentially and not to use it other than to perform under this Agreement. Each party shall be responsible for its Representatives' use and disclosure of the other party's Confidential Information.

6.1.3. The restrictions in this **Section 6.1** shall not apply to: (a) information which is or becomes generally available to the public, other than as a result of a disclosure by the receiving party; (b) information a party obtains from a third party which has no obligation to keep the information confidential; (c) information which a party had in its possession prior to receiving Confidential Information from the disclosing party; (d) information which is independently developed by a party without reference to the Confidential Information disclosed by the other party; or (e) information required to be disclosed by law, subject to compliance with **Section 6.1.4**.

6.1.4. The parties agree that if a party is required (by subpoena, civil investigative demand or similar process) to disclose the other party's Confidential Information, the disclosing party shall notify the other party of the request or requirement so that the other party may seek an appropriate protective order or waive compliance with the sections or provisions of this Agreement. The parties agree to exercise their commercially reasonable efforts to assist each other in obtaining a protective order or other reliable assurance that confidential treatment will be accorded the Confidential Information.

6.1.5. Manager recognizes and agrees that HMO has a valuable business relationship with each of its Covered Persons and, further, that Manager stands in a position to influence Covered Persons decisions concerning insurers. In recognition of HMO's valuable business relationships with its Covered Persons, Manager agrees that, during the term of this Agreement, and after termination of this Agreement for any reason whatsoever, Manager shall not solicit Covered Persons, directly or indirectly, to enroll in any other health insurance or health coverage or alternative health care delivery system. Manager's obligation not to solicit Covered Persons is a material inducement for Manager's engagement by HMO pursuant to this Agreement.

6.1.6. The parties acknowledge and agree that irreparable injury will result to the other party in the event of a party's breach of these covenants, that a material inducement for the parties engagement by the other party are the covenants set forth in this **Section 6.1**, and that monetary damages in an action at law would not provide an adequate remedy in the event of a breach of this **Section 6.1**. The parties further acknowledge and agree that the covenants set forth in this **Section 6.1** are necessary for the protection of each party's legitimate business and professional duties, ethical obligations, and interests, and are reasonable in scope and content. Accordingly, in the event of either party's breach of this **Section 6.1**, or any part of this **Section 6.1**, this **Section 6.1** may be enforced by the obtaining of an injunction to restrain the violation thereof by the breaching party and all persons acting for or with such party.

6.1.7. Upon termination of this Agreement each party will immediately discontinue use of the other party's Confidential Information, and shall return the other party's Confidential Information to it, or destroy the other party's

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Confidential Information in its possession or control. However, each party may retain the other party's Confidential Information to the extent such Confidential Information has been used in or integrated into reports, studies, analyses, compilations or other documents in the receiving party's possession or control. Any oral Information will continue to be subject to the terms of this letter agreement. The parties agree that the Confidentiality obligations of this **Article VI** shall survive termination of this Agreement.

6.2. Privacy of Individually Identifiable Health Information. HMO and Manager will maintain the privacy and confidentiality of all individually identifiable protected health Information (PHI) regarding Covered Persons in accordance with all applicable statutes and regulations. In addition, Manager will:

6.2.1. Not use or further disclose the Protected Information other than as permitted or required by this Agreement or as required by law;

6.2.2. Use appropriate safeguards to prevent use or disclosure of the Protected Information other than as provided by this Agreement;

6.2.3. Report to HMO any use or disclosure of the Protected Information not provided for by this Agreement of which it becomes aware;

6.2.4. Ensure that any agents, including a subcontractor, to whom Manager provides Protected Information received from, or created or received by Manager on behalf of, HMO agrees to the same restrictions and conditions that apply to Manager with respect to such Protected Information;

6.2.5. Make available to Covered Persons Protected Information in accordance with those provisions of the Health Insurance Portability and Accountability Act ("HIPAA") relating to a Covered Person's right to access his or her health information;

6.2.6. Make available to Covered Persons Protected Information for amendment and incorporate any amendments to Protected Information in accordance with the HIPAA provisions providing therefor;

6.2.7. Make available to Covered Persons the information required to provide an accounting of disclosures in accordance with the HIPAA provisions providing therefor;

6.2.8. Make its internal practices, books, and records relating to the use and disclosure of Protected Information received from, or created or received by Manager on behalf of, HMO available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining HMO's compliance with this subsection; and

6.2.9. At termination of this Agreement, if feasible, return or destroy all Protected Information received from, or created or received by Manager on behalf of, HMO that Manager still maintains in any form and retain no copies of such Protected Information or, if such return or destruction is not feasible, extend the protections of this Agreement to the Protected Information and limit further

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uses and disclosures to those purposes that make the return or destruction of the Protected Information feasible.

Manager and HMO shall require all employees to comply with this subsection. Manager agrees that all Covered Person information provided to Manager by HMO belongs exclusively to HMO.

6.3. HMO's Database. Subject to **Section 6.4** below, Manager agrees that all data of HMO and its affiliates, including but not limited to Covered Person, customer, and provider related data, which is in Manager's possession, whether obtained by Manager in the course of providing services for HMO or as a result of a data transfer between HMO and Manager, belongs solely to HMO. Manager has the right to possess and use such data only to the extent permitted by contracts between the parties or as otherwise provided in this Agreement, subject to applicable legal restrictions. All information contained in HMO's database and systems belongs exclusively to HMO. Manager shall not have direct access to HMO's database and systems without signing a separate agreement with HMO. Manager and HMO recognize and agree that only information necessary for Manager performance under the Agreement shall be supplied by HMO to Manager, and Manager agrees that such data belongs exclusively to HMO.

6.4. Manager Use of Data. Notwithstanding the foregoing provisions of this **Article VI**, Manager may incorporate prescription data into Manager's prescription database when that database is used by Manager or provided to others for research, statistical, marketing, sales tracking or similar purposes. Manager agrees that if such prescription data is identifiable as to (a) Covered Persons, (b) employers and/or customers, and/or (d) HMO, such identifiable information will be deleted or encrypted before it is provided to others. This section only applies to Manager's use of prescription data and does not apply to medical data.

6.5. Pharmaceutical Agreements. Manager's agreements with pharmaceutical manufacturers are subject to confidentiality agreements. Any audit of Manager's agreements with pharmaceutical manufacturers conducted pursuant to this Agreement, shall be conducted by a third party public accounting firm reasonably acceptable to Manager whose audit department is a separate stand alone function of its business, subject to execution of a confidentiality agreement, and shall include only those portions of such pharmaceutical manufacturer agreements as necessary to determine Manager's compliance with **Article VI** in respect to PDL Rebates.

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VII. INTELLECTUAL PROPERTY

7.1. Manager's Property. Any Intellectual Property developed solely by Manager without using HMO's Confidential Information shall remain the property of Manager. HMO's right to use such Manager Intellectual Property shall be limited to those permitted by this Agreement or as otherwise agreed to in writing by the parties.

7.2. HMO's Property. Any Intellectual Property developed solely by HMO, without utilizing Manager's Confidential Information shall remain the property of HMO. Manager's right to use such Intellectual Property shall be limited to those permitted by this Agreement or as otherwise agreed to in writing by the parties.

7.3. Joint Property. The parties agree that any Intellectual Property or work product: (a) created jointly by the parties; or (b) created by Manager under this Agreement; or (c) created by Manager upon HMO's request (the "Work Product"), shall be the joint property of Manager and HMO.

7.4. Name, Symbol, and Service Mark. Manager and HMO agree that each party may use the other party's name in its discussions with prospective clients and in marketing and promotional materials, directories, and other communications. Each party shall provide to the other party a copy of any written materials containing the other party's name and shall obtain the prior written consent to such use from the other party. No use of the registered service marks of Manager or HMO by the other is permitted without prior written consent.

VIII. INDEMNIFICATION

8.1. By HMO. HMO agrees to indemnify and hold Manager, its subsidiaries and affiliates, and their respective officers, directors, agents, and employees harmless from and against any and all liabilities, losses, proceedings, actions, damages, claims, or expenses of any kind, including reasonable attorneys' fees, which result from (a) a breach by HMO of any of its obligations under this Agreement or (b) the negligent or willful acts or omissions by HMO, its agents, directors, officers, or employees, in connection with the representations, duties, and obligations of HMO under this Agreement.

8.2. By Manager. Manager agrees to indemnify and hold HMO, its subsidiaries and affiliates, and their respective officers, directors, agents, and employees harmless from and against any and all liabilities, losses, proceedings, actions, damages, claims, or expenses of any kind, including reasonable attorneys' fees, which result from (a) a breach by Manager of any of its obligations under this Agreement or (b) the negligent or willful acts or omissions by Manager, its agents, directors, officers, or employees, in connection with the representations, duties, and obligations of Manager under this Agreement.

IX. TERM AND TERMINATION

9.1. Term. The term of this Agreement is for the period of one year, commencing on the Commencement Date, unless terminated earlier as outlined in this **Article IX**. This Agreement shall automatically renew for successive one-year periods, unless terminated pursuant to this **Article IX**.

9.2. Termination. This Agreement may be terminated as follows:

9.2.1. By either party at the end of any term, without cause, by providing at least ninety (90) days prior written notice of termination to the other party.

9.2.2. At any time by the mutual written consent of the parties.

9.2.3. By either party at any time, for cause, by providing sixty (60) days prior written notice to the other party upon the breach by such party of any material term, covenant, or condition of this Agreement, unless such breach is cured to the reasonable satisfaction of the terminating party within such sixty (60) day notice period.

9.2.4. Immediately by HMO, by providing notice to Manager, upon the expiration, non-renewal, or revocation of any license, certificate, approval, or authorization of Manager to perform any or all of the PBM Services.

9.2.5. By either party, effective immediately upon provision of written notice to the other party, if the other party has become insolvent or has been dissolved or liquidated, makes a general assignment for the benefit of creditors, or has a receiver appointed for a substantial portion of its assets.

9.2.6. Automatically and without any notice or other action on the part of either party if either party files, or has filed against it, a petition in bankruptcy and such petition is not dismissed within 60 days of the filing, unless the party which is not subject to such petition elects to waive such termination prior to the expiration of such 60 day period.

9.2.7. By either party immediately due to loss of insurance or inability to self-insure as required under this Agreement.

9.3. Information to Covered Persons. Manager acknowledges the right of HMO to inform Covered Persons of Manager's termination.

9.4. End of Term or Termination. In the event this Agreement is terminated for any reason prior to its expiration or upon the end of the term, Manager and HMO shall cooperate reasonably with each other for up to a six (6) month period following such termination or expiration to effect a quality, cost-effective and smooth transition of HMO's business previously operated or managed by Manager to HMO or HMO's designee.

9.5. Effect of Termination. Any termination of this Agreement shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Termination of this Agreement shall not release Manager or its Participating Pharmacies from their obligations to continue to provide PBM Services and Covered Prescription Drug Services for which compensation has been received prior to the effective date of termination.

9.6. Continuity of Care. Upon termination of this Agreement for any reason other than a quality of care issue, Manager and HMO shall comply with any applicable

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requirements for continuity of care as set forth in Wisconsin Insurance statutes Section 609.24.

X. ADHS CONTRACT REQUIREMENTS

10.1. Compliance with ADHS Contract. Manager shall abide by all applicable provisions of the ADHS Contract. Manager's compliance with the ADHS Contract specifically includes but is not limited to:

10.2. State Approval. This Agreement is subject to the prior review and approval by ADHS. HMO shall submit and obtain this approval prior to the Commencement Date.

10.3. Arizona Licensed Pharmacy Administrator. Manager shall use only an Arizona licensed pharmacist to oversee the Contractors medication services per the ADHS Contract.

10.4. Legal Liability. Nothing in this Agreement shall affect the legal liability of HMO in accordance with the ADHS Contract.

10.5. Quality Data. Manager shall participate in and contribute required data to HMO Quality Assessment/Performance Improvement programs, as defined in and required by ADHS Contract.

10.6. Pharmacy Encounter Data. Manager shall submit to HMO pharmacy encounter data in the format specified by HMO so that HMO can meet the State of Arizona ADHS contract specifications.

10.7. Non-discrimination. Manager shall comply with all non-discrimination requirements in ADHS Contract.

10.8. Access to and Confidentiality of Pharmacy Records. Manager shall provide to representatives of HMO, as well as duly authorized agents or representatives of ADHS and the federal Department of Health and Human Services, access to its premises and its contract and/or pharmacy records.

10.9. Referrals. Manager shall clearly specify referral approval requirements to its Participating Pharmacies and in any provider contracts.

10.10. Payment for Services. Manager shall not bill a RBHA Covered Person for Medically Necessary pharmacy services covered under the ADHS Contract and provided during the Covered Person's period of enrollment.

10.11. Grievances. Manager shall forward to HMO applicable medical records pertaining to grievances, within fifteen (15) working days of HMO's request. If Manager does not meet the 15-day requirement, Manager must explain the delay and indicate when the medical records will be provided.

10.12. Non-payment of Providers. Manager shall abide by the terms of the ADHS Contract regarding appeals to HMO and to ADHS for non-payment of providers.

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XI. GENERAL PROVISIONS

11.1. Notices. All notices or other communications required or permitted hereunder shall be in writing and shall be delivered personally, by commercial overnight delivery service, by facsimile or sent by certified, registered or express air mail, postage prepaid, and shall be deemed given when so delivered personally, by overnight delivery service or by facsimile, or if mailed, five days after the date of mailing, addressed as follows:

If to Manager:	If to HMO:
Caremark Rx Contract Services 2211 Sanders Road Northbrook, IL 60062 Attention: President	Cenpatico Behavioral Health 823 Congress Ave., Suite 600 Austin, TX 78701 Attention: President & CEO

or to such other address or to such other person as may be designated by written notice given from time to time during the term of the Agreement by one party to the other.

11.2. Force Majeure. Noncompliance with the obligations of this Agreement due to force majeure, laws or regulations of any government, war, civil commotion, destruction of production facilities and materials, fire, earthquake or storm, labor disturbances, shortage of materials, failure of public utilities or common carriers, and any other causes beyond the reasonable control of the applicable party, shall not constitute breach of contract.

11.3. Assignment. HMO may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with HMO; provided, however, that any such entity is reasonably able to perform any responsibilities which it assumes. HMO may assign its rights and responsibilities in such a way that both HMO and Assignee share in the rights and responsibilities that, prior to such assignment, were solely those of HMO. Manager may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with such party; provided, however, that any such entity is reasonably able to perform any responsibilities which it assumes. Manager and HMO each acknowledge that persons and entities under contract with such party, or in the case of HMO, Health Plans, may perform certain administrative services under this Agreement. Other than above, HMO and Manager agree that they shall not assign any of the rights and responsibilities under this Agreement without the prior written consent of the other party.

11.4. Amendment. Any amendments to this Agreement shall require written approval of the parties.

11.5. Dispute Resolution. In the event of a dispute arising out of this Agreement, the parties shall first attempt in good faith to resolve the dispute through informal discussions between themselves. Any claim, controversy, dispute or disagreement between the parties hereto which the parties are unable to resolve informally shall be resolved by binding arbitration by a single arbitrator in accordance with the Commercial Arbitration Rules of the American Arbitration Association (the "AAA") and administration of the

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arbitration shall be performed by AAA or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures of the AAA will be utilized. Arbitration hearings shall be held in Austin, TX or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by applicable law. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a district court of Missouri including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by applicable law, except that punitive damages shall not be awarded. The parties shall divide equally the expenses of the AAA and the arbitrator, but the arbitrator may assess all such costs and expenses to the non-prevailing party in the arbitrator's award. The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to applicable law.

11.6. Relationship Between HMO and Manager. The relationship between HMO and Manager is solely that of independent contractors, and nothing in this Agreement or otherwise will be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

11.7. Severability. If any provision of this Agreement shall be determined by any court of competent jurisdiction or arbitrator to be invalid and unenforceable to any extent under the law of any relevant jurisdiction, the remainder of this Agreement shall not be affected thereby, and each remaining provision shall be valid and shall be enforced to the fullest extent permitted by law.

11.8. Headings. The headings of the various sections herein are for convenience of reference only and shall not define, limit, or otherwise affect any of the terms or sections or provisions hereof.

11.9. Counterparts. This Agreement may be executed in one (1) or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

11.10. Governing Law. This Agreement shall be governed by and construed in accordance with applicable Illinois law without giving effect to conflict of law principles.

11.11. Entire Agreement. This Agreement and its Appendix, Exhibits, and Attachments constitute the entire Agreement between the parties with regard to the subject matter hereof and supercede any and all prior agreements, oral or written, between the parties with regard to the subject matter of this Agreement.

11.12. Regulatory Approval. The parties agree and acknowledge that the terms of this Agreement may be subject to review by state regulators.

11.13. Approvals. Approvals required under this agreement shall not be unreasonably delayed or withheld.

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11.14. No Third Party Beneficiaries. Nothing in this Agreement shall create or be deemed to create any third party beneficiary rights in any person or entity not a party to this Agreement.

11.15. Additional Agreements. Upon request, Manager agrees to enter into an additional separate agreement with any HMO affiliate receiving services hereunder reflecting the services received and obligations of such affiliate.

[SIGNATURE PAGE FOLLOWS]

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first set forth above.

CENPATICO BEHAVIORAL HEALTH 823 CONGRESS AVE., SUITE 600 AUSTIN, TX 78701	**CAREMARK RX** 2211 Sanders Rd. Northbrook, IL 60062
By:_____ Name: _____ Title: _____	By:_____ Name: _____ Title: _____

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EXHIBIT A
Financial Arrangements

"Average Wholesale Price" or **"AWP"** means the average wholesale price of the Covered Prescription Drug Services dispensed, utilizing the current price list in a nationally recognized pricing source, which Manager uses for all of its other customers, or, if Manager uses more than one source, then the source used for HMO shall be the source mutually agreed to by the parties. Under the Retail Pharmacy Program, AWP is based on the package size submitted.

"Maximum Allowable Cost" or **"MAC"** means the maximum acceptable cost of a generic product as determined from time to time by Manager. Manager shall provide its MAC list and prices to HMO upon request. Manager represents that its MAC pricing is generally no higher than HCFA MAC pricing and covenants that it shall give HMO written notice when any MAC price shall exceed the HCFA MAC price, which notice shall include the reasons for the discrepancy, if known, and the projected length of time that the MAC price will likely exceed the HCFA MAC price (if reasonable to estimate).

2. Charges for Covered Prescription Drug Services.

The following formulas shall be used to determine (a) the prices Manager shall pay for Covered Prescription Drug Services that are included as Covered Prescription Drug Services:

Lesser of Manager's actual payment or AWP minus 14% plus $2.00 dispensing fee for brands.

For generics, MAC plus $2.00 or AWP-20% plus $2.00 (whichever is actually paid to the dispensing pharmacy).

Plus, in each case (brands and generics), $0.35 administrative fee per paid claim.

4. Changes to the PDL.

Except as required by the ADHS or as mandated by applicable law, no changes to the PDL or Benefit Design (Exhibit D) will be implemented unless and until the change is agreed to by Manager and HMO.

5. Additional Administrative Fees.

HMO shall pay Manager for additional PBM Services HMO utilizes as follows:

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Exhibit B
PBM Services

The services listed below will be performed by Manager for behavioral health and ADHS Contract business. HMO can request the discontinuation of any service listed below and/or may perform any services listed below internally at HMO. Manager acknowledges that, from time to time, it will modify the services on this Agreement or add new services to be more effective. Such modified or new services will be provided to HMO.

1. **Claims Processing**
   - Electronic processing in-network
   - Paper claims processing in-network and out-of-network
   - Coordination of benefits administration
   - Twelve month on-line claims history retention
   - Monitor Participating Pharmacy compliance
   - On-line viewing access to claims history

2. **Eligibility Management**
   - Administration of eligibility submitted by multiple sources per tape or electronically with variable HMO formats with reasonable notice of changes to such formats
   - Load eligibility tapes within one (1) business day and inform HMO upon completion
   - Toll-free access to Manager's help desk for eligibility/claims processing assistance
   - Administration of paper adds/deletes/changes
   - 24 hour eligibility/claims processing support

3. **Benefits Management/Utilization Management**
   - Administration of benefits submitted electronically or by tape or by paper
   - Administration of paper adds/deletes/changes

4. **Pharmacy Network Management**
   - Establish, license-verification, contract, and maintain Participating Pharmacy networks for HMO
   - Develop and distribute communications to Participating Pharmacies following review by HMO

5. **Call Center Services**
   - 24 hour, seven day a week live customer service
   - Toll-free telephone access to Customer Service for the Program for use by Covered Persons, benefits personnel, pharmacists and physicians

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EXHIBIT C
Performance Standards and Requirements for PBM Services

1. Network Pharmacy License Verification

Activities include, but are not limited to, the following:

(a) Verification of active pharmacy licenses for all Participating Pharmacies;
(b) Verification of current Wisconsin Medicaid certification; and
(c) Provision of policies and procedures for reducing, suspending, or terminating pharmacy privileges.

INDICATOR	DUE DATE
Verify active pharmacy licenses and Wisconsin Medicaid certification for all Participating Pharmacies.	Once every three years.
Provide policies and procedures for reducing, suspending, or terminating pharmacy privileges.	Initial and forward any revisions made within 30 days of revision, or send a letter postmarked by January 31st of each year verifying no revisions have been made in the previous year.
Pharmacies terminated or disciplined	For termination of pharmacies: As per Section 3.3 of this agreement. For termination of pharmacists: 30 business days after the close of each quarter.
Complete pharmacy network.	15th of each month (per ADHS requirements).

2. Quality Improvement

Quality Improvement ("QI") activities may include, but are not limited to, the following:

(a) Planned monitoring of previously identified issues, including tracking and trending of issues over time;
(b) Customer service indicators such as call monitoring (for both Covered Person and provider calls) shall be reported and include, but are not limited to: number of calls, calls answered, calls abandoned, abandonment rate, and average time on hold;
(c) A process by which findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QI activity are documented and reported to the appropriate individuals of Manager and HMO;
(d) Coordination of QI activities are coordinated with other performance monitoring activities;

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(e) Identify important areas for improvement and set meaningful priorities through annual physician and pharmacy surveys;
(f) A process for monitoring pharmacy access and availability; and
(g) A process that uses measurements, QI data collection, and analysis to track quality improvement, takes action to improve quality and assesses the effectiveness of these actions through systematic follow-up.

INDICATOR	DUE DATE
Submission of policies and procedures.	Initial and forward any revisions made within 30 days of revision, or send letter postmarked by February 28th of each year verifying no revisions have been made in the previous year.
Submission of Manager QI work plan and Manager QI program description.	Annually by February 28th.
Submission of the QI program evaluation of the prior year.	Annually by February 28th.
Copies of all QI meeting minutes included in the quarterly report.	60 days after close of the quarter.

3. Utilization Management/Appeals

Utilization management activities include the following:

(a) Prior authorization;
(b) Concurrent review; and
(c) Retrospective review.

INDICATOR	DUE DATE
Submission of annual utilization written plan.	Annually by February 28th.
Submission of annual utilization management program evaluation.	Annually by February 28th.
Monthly reports.	15th day following the end of the previous month.
Quarterly Executive Summary Reports.	60th day following the end of the previous quarter.

4. Complaints/Appeals/Grievances

Complaint, appeal, and grievance activities include the following:

(a) Registering and responding to complaints, appeals, and grievances;
(b) Documentation of substance of complaints, appeals, grievances, and actions taken; and
(c) Aggregation and analysis of complaint and grievance data.

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INDICATOR	DUE DATE
Electronic submission of policies and procedures.	Initial and forward any revisions made within 30 days of the revision, or send a postmarked letter by February 28th of each year verifying no revisions have been made in the previous year.
Submission of complaint and grievance activity by the 15th day following the end of the month.	15th day following the end of the previous month.

5. Claims Administration

Claims administration activities include the following:

(a) Development and submission to HMO of Manager's documented claims processing program that, at a minimum, satisfies the standards and procedures required by Manager's claims processing policies and procedures and the requirements under the Medicaid/BadgerCare HMO Contract. The documentation shall be provided by Manager to HMO for review and approval, on or before the Commencement Date, at any time thereafter upon HMO's request, and whenever a material modification to such documented claims processing program is made by Manager. All claims processing related delegated duties shall be performed by Manager in strict compliance with Manager's written clean claims processing program, and subsequently paid as approved by HMO.

(b) Manager represents and warrants that Manager's claims processing program will be administered in accordance with Manager's claims processing program standards and procedures established in accordance with state and federal laws and shall include, but is not limited to, the following:

(1) Verification of eligibility;
(2) Verification of authorization (if applicable);
(3) Verification of payee;
(4) Application of benefits in accordance with Benefit Contracts;
(5) Payment in accordance with provider contract terms;
(6) Appropriate level of medical review;
(7) Timely payment for "clean" claims in accordance with pharmacy contract terms, or within 30 days for non-contracted providers.

INDICATOR	DUE DATE
Electronic submission of all HMO pharmacy claims.	15th day following the end of the previous month.

7. Subcontracting

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All Manager's subcontracting arrangements for delegation of any portion of the PBM Services to another entity requires prior written approval of HMO. If Manager, with HMO's prior written approval, partners with another entity to perform any portion of the PBM Services, Manager shall provide documentation and demonstrate oversight of such entity by Manager to include:

(a) An executed agreement, including what is to be delegated and made available to HMO;
(b) The responsibilities of Manager and subcontractor;
(c) The process by which Manager evaluates the subcontract;
(d) The remedies, including revocation of the delegation available to Manager if the subcontractor does not fulfill its obligation;
(e) Evaluation of the subcontractor's capacity to perform the delegated activities prior to the execution of the contract;
(f) Annual evaluation of performance in accordance with HMO's accreditation and regulatory and statutory standards;
(g) The role of Manager and any subcontractor under this Agreement limited to performing certain delegated functions of HMO, using standards approved by HMO and which are in compliance with applicable statutes and rules.

HMO retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by HMO. Further, HMO retains the right to modify, rescind, or terminate at any time any one or all delegated activities under this amendment, regardless of any sub-delegation that may be approved.

8. Reporting Requirements

All reports specified by ADHS will be provided per specifications. The following table of standard reports may or may not be required by ADHS:

All Hedis and detailed reports will be submitted in test format initially for verification of set up and data pull by the HMO.

REPORTS	DUE DATE
Hedis (Beta-Blockers)	Quarterly
Hedis (Asthma)	Quarterly
Hedis (Diabetic Care-Oral Hypoglycemics/Insulin)	Quarterly
Hedis (Out-patient Drug Utilization)	Quarterly
Hedis (Anti-depressants)	Quarterly
Detailed Prenatal Vitamin Report	Bi-Weekly
Detailed ADHD Medication Reports	Monthly
Detailed Antibiotic Utilization	Monthly
Detailed HIV Medication Utilization	Monthly
Smoking Cessation	Monthly
Pharmacy Network List	Monthly
Executive Profile (electronic, as currently submitted)*	Monthly
Executive Summary (electronic, as currently submitted)*	Monthly
BioScrip Reporting (per BioScrip contract)	Quarterly
P & T Document Support	Quarterly

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2020R Group utilization summary	Monthly
3010R Therapeutic class profile summary	Monthly
3070R Drug cost ranking summary	Monthly
3140R Drug Therapeutic class usage ranking summary	Monthly
5050R Prescriber utilization summary ranked by volume	Monthly
Hedis (Eligibility report)	Quarterly
Hedis (Utilization report)	Quarterly
Hedis (HIV report)	Quarterly
Monthly Claims Data – agreed upon format	Monthly
Monthly PA Denials and approvals	Monthly
TPL Reporting	Quarterly

8. Corrective Action Plan

(a) If HMO receives information through its monitoring plan and/or audit processes that Manager or its subcontractors are not operating in accordance with this Agreement or federal or state requirements, and is operating in a condition that renders the continuance of its business hazardous to Covered Persons, HMO will request a written and signed Corrective Action Plan (CAP) from Manager. Each CAP shall include, but is not limited to, the following:

(1) Expected, measurable results indicating completion of the CAP;
(2) Detailed action plan to complete activities required by the CAP; and
(3) Due date for completion of CAP.

(b) Submission of the CAP shall be made by Manager to HMO within two (2) weeks of the notification with a written explanation of:

(1) Manager noncompliance with the CAP written agreement; or
(2) The existence of the condition that renders the continuance of Manager's business hazardous to Covered Persons.

(c) Implementation of the CAP shall be completed within thirty (30) days of Manager's receipt of written approval of the proposed CAP by HMO, unless an alternative completion period is approved by HMO in writing. The CAP shall accomplish the written expected results and such results must be validated by a HMO audit within the stated time frame. Failure of the Manager or any of its subcontractors to comply with this provision may result at HMO's discretion, in the suspension or revocation of PBM Services delegation.

(d) HMO will cooperate with Manager or its subcontractors to correct any failure by Manager to comply with the ADHS regulatory requirements relating to any contractual matters.

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EXHIBIT D

Benefit Contract Design

[INSERT FROM CENPATICO/ADHS]

1

EXHIBIT E

Preferred Drug List ("PDL")

[To be inserted by CENPATICO on or after the Commencement Date]

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4. Medical Verification Solutions, LLC (MVS)

GREABHA will perform delegation oversight of the Primary Source Verification (PSV) functions delegated to MVS. MVS is certified by NCQA in all elements of PVS in their function as a Credentialing Verification Organization (CVO).

Name of Subcontractor	Medical Verification Solutions (MVS)
Address	6700 Jefferson Blvd NE Building B, Suite 4 Albuquerque, NM 87109
Telephone Number	505-468-0504
Ownership	Owned by The Medical Reliance Group, a privately held organization
Specific Management Service (including Delegated Administrative Functions)	• Primary source verification of the credentials of clinical professionals who apply for membership in GREABHA's provider network, including verification of licensure, educational history, and any sanctions or limitations on behavioral health providers' clinical practice • Provide routine reports to GREABHA on all primary source verifications performed
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Dependent on the number of providers in GSA 1 who will need credentialing
Compensation Arrangement including expected Total Annual Compensation	Initial Credentialing, Price Per File: $55 Re-credentialing, Price Per File: $50 Total Annual Compensation is dependent on the number of providers in GSA 1 who will need credentialing
Plans for Monitoring	Initial and Annual Delegation Audit

MVS
Medical Verification Solutions
A Member of the Medical Reliance Group

6700 Jefferson Blvd. NE
Building B, Suite 4
Albuquerque, NM 87109
Phone: 505.468.0504
Fax: 505.468.0554
Toll Free: 800.677.0944

MEDICAL VERIFICATION SOLUTIONS

Subcontractor Attestation

I the undersigned hereby attest that Medical Verification Solutions, a subsidiary of the Medical Reliance Group, has never been suspended or excluded from any federal program.

Kristi J. Beck, Chief Operating Officer

9-27-04
Date

MEDICAL VERIFICATION SOLUTIONS, LLC

CREDENTIALS VERIFICATION SERVICES AGREEMENT

This Services Agreement (the "Agreement") is entered into as of July August 1, 2004 (the "Effective Date"), by and between MEDICAL VERIFICATION SOLUTIONS, LLC, a Michigan limited liability company ("MVS"), and CENTENE CORPORATION a Healthcare Organization (the "Healthcare Organization").

RECITALS

A. The Healthcare Organization is required by law to verify the credentials of the heath care professionals who provide certain healthcare services to or on behalf of the Healthcare Organization.

B. MVS provides certain credentials verification services on behalf of the healthcare organizations.

B. The Healthcare Organization wishes to secure such services of MVS and MVS wishes to provide such services upon terms and conditions more fully described in this Agreement.

AGREEMENT

NOW, THEREFORE, in consideration of mutual covenants and promises contained in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties, intending to be legally bound, agree as follows:

1. SERVICES

1.1 Scope of the Services. Subject to the terms and conditions of this Agreement, MVS will perform the credentials verification services authorized by the Healthcare Organization and set forth on Exhibit A attached hereto and incorporated by reference herein (collectively, the "Services"), upon receipt of an application form in accordance with JCAHO or NCQA or other applicable agency or organization, as designated by the Healthcare Organization and further defined in the Scope of Services. Additional services may be added from time to time by execution of an addendum to such exhibit, which services are incorporated by reference into this Agreement and will become part of the Services. The Services will be provided by MVS within an agreed upon time schedule in order to collect, verify, maintain and provide data and information needed by the Healthcare Organization to evaluate Applicants and comply with state and federal laws.

1.2 Deliverables. MVS will deliver its work product (regardless as to whether for an initial credentialing or a recredentialing, the "Credentials Verification Report") to the Healthcare Organization in the form of the electronic report format available from MVS and with content as specified in the Credentials Verification Report Summary form (substantially in the form of Exhibit C) with supporting documents (e.g. the verified items), and/or in a materially similar electronic format as may be changed from time to time as may be necessary to, amongst other

reasons, comply with appropriate regulations and accreditation standards. Notwithstanding the foregoing, nothing contained in this Agreement will be deemed to require MVS to provide to the Healthcare Organization any information that is protected by the confidentiality provisions of any applicable federal, state, or other peer review protection law, or any related rule, regulation or judicial decision.

1.3 Performance of the Services.

(a) MVS will abide by all applicable federal and state legal requirements with respect to maintaining the confidentiality of information in connection with the Services.

(b) As a business associate of the Healthcare Organization, MVS will abide by the privacy and security requirements of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) and with all of the terms and conditions of Exhibit D, which is attached hereto.

(c) In the event MVS discovers facts or encounters circumstances impairing its ability to perform the Services with respect to a particular Applicant(s), MVS will promptly advise the Healthcare Organization and, at the discretion of the Healthcare Organization will make accommodations to rectify those inhibiting facts or circumstances

(d) During the term of this Agreement, the Healthcare Organization may, at the Healthcare Organization's expense, review the activities of MVS, as they relate to the provision of Services for the Healthcare Organization, on an annual basis. MVS will cooperate with the Healthcare Organization's auditors in connection with these reviews; *provided, however*, that the Healthcare Organization will give MVS reasonable prior notice of each review and the Healthcare Organization will conduct each such review in a manner that does not unreasonably interfere with the ongoing activities of MVS.

1.4 Healthcare Organization Responsibilities. To assist MVS in the performance of its responsibilities under this Agreement, the Healthcare Organization agrees to perform the following duties:

(a) To complete the National Practitioner Data Bank ("NPDB") form and to designate MVS as its querying agent.

(b) To provide all reasonably needed information (including that outlined in Exhibit A), and assistance in communication, or execution of any additional documents, and other reasonably necessary coordination, in cooperation with MVS's credentials verification activities and timetables so that MVS may best adhere to a consistent and efficient schedule for the provision of the Services.

(c) To oversee the contracted Services in accordance with the Healthcare Organization's federal, state and accreditation requirements and guidelines.

(d) To verify that the Services provided by MVS comply with and fulfill all aspects of Healthcare Organization's by-laws and other such applicable guidelines and regulations.

(e) To notify MVS, in writing, with regard to any operational matter not acceptable to the Healthcare Organization. MVS will acknowledge in writing to the Healthcare Organization its receipt of such written notice within seven business days following such receipt. MVS will thereafter, but in no event later than 60 days after its receipt of such written notice, take every reasonable action necessary to correct such matter.

(f) To utilize MVS as the Healthcare Organization's sole solution for the provision of the contracted Services.

1.5 Commitments of Timeliness and Accuracy.

(a) Subject to the provisions of this Agreement, MVS guarantees the following:

(i) *On-Time Commitment*. Subject to Section 1.5(a)(ii), MVS will deliver each Credentials Verification Report to the Healthcare Organization within 21 calendar days of the that date on which MVS receives a fully executed and accurate Application and associated Attestation (the "Full Attestation Receipt Date").

(ii) *Accuracy Commitment*. MVS further guarantees that the information contained within a Credentials Verification Report Summary shall be without material error. This guarantee, as outlined in this Section 1.5(a)(ii) (the "Accuracy Commitment"), shall not apply in those cases where MVS has determined in good faith that: x) the information provided on the Application was inaccurate, incomplete, or materially misleading; or y) the information provided by any verification source was inaccurate, incomplete, or materially misleading (the "Inaccurate Sources Exclusion").

(b) In the case where either the On-Time Commitment or the Accuracy Commitment (as provided in Section 1.5(a) above) is not upheld by MVS, Healthcare Organization shall have no obligation to pay for Services associated with the processing and provision of the applicable Credentials Verification Report. The relief provided hereunder shall be Healthcare Organization's sole recourse against MVS.

2. MVS STATUS, PROVIDER DECISIONS

2.1 Independent Contractor Status. MVS is an independent contractor performing certain data collection and verification services for the Healthcare Organization and is not an employee, representative, officer, or partner of the Healthcare Organization. Except as expressly set forth in this Agreement, MVS has no power or authority to act for, represent, or bind the Healthcare Organization in any manner. Nothing contained in this Agreement will be deemed to create any

relationship between the parties other than that of a principal and independent contractor. MVS is not an "independent review body" as that term is used in HCQIA, nor is it a "review organization".

2.2 Healthcare Organization Provider Decisions. The Healthcare Organization will be solely responsible for decisions regarding the granting, revoking, denying, terminating, suspending, restricting or otherwise conditioning contracted physician appointments, privileges, and participation status, and for all reporting required by federal or state law, or accreditation entities relating to such action. MVS will have no authority, nor represent itself as having any authority, with respect thereto.

3. TERM AND TERMINATION

3.1 Term. This Agreement will commence on the Effective Date and will remain in effect for two years following the Effective Date, unless sooner terminated as herein provided; provided, however, that the term will be automatically renewed for subsequent one-year periods unless either party gives written notice of its desire not to renew the term at least 60 days prior to the end of the then current one-year period, at which point the term will expire at the conclusion of such one-year period. This contract may be terminated for no cause at any time by either party with a written 60 day notice.

3.2 Termination. This Agreement will terminate upon occurrence of any of the following events:

(a) Failure to pay MVS its fees when due which remains uncured for a period of 10 days after receipt by the Healthcare Organization of written notice of such breach;

(b) A material breach of the Agreement (other than for failure to pay) which remains uncured for a period of 30 days after receipt of written notice specifying the breach, with reasonable opportunity for cure having been afforded the notified party;

(c) Either party is adjudged bankrupt, makes a general assignment for the benefit of creditors, seeks reorganization under bankruptcy or insolvency laws, or a proceeding relating to bankruptcy or insolvency laws is commenced against the other party.

3.3 Survival. Notwithstanding anything to the contrary contained in this Agreement, the provisions of Sections 5, 6, 8 and 9 will survive any termination, expiration or cancellation of this Agreement, regardless of the basis for such termination or cancellation.

4. PAYMENT FOR THE SERVICES

The Healthcare Organization will pay MVS for the Services in accordance with the reimbursement and payment schedule set forth on Exhibit B (respective of the services for which Healthcare Organization has authorized) attached hereto and incorporated herein by reference, which may be revised from time to time as mutually agreed by the parties.

5. RIGHTS, USE, AND OWNERSHIP

5.1 MVS will grant to Healthcare Organization the right to use, copy, and maintain MVS Intellectual Property (herein defined) and data that has been fully paid for by Healthcare Organization and provided to or collected by MVS for Healthcare Organization for the purposes of Healthcare Organization's: i) credentialing, regulatory, and quality management; ii) internal or external evaluations; and iii) other purposes that do not violate the provisions of this Agreement.

5.2 MVS is the sole owner of all MVS-created deliverables and all U.S. copyrights and other intellectual property rights in those MVS-created deliverables; data collection, analysis, and review tools; and data processing and management systems or processes, including all tangible and intangible items, processes, or information incorporated therein (the "MVS Intellectual Property"). If any such MVS-created deliverables or other MVS Intellectual Property may, by operation of law, be considered "works made for hire" (or if ownership of all right, title and interest of the U.S. copyrights therein will not otherwise vest exclusively in MVS), the Healthcare Organization will be deemed to have automatically assigned, without further consideration, the ownership of all U.S. copyrights therein to MVS, its successors and assigns. MVS, its successors and assigns will then have the right to obtain and hold in its or their own name copyrights, registrations and any other protection available in the foregoing. The Healthcare Organization agrees that it will not market, parcel, distribute, sell or otherwise communicate the MVS Intellectual Property without the express written consent of MVS.

6. PROPRIETARY INFORMATION

6.1 Definition. The parties acknowledge that MVS owns and may develop proprietary information during the course of the Agreement, which is privileged and confidential. MVS will use the proprietary information in the discharge of its contracted-for obligations to the Healthcare Organization. "Proprietary information" includes trade secrets and computer programs and software (including source codes), processes, technical information, know-how, plans, specifications, identity of Healthcare Organizations and suppliers, financial information, and other proprietary or confidential information related to the Services and business affairs of MVS which is treated by MVS as confidential; *provided, however*, that proprietary information will not include (a) information known by the Healthcare Organization prior to the Effective Date, or which is in the public domain at the time of disclosure, or which is disclosed to the Healthcare Organization through a third party; (b) all information on the Credentials Verification Report forms, or the documents and information upon which such information is based.

6.2 Use, Disclosure. The parties agree that MVS will disclose proprietary information to the Healthcare Organization only to the extent that such information is necessary to conduct the Services. With respect to any proprietary information disclosed by MVS to the Healthcare Organization in the course of or in connection with this Agreement, the Healthcare Organization will not use, copy, reveal, report, publish, transfer or otherwise disclose such information to any person, company or other entity, without the prior written consent of MVS, and the proprietary information will not be utilized for the detriment or intended detriment of the supplier of the information including the solicitation of any of that party's Healthcare Organizations, leads or employees. Upon expiration or earlier termination of this Agreement, the Healthcare Organization will return to MVS all proprietary information in its possession. The parties acknowledge that no license is created by the use of the proprietary information.

6.3 Equitable Relief. Since a remedy at law for any breach or attempted breach of the provisions of this Section 6 will be inadequate, either party hereto will be entitled to specific performance and injunctive or other equitable relief in case of any such breach or attempted breach, in addition to any remedies available at law.

7. DISPUTE RESOLUTION

7.1 Duty to Negotiate in Good Faith. If a party has reason to believe the existence of a dispute in connection with this Agreement and the Services provided hereunder, it will give written notice to the other party, describing the dispute and a proposed resolution. The parties will then meet as soon as practicable thereafter and negotiate in good faith to resolve the dispute.

7.2 Mediation. If the dispute cannot be resolved by negotiation within 30 days of notice of a dispute having been given as described above, unless otherwise agreed to by the parties in writing, the parties will be obligated to submit the dispute to a mediator.

7.3 Binding Arbitration. If the dispute cannot be resolved by way of direct negotiation or mediation within 60 days of notice of a dispute having been given as described above, the dispute will be decided by arbitration, which will be conducted by a single arbitrator and, except as otherwise expressly provided herein, in accordance with the commercial arbitration rules of the American Arbitration Association or the American Health Lawyers Association. The arbitration will be conducted in Ingham County, Michigan, unless the parties in the proceeding mutually agree otherwise. In the event that there will be more than one dispute to be arbitrated, the parties agree that all pending disputes will be consolidated to the extent feasible. Within 30 days of the hearing, the arbitrator will render a decision concerning all contested issues considered during the arbitration and the arbitrator will notify the parties in writing of his or her decision, setting forth the arbitrator's findings of fact and conclusions of law and the dollar amount, if any, awarded. Unless the parties mutually agree otherwise, the arbitrator may fix his or her compensation. The fees of the American Arbitration Association or the American Health Lawyers Association and of the arbitrator will be paid equally by the parties, unless the arbitrator determines that a particular party has prevailed on all major substantive issues presented, in which case the fees and costs will be paid by the party not so prevailing. This agreement to arbitrate will be specifically enforceable under the Michigan Arbitration law. The arbitrator's decision will be final, and judgment, including specific enforcement of the decision, may be entered upon the decision in any court of competent jurisdiction in accordance with applicable law. The amount of any dollar award, including applicable fees and costs of the prevailing party, will be paid in cash by the party not so prevailing to the prevailing party, within 10 days following the date of such award. In the event that payment is not made within the time period provided herein, the prevailing party will have the right to commence an action, at law or in equity, in any state or federal court in the State of Michigan to have the decision of the arbitrator enforced. In the event such an action is filed, the costs of such action (including reasonable attorneys' fees) will be borne by the party against whom such performance is sought. A pending arbitration will not extend the term of this Agreement or affect any termination provided for hereunder. All statutes of limitations will be tolled from the date of giving notice of the intention to submit to arbitration and for 90 days after the delivery of the arbitrator's written determination.

7.4 Certain Exclusions. The binding arbitration procedure, described in Section 7.3 above, will not apply to any claims between the parties arising out of third party claims asserting professional negligence, and the parties are not precluded from asserting claims against each other based on contribution, indemnity, breach of contract, or other legal theories, by way of cross-claim or third-party complaint in any circuit court action, commenced by a third party, which alleges professional negligence against either or both of the parties to this Agreement. In the event of a dispute, which is not subject to arbitration, each party hereto consents and agrees that any litigation arising therefrom will be commenced and maintained exclusively in the state and federal courts of competent jurisdiction located in Ingham County, Michigan.

7.5 Equitable Relief. To the extent that arbitrator acting under the applicable rules of the American Arbitration Association or the American Health Lawyers Association and pursuant to Michigan law does not have legal jurisdiction and authority to impose injunctive or other equitable relief, a party seeking the same will be entitled to pursue the same through court litigation. Such action may be pursued during, after or in lieu of arbitration. Any such action will be pursued only in the state or federal courts with requisite jurisdiction located in Ingham County, Michigan.

8. INDEMNIFICATION

8.1 Indemnification of MVS. The Healthcare Organization will indemnify and hold MVS and its officers, directors, employees, agents, consultants, affiliates, and representatives harmless from and against any and all actions, suits, proceedings, liabilities, losses, damages, judgments, fines, amounts paid in settlement, losses, costs and expenses which may arise out of acts or omissions of the Healthcare Organization or its officers, directors, employees, agents, consultants, affiliates, and representatives in the performance of the Healthcare Organization's responsibilities under this Agreement or which may arise out of any action taken by the Healthcare Organization or decision made by the Healthcare Organization regarding medical staff appointments or privileges, participation status or disciplinary matters, whether in contract, tort, or otherwise. Without limiting the generality of the foregoing, MVS will have no liability for any claims relating to the issuance of, denial of, or claims made to, any insurance coverage(s) for, from, or to the Healthcare Organization, regardless of the form of the claim, and this indemnification provision will likewise apply to any such claims.

8.2 Indemnification of the Healthcare Organization. MVS will indemnify and hold the Healthcare Organization and its officers, directors, employees, agents, consultants, affiliates, and representatives harmless from and against any and all actions, suits, proceedings, liabilities, losses, damages, judgments, fines, amounts paid in settlement, losses, costs and expenses which may arise out of acts or omissions of MVS and MVS's officers, directors, employees, agents, consultants, affiliates, and representatives in the performance of its or their responsibilities under this Agreement.

9. LIMITATION OF LIABILITY

Except as to the damages, amounts and/or costs provided in Sections 7 and 8 above, in no event will either party here to be liable under this agreement to the other party for any special consequential punitive, reliance or incidental damages, including lost profits or revenues of such party, whether or not such damages were foreseeable.

10. MISCELLANEOUS

10.1 Certain Definitions. The following terms will have the following respective meanings:

"Applicant" means a qualified Physician or Licensed Health Care Practitioner who is applying for an appointment or reappointment to the Medical Staff or health plan panel, and the receipt of Privileges at the Member's organization.

"Application" means a form (whether existing in electronic or paper format) to be supplied by MVS on which all necessary information may be acquired by MVS from Applicant needed by MVS to perform the credentialing and recredentialing Services of this Agreement.

"Attestation" means the attestment of an Applicant to the accuracy of the content provided by the Applicant within their Application.

"Board of Medical Examiners" means the board established pursuant to the statute set forth in Appendix D.

"Continuous File Maintenance" means the process of verifying certain information as it expires and providing this verification to the Healthcare Organization within 30 days of the expiration date of the information.

"HCQIA" means the Health Care Quality Improvement Act of 1986, Title IV of Public Law 99-660, as amended (42 U.S.C. 11101 et seq.).

"JCAHO" means Joint Commission for Accreditation of Healthcare Organizations, which provides accreditation for hospitals and other health care organizations.

"Licensed Health Care Practitioner" means an individual who is licensed or otherwise authorized by the laws of the state or states set forth in Appendix D to provide health care services.

"Medical Staff" means a group of Physicians and, if applicable, other Licensed Health Care Practitioners who provide medical and other health care services to patients and who are required to acquire privileges or health plan panel membership.

"National Practitioner Data Bank" or "NPDB" means the national practitioner data bank authorized and created by HCQIA.

"NCQA" means the National Commission for Quality Assurance, which provides accreditation for Managed Care Organizations ("MCO's") and certification of Credentials Verification Organizations ("CVO's").

"Physician" means a doctor of medicine (M.D.) or Osteopathy (D.O.) or a doctor of dental surgery (D.D.S.) or medical dentistry (D.M.D.) legally authorized to practice medicine and surgery or dentistry in state or states identified in Appendix C.

"Privileges" means clinical privileges, membership on the Medical Staff, or membership on a health plan panel, and other circumstances pertaining to the furnishing of medical care under which a Physician or other Licensed Health Care Practitioner is permitted to furnish such care by the Healthcare Organization.

"Credentialing Requests" means the provision of a formal request (as submitted via electronic means, facsimile, telephone, or by paper copy) by Healthcare Organization for MVS to initiate the process by which a Credentials Verification Report may be delivered by MVS to Healthcare Organization.

10.2 Mutual Agreement Not to Solicit Employees. During the term of this Agreement and for a period of two years thereafter, neither party will, either directly or indirectly, on its own behalf or on behalf of others, solicit, divert or hire away, or attempt to solicit, divert, or hire away, any person employed by the other party, whether or not such employee is a full-time employee or a temporary employee of, consultant to, or independent contractor to such other party and whether or not such employment or engagement is pursuant to written agreement and whether or not such employment or engagement is for a determined period or is at will.

10.3 Notices. All notices, consents, waivers and other communications under this Agreement must be in writing and will be deemed to have been duly given when (a) delivered by hand (with written confirmation of receipt), (b) sent by facsimile or electronic mail (with written confirmation of receipt), provided that a copy is mailed by registered mail, return receipt requested, or (c) when received by the addressee, if sent by a nationally recognized overnight delivery service (receipt requested), in each case to the appropriate addresses and facsimile numbers set forth on the signature page below (or to such other addresses and facsimile numbers as a party may designate by notice to the other party).

10.4 Entire Agreement and Modification.

(a) This Agreement, together with all referenced and attached exhibits, contains the entire agreement between the parties hereto, supersedes all prior agreements, arrangements, or understandings between the parties and constitutes a complete and exclusive statement of the terms of the agreement between the parties with respect to its subject matter. This Agreement may not be modified or amended except by a written agreement duly signed by persons authorized to act on behalf of the party to be charged with the amendment.

(b) Notwithstanding the foregoing, subject to the following procedure, the Exhibits to this Agreement will be deemed to be automatically amended in order to permit MVS and the Healthcare Organization to comply with any applicable amendments to HCQIA, the Guidebook, any related changes in state and federal regulations promulgated pursuant to such acts, NCQA, or in order to comply with changes of policy or procedures required by MVS for the operation its systems used in connection with the Services.

(i) MVS will give written notice to the Healthcare Organization of regulatory changes or changes in MVS policy or procedures which are applicable to the Healthcare Organization ("Notices"). The Notice will include revised Exhibits to this Agreement, as applicable, setting forth the revisions required by changes in statutes, regulations or MVS policy and procedure.

(ii) The Healthcare Organization may, within 60 days of receipt of the Notice and revised Exhibits, give notice of termination of the Agreement pursuant to Section 3 hereof. The Healthcare Organization must comply with the Notice during any period in which the changes are effective and before this Agreement is terminated.

(iii) If notice of termination is not given by the Healthcare Organization as set forth above, the Healthcare Organization will accept, initial and return the revised Exhibits to MVS, which will become effective as of the later of the date so accepted or 30 days following the date of the Notice.

10.5 Assignments, Successors and Third-Party Rights. Neither party may assign any of its rights under this Agreement without prior written consent of the other party; provided, however, such consent will not be necessary in connection with an assignment on the part of MVS of this Agreement to an affiliate of MVS as a part of any reorganization or corporate restructuring of MVS. Subject to the preceding sentence, this Agreement will apply to, be binding in all respect upon and inure to the benefit of the respective successors and permitted assigns of the parties. Nothing expressed or referred to in this Agreement will be construed to give any person other than the parties to this Agreement any legal or equitable right, remedy or claim under or with respect to this Agreement or any provision of this Agreement. This Agreement and all of its provisions and conditions are for the sole and exclusive benefit of the parties to this Agreement and their successors and permitted assigns.

10.6 Severability. If any provision of this Agreement is held invalid or unenforceable by any court of competent jurisdiction or an arbitrator pursuant to Section 7.3 hereof, the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable.

10.7 Section Headings, Construction. The headings of sections in this Agreement are provided for convenience only and will not affect its construction or interpretation. All words used in this Agreement will be construed to be of such gender or number as the circumstances require. Unless otherwise expressly provided, the word "including" does not limit the words or terms preceding it.

10.8 Governing Law. This Agreement will be governed by and interpreted pursuant to the laws of the State of Michigan without regard to conflicts of laws principles.

10.9 Counterparts. This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and delivered by their duly authorized officers or agents as set forth below.

MEDICAL VERIFICATION SOLUTIONS, LLC
"MVS"

Date: _____

By: _____
Name: Kristi Beck
Title: Chief Operating Officer

Address:
3410 Belle Chase Way, Suite 600
Lansing, Michigan 48911
Tel: 800-677-0944
Fax: 517-702-4000
Email: kbeck@mvshome.com

CENTENE CORPORATION
"Healthcare Organization"

Date: _____

By: _____
Name: Aron Halfin
Title: Vice President of Clinical Operations

Address:
823 Congress Avenue
Suite 600
Austin, Texas 78701
Tel: 512-406-7200
Fax: _____
Email: ahalfin@centene.com

EXHIBIT A

SCOPE OF SERVICES

1. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by JCAHO criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) Board certification
   (c) Medical/dental/podiatry or other professional education and training obtained
   (d) DEA and CSR certificate
   (e) Hospital affiliation/work history for previous 5 years
   (f) Professional liability insurance for previous 5 years
   (g) Malpractice claims history for previous 5 years (via confirmation with insurance provider or NPDB query)
   (h) Medicaid/Medicare sanctions (via NPDB query)
   (i) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (j) Minimum of two professional references
   (k) Other information, specified as follows:_____
   _____
   _____

2. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by NCQA criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) Board certification (or)
   (c) Medical/dental/podiatry residency training or highest level of education or training obtained
   (d) DEA or CSR certificate
   (e) Professional liability insurance (copy of the policy cover page)
   (f) Malpractice claims history for previous 5 years (via confirmation with insurance provider or NPDB query)
   (g) Work history that has been provided by the Applicant (5 years as evident via application, curriculum vitae, or resume; verification not required)
   (h) Medicaid/Medicare sanctions (via NPDB query) for a period of 3 years

(i) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)

(j) Other information, specified as follows:_____

_____

_____

Signed Attestation that addresses:

reasons for any inability to perform the essential functions of the position, with or without accommodation

lack of present illegal drug use

history of loss of license and felony convictions

history of loss or limitation of privileges or disciplinary activity

current malpractice insurance coverage

the correctness and completeness of the application.

3. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by URAC criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

(a) Licensure in the applicable state or states [State *licensure* information, including current *license(s)* and history of *licensure* in all jurisdictions;]

(b) DEA or CSR certificate

(c) Board certification

(d) Professional liability insurance (copy of the policy cover page)

(e) NPDB query [Professional liability claims history]

(f) Other information, specified as follows:_____

_____

_____

The following items will be obtained via a completed Application, release, and Attestation:

(a) History of education and professional training, including *board certification* status;

(b) Work history for at least the last five years (or since last credentialed by the *organization*);

(c) Listing of all sanctions or penalties imposed by hospitals, licensing boards, government entities, and managed care organizations;

(d) Documentation of any voluntary or involuntary relinquishment of privileges to practice in a *facility* or jurisdiction;

(e) Hospital affiliations or privileges, if applicable;

(f) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the *practitioner's* ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;

(g) A signed and dated statement attesting that the information submitted with the application is complete and accurate to the *practitioner's* knowledge; **and**

1

(l) A signed and dated statement authorizing the *organization* to collect any information necessary to verify the information in the credentialing application.

4. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by JCAHO criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) DEA and CSR certificate
   (c) Hospital affiliation/work history for previous 2 years
   (d) Professional liability insurance for previous 2 years
   (e) Malpractice claims history for previous 2 years (via confirmation with insurance provider or NPDB query)
   (f) Medicaid/Medicare sanctions (via NPDB query)
   (g) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (h) Minimum of two professional references
   (i) Other information, specified as follows:_____
   _____
   _____

5. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by NCQA criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) DEA or CSR certificate
   (c) Professional liability insurance (copy of the policy cover page or declaration in application)
   (d) Malpractice claims history for previous 3 years (via NPDB query)
   (e) Medicaid/Medicare sanctions for a period of 3 years (via NPDB query)
   (f) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 3 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (g) Other information, specified as follows:_____
   _____
   _____

Signed Attestation that addresses:

reasons for any inability to perform the essential functions of the position, with or without accommodation

lack of present illegal drug use

history of loss of license and felony convictions in the past 3 years

history of loss or limitation of privileges or disciplinary activity in the past 3 years

current malpractice insurance coverage

the correctness and completeness of the application.

6. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by URAC criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

(a) Licensure in the applicable state or states [State *licensure* information, including current *license(s)* and history of *licensure* in all jurisdictions;]
(b) DEA or CSR certificate
(c) Professional liability insurance (copy of the policy cover page)
(d) NPDB query [Professional liability claims history]

Other information, specified as follows:_____

_____

The following items will be obtained via a completed Application, release, and Attestation:
(a) Listing of all sanctions or penalties imposed by hospitals, licensing boards, government entities, and managed care organizations during the past 3 years;
(b) Documentation of any voluntary or involuntary relinquishment of privileges to practice in a *facility* or jurisdiction during the past 3 years;
(c) Current hospital affiliations or privileges, if applicable;
(d) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the *practitioner's* ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;
(e) A signed and dated statement attesting that the information submitted with the application is complete and accurate to the *practitioner's* knowledge; **and**
(f) A signed and dated statement authorizing the *organization* to collect any information necessary to verify the information in the credentialing application.

7. Upon MVS' receipt of the data outlining, in sufficient detail (see Section 3(b) below), the Healthcare Organization's care provider network (the "Care Provider Network"), MVS shall initiate a process designed to maintain as current the credential verification records pertaining to the members of the Care Provider Network (the "Credentials Monitoring Process").

(a) The credentialing data maintained through the execution of the Credentials Monitoring Process shall include:
i. Licensure;
ii. Board certification;
iii. DEA and/or CSR certificate; and
iv. Professional liability insurance.

1

(b) The data and materials that Healthcare Organization shall provide to MVS to identify and initiate the Credentials Monitoring Process for each member of the Care Provider Network shall be:
   i. Member's name, professional degree, address, and phone number;
   ii. State licensure number and expiration date;
   iii. Board certification and expiration date;
   iv. CSR certificate number and expiration date;
   v. DEA certificate number, expiration date, and physical copy; and
   vi. Professional liability insurance carrier and policy number.

8. Upon MVS' receipt of the data outlining, in sufficient detail (see Section 4(b) below), the Healthcare Organization's care provider network (the "Care Provider Network"), MVS shall initiate a process of monitoring for sanctions pertaining to the members of the Care Provider Network (the "Sanctions Monitoring Process") on a monthly basis.

(c) The sanctions data monitored through the execution of the Sanctions Monitoring Process shall include:
   i. Medicaid sanctions;
   ii. Medicare sanctions;
   iii. State sanctions; and
   iv. Limitations of licensure.

(d) The data and materials that Healthcare Organization shall provide to MVS to identify and initiate the Sanctions Monitoring Process for each member of the Care Provider Network shall be:
   i. Member's name, professional degree, address, and phone number;
   ii. Date of birth;
   iii. Social Security number; and
   iv. State licensure number.

9. If the Healthcare Organization requires additional information from the Applicant which is not contained on the application form or within the materials provided to MVS by the Healthcare Organization, the Healthcare Organization will mail directly to the Applicant whatever additional information the Healthcare Organization requires. A copy of the application form required by the Healthcare Organization is attached this Scope of Services.

10. For all Applications completed under this Agreement, MVS will collect all data required to meet both NCQA and URAC standards, as detailed above.

11. The Healthcare Organization hereby designates the following staff member as the recipient of the information provided to the Healthcare Organization under this Agreement, including responses from the National Practitioner Data Bank (NPDB) (provide the name of the specific job title of the person to whom MVS is to provide information):

Name: Aron Halfin
Address: 823 Congress Avenue
Suite 600

Austin, TX 78701
Telephone:512-406-7200

Effective Date: August 1, 2004

1

EXHIBIT B

PAYMENT/FEE SCHEDULE & TERMS

Summary MVS Fee Schedule For Initial and Recredentialing Verifications	
	NCQA Profile
Initial Credentialing	
Pricing per File:	$55.00
Recredentialing	
Pricing per File:	$50.00

Table B-1: Summary Fee Schedule For Initial and Recredentialing Verifications

Summary MVS Fee Schedule For Bundled Sanction Monitoring and Credentials Monitoring	
Element:	**Sanction & Credential Monitoring**
License Sanctions and Limitations	✓
Medicare / Medicaid Sanctions	✓
Valid License	✓
Valid DEA	✓
Valid CSR	✓
Board Certification	✓
Malpractice Insurance	✓
Malpractice Claims History through NPDB	✓
Pricing per Practitioner per Year:	$43.00

Table B-2: Summary Fee Schedule For Sanction and Credentials Monitoring

	60 Day Guarantee	45 Day Guarantee	30 Day Guarantee	15 Day Guarantee	2 Day Guarantee
Initial Credentialing					
Expedited Fees:	No Additional Charge	25% Additional Charge	50% Additional Charge	75% Additional Charge	150% Additional Charge
Recredentialing					
Expedited Fees:	No Additional Charge	25% Additional Charge	50% Additional Charge	75% Additional Charge	150% Additional Charge

Table B-3: Summary Fee Schedule For Expedited Files

1

1. Fees.

   a. Credential Verifications: The fees (the "Credentialing Verification Fees") due to MVS from Healthcare Organization for each initial and recredentialing verification requested by the Healthcare Organization shall be as outlined in Table B-1 (Summary Fee Schedule For Initial and Recredentialing Verifications), as may be adjusted by expedition requests as outlined in Table B-3. In the case that Healthcare Organization requests the provision of a Credentialing or Recredentialing report within a period of time less than 60 calendar days (the "Expedited Request"), the respective Credentialing Verification Fees shall be adjusted by the addition of that amount outlined within Table B-3 (the "Expedite Fee").

   b. Credentials & Sanction Monitoring: The fees (the "Monitoring Fees") due to MVS from Healthcare Organization for Credentials and Sanctions Monitoring shall be calculated by multiplying the number of members within the Care Provider Network by the fees outlined in Table B-2 (Summary MVS Fee Schedule For Bundled Sanction Monitoring and Credentials Monitoring). The Monitoring Fees shall be invoiced in advance on a quarterly basis.

2. Invoicing.

   a. Monthly Invoicing: MVS will, on a monthly basis, provide an invoice outlining in reasonable detail the fees due to MVS by Healthcare Organization for the following:
      i. Initial Verifications;
      ii. Recredentialing Verifications; and
      iii. Pass-Through Fees.

   b. Quarterly Invoicing: MVS will, on a quarterly basis, provide an invoice outlining in reasonable detail the fees due to MVS by Healthcare Organization for one quarter of the projected annual price (in advance) for Sanctions and Credentials Monitoring indicated for the respective quarterly period and in accordance with the pricing on Table B-2. MVS shall make adjustments in arrears (and invoice for such adjustments) for any additions to the Healthcare Organizations provider network as submitted by the Healthcare Organizations or that become known to MVS during the respective quarterly period.

3. Payment Term. Payment is due within 15 days from the date of receipt of an invoice by the Healthcare Organization (the "Due Date").

4. Late Charges. If any undisputed fee for services by MVS is not paid within 10 days after the Due Date, interest will accrue from such Due Date at a rate equal to two percent (2%) per month. The Healthcare Organization will pay such interest upon demand by MVS, and such interest charge will be in addition to the amounts otherwise charged by MVS for its services. The amount of interest payable pursuant to this provision will not exceed the maximum effective rate of interest permitted to be paid under the laws of the State of Michigan. If such amounts result in an effective rate of interest in excess of such maximum effective rate of interest, then the amount payable pursuant to this provision will be reduced to the highest amount permitted under the laws of the State of Michigan.

5. Pass Through Fees. Certain components of the service processes generate expenses from third-parties. These expenses are passed through to Healthcare Organization at cost (the "Pass-Through Fees"). A non-exhaustive list of typical Pass-Through Fees is provided below in Table B-4. This list may change from time to time and is independent of MVS. MVS shall invoice Healthcare Organization for such Pass-Through Fees as outlined in Paragraph 2 of this Exhibit B. Upon request from the Healthcare Organization, MVS shall provide, in reasonable detail, information outlining the Pass-Through Fees.

Typical Pass-Through Fees Associated with Credential Verifications	
Verification Source	**Pass-Through Fees**
Educational Commission for Foreign Medical Schools (ECFMG)	$ 25.00
National Practitioner Data Bank (NPDB)	$4.25
Healthcare Integrity and Protection Data Bank (HIPDB)	$4.25
DPM Board Certification	$25.00
American Medical Association (AMA) Profile	$26.00
American Nursing Credentialing Center (ANCC)	$10.00
DO Board Certification	$10.00
DC license	$5.00
OD License	$15.00
Various Insurance Companies	$20.00
Various Universities	$20.00
Various Medical Centers	$20.00

Table B-4: Typical Pass-Through Fees Associated with Credential Verifications

6. Cancellations. If an initial or recredentialing verification request is canceled (directly or indirectly by any means or necessity) by the Healthcare Organization within two business days of the date of the original request (a "Early Cancellation") shall result in a cancellation fee of $25 (the "Early Cancellation Fee"), in addition to any Pass-Through Fees incurred, being charged as the only Credentialing Verification Fees for such initial or recredentialing verification request. Any initial or recredentialing verification request that is canceled (directly or indirectly by any means or necessity) by the Healthcare Organization more than two business days after the date of the original request (a "Late Cancellation") shall result the charging of the full amount of the Credentialing Verification Fees, and any Pass-Through Fees incurred, as if the request were completed in a timely and accurate fashion. In the case of any cancellation in which the original request by the Healthcare Organization was for such request to be handled in an expedited fashion (the "Expedition Cancellation"), the aforementioned cancellation fees (whether Early Cancellation or Late Cancellation, as the case may be) shall be adjusted as outlined within Table B-3 above. MVS is not responsible for determining whether any (e.g. repeated, changed, or otherwise) submissions of initial or recredentialing verification requests by the Healthcare Organization are appropriate, needed, or otherwise. Hence, any cancellation (or change which shall be interpreted as a cancellation followed by a re-submission) necessitated by such submissions are treated as cancellation as described within this Paragraph 6.

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7. Fee Adjustments. To accommodate changes in labor, data processing, and other operating expenses that may occur from time to time, MVS reserves the right to make adjustments to the fees upon 30 days prior written notice to Healthcare Organization. Such fees may be adjusted no more frequently than once per annual period.

1

EXHIBIT C

SAMPLE CREDENTIALS VERIFICATION REPORT FORM

MVS
Medical Verification Solutions
A division of the Medical Reliance Group

Practitioner Summary

Prepared for <<Client>>

<<RequestType>> of <<NameLast>>, <<NameFirst>> <<NameMI>>, <<Degree>>

Social Security Number:	<<SSN>>	**Report Date:**	<<CompletionDate>>
Date of Birth:	<<DOB>>	**Attestation Date:**	<<AttestationDate>>
		Quality Control Date:	<<AttestationDate>>

Addresses

<<AddressDescription>>

<<Organization>>
<<Address1>>, <<Address2>>
<<City>>, <<State>>, <<Zip>>

Phone:	<<Phone>>
Fax:	<<Fax>>
Email:	<<Email>>
Contact:	<<Contact>>

Education and Training

<<Institution Name>>

Education Type:	<<EducationType>>
Degree/Training Type:	<<DegreeType>>
Attendance Dates:	<<StartDate>> to <<EndDate>>
Degree/Training Completion:	<<Completion>>
Verification Date:	<<VerDate>>

Work History

Organization	Start Date	End Date	Verification Date
<<InstitutionName>>	<<StartDate>>	<<EndDate>>	<<VerDate>>

Work History Gaps	Start Date	End Date	Verification Date
<<GapDescription>>	<<StartDate>>	<<EndDate>>	<<VerDate>>

Speciality & Board Certification

Type	Board Certification Date	Expiration Date	Verification Date
<<Specialty>>	<<CertDate>>	<<ExpDate>>	<<VerDate>>

Page 1 MVS

MVS Service Agreement
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<<RequestType>> of <<NameLast>>, <<NameFirst>> <<NameMI>>, <<Degree>>

Social Security Number:	<<SSN>>	**Report Date:**	<<CompletionDate>>
Date of Birth:	<<DOB>>	**Attestation Date:**	<<AttestationDate>>
		Quality Control Date:	<<AttestationDate>>

Sanctions

Data Source	Verification Date	Findings
<<DataSourceName>>	<<VerDate>>	<<Finding>>

Page 3

MVS

EXHIBIT D

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum amends and is made part of the Credentials Verification Services Agreement (the "Agreement") by and between Healthcare Organization ("Covered Entity") and Medical Verification Services, LLC ("Business Associate").

Covered Entity and Business Associate mutually agree to modify the Agreement to incorporate the terms of this Addendum to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing privacy regulations at 45 CFR Parts 160-164 ("HIPAA Privacy Rule"). The parties acknowledge and agree that if any of the terms and conditions set forth in this Addendum are in conflict with or in addition to the terms and conditions set forth in the Agreement, then this Addendum will control in connection with the request, use, or disclosure of Protected Health Information ("PHI"), as that term is defined in Section 1(c) of this Addendum.

1) Definitions. For purposes of this Section, the following terms will have the indicated meanings:

   a) *Affiliated Entity*. "Affiliated Entity" will mean an entity under common control or common ownership.

   b) *HIPAA Regulations*. "HIPAA Regulations" will mean the regulations promulgated by the Secretary of Health and Human Services under the authority of Title II, Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-191)

   c) *Protected Health Information*. "Protected Health Information" will have the meaning set forth in 45 CFR § 164.501, as amended from time to time. Generally, this term means individually identifiable health information including all information, data and materials, including demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2) Protected Health Information.

   a) *Permitted Uses and Disclosures*. Business Associate agrees to use or disclose PHI it creates for or receives from Covered Entity only as follows:

      i *Functions and Activities on Covered Entity's Behalf*. Business Associate is permitted to use and disclose PHI it creates for or receives from Covered Entity in order to provide services as described in the Agreement, provided that such use or disclosure would not violate the HIPAA Privacy Rule if done by Covered Entity.

      ii *Business Associate's Operations – Use of PHI*. Business Associate is permitted by this Addendum to use PHI it creates for or receives from Covered Entity if such use is essential

for Business Associate's proper management and administration, or is essential to carry out Business Associate's legal responsibilities.

iii *Business Associate's Operations – Disclosure of PHI*. Business Associate is permitted by this Addendum to disclose PHI it creates for or receives from Covered Entity if such disclosure is essential for Business Associate's proper management and administration, or is essential to carry out Business Associate's legal responsibilities, provided that such disclosure would be permitted under state and federal confidentiality laws if done by Covered Entity, and only if the following conditions are met: (1) the disclosure is required by law; or (2) Business Associate obtains reasonable assurances in writing from any person or organization to which Business Associate will disclose such PHI that the person or organization will hold such PHI as confidential, and will only use or further disclose such PHI as required by law, or for the purpose for which the Business Associate disclosed such PHI to the person or organization. The person or organization shall promptly notify the Business Associate (who shall in turn promptly notify Covered Entity) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI has been breached.

iv *Minimum Necessary Standard*. In performing the functions and activities on Covered Entity's behalf as set forth above, Business Associate agrees to use, disclose or request only the minimum necessary PHI to accomplish the purpose of the use, disclosure or request.

b) *Certain Representations and Warranties*. Business Associate represents and warrants that to the extent that Business Associate is provided with any Protected Health Information, Business Associate will:

i Not use or further disclose the information other than as specifically set forth in this Business Associate Addendum;

ii Not use or further disclose the Protected Health Information in a manner that would violate the requirements of any state or federal law including the provisions of the HIPAA Regulations;

iii Use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for in this Business Associate Addendum;

iv Report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Business Associate Addendum of which Business Associate may become aware;

v Ensure that any agents, including subcontractors, to whom Business Associate provides Protected Health Information received from Covered Entity or Affiliated Entities agrees to the same restrictions and conditions that apply to Business Associate with respect to such Protected Health Information;

vi Make the Protected Health Information available in accordance with the HIPAA Regulations;

vii Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the HIPAA Regulations;

viii Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Covered Entity available to the Secretary of Health and Human Services for purposes of determining the Covered Entity's compliance with the HIPAA Regulations;

ix Return or destroy all Protected Health Information received from the Covered Entity which Business Associate maintains in any form at the termination of this Business Associate Addendum; and

x Incorporate any amendments or corrections to the Protected Health Information which may be requested pursuant to the HIPAA Regulations.

3) Audit Rights. In order to allow Covered Entity to certify its compliance with the HIPAA Regulations, Business Associate will permit Covered Entity, at Covered Entity's expense and on five (5) days prior notice, to audit Business Associate's business systems and services, with specific emphasis on Business Associate's compliance with the provisions of this Section. Such audit, which may be conducted by Covered Entity's personnel under obligations of confidentiality or by an independent auditing firm, will not interfere unreasonably with Business Associate's business activities, and will be conducted no more than once per calendar year, unless Covered Entity has received a request from the Secretary of Health and Human Services, or unless a previous audit has disclosed a material issue indicating non-conformance to the provisions of this Business Associate Addendum. Covered Entity will use information received during an audit solely for the purposes of the Agreement and will otherwise maintain the confidentiality of such information.

4) Breach. In addition to any other rights Covered Entity may have in this Business Associate Addendum, the Agreement or by operation of law, Covered Entity may immediately terminate this Business Associate Addendum and the Agreement, if Business Associate breaches this Business Associate Addendum.

5) Third Party Rights. The terms of this Business Associate Addendum are not intended nor should they be construed to grant any rights to parties other than Business Associate and Covered Entity.

6) Applicable Law and Forum. This Business Associate Addendum will be interpreted and construed in accordance with the laws of the State of Michigan. Any dispute arising under this agreement will be resolved pursuant to the Dispute Resolution provisions of Section 7 of the Agreement.

7) Waiver. No delay or omission on the part of either party in exercising any right hereunder will operate as a waiver of such right or of any other right under this Business Associate Addendum. A waiver on any one occasion will not be construed as a bar to or waiver of any right or remedy on any further occasion. The election of either party of a particular remedy on default will not be exclusive of any other remedy, and all rights and remedies of the parties hereto will be cumulative.

8) Amendments. Any amendment to this Business Associate Addendum will not be binding on either

of the parties to this Business Associate Addendum unless such amendment is in writing and executed by the party against whom enforcement is sought.

9) Notices. Any notices required or permitted under this Business Associate Addendum will be in writing and delivered in person or sent by registered or certified mail, return receipt requested, proper postage prepaid, properly addressed to the address of the addressee set forth above or to such other more recent address of the addressee of which the sending party has received written notice.

10) Binding Effect. Entry into the Agreement constitutes entry into this Business Associate Addendum and no separate signatures or executions are required.

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MVS Service Agreement
Exhibit E - Page 1 of 1

MVS Base Agreement (Centene Corporation) v2.0.01

Initials: MVS _____ HP _____

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i. Management Services Subcontracts – GSA 2

To facilitate implementation and to fulfill the requirements in the Arizona RFP, GREABHA has contracted with four organizations:

- The Southwest Network
- META Services
- Caremark, Inc.
- Medical Verification Solutions, LLC (MVS)

The requested information regarding these three organizations is provided below.

1. The Southwest Network

The Southwest Network has a proven track record of leadership and innovation in the implementation of the Arizona principles.

Name of Subcontractor	The Southwest Network
Address	3707 N. 7th Street #200, Phoenix 85014
Telephone Number	602-266-8402
Ownership	Nonprofit
Specific Management Service (including Delegated Administrative Functions)	Training and coaching to providers in GSA 2
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Team of Mentoring and Training Staff 175 hours
Compensation Arrangement including expected Total Annual Compensation	Not to exceed $17,500
Plans for Monitoring	GREABHA will meet with The Southwest Network monthly to evaluate the needs of providers and to evaluate the effectiveness of the training and coaching.

09/28/2004 15:07 DESERT SPRINGS → 13147254658 NO.228 P002
09/28/2004 14:56 NO.486 P02

GPA
FOCUSED BEHAVIORAL SOLUTIONS

LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH GROUP PRACTICE AFFILIATES FOR PROVISION OF SERVICES TO ARIZONA MEDICAID MEMBERS

Group Practice Affiliates, "GPA" is proposing to become the Regional Behavioral Health Authority in one or more of the GSA Regions for which the State of Arizona is currently soliciting proposals. This Request for Proposals ("RFP"), Numbered HP532003, is issued by the Arizona Department of Health Services for provision of services to Title XIX and Title XXI Covered consumers, Developmentally Disabled Children and Adults, and Non-Title XIX and XXI Persons with a Serious Mental Illness.

If GPA is awarded the contract to become the Regional Behavioral Health Authority for GSA 1, GSA 2, or GSA 4, Southwest Network will provide training and coaching to the providers in those regions at the direction of GPA.

1. CONTRACTOR PRINTED NAME

The Southwest Network

2. ADDRESS (primary address if more than one location)

3707 N. 7th Street #200, Phoenix, AZ

3. ZIP CODE 85014 4. COUNTY Maricopa

5. TELEPHONE (602) 2610-8402 6. FAX (602) 264-0887

7. TAX ID# 86-0966400 8. AZ PROVIDER ID# 5452416

HOURS TO BE SUBCONTRACTED

GSA 1 350

GSA 2 175

GSA 4 175

COMPENSATION

Not to exceed $70,000

MONITORING

Southwest Network will meet with GPA monthly to evaluate the needs of providers and to evaluate the effectiveness of training and coaching.

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09/28/2004 15:07 DESERT SPRINGS → 13147254658 NO.228 P003
09/28/2004 14:56 NO.486 P03

GPA
FOCUSED BEHAVIORAL SOLUTIONS

ATTESTATION

Southwest Network has never been suspended or excluded from any Federal program.

9. PROVIDER'S SIGNATURE

10. DATE 9/28/04

11. PRINTED NAME OF SIGNER Jeff Jorde

12. TITLE President/CEO

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2. META Services, Inc.

META Services has a proven track record of leadership and innovation in the implementation of the Arizona principles.

Name of Subcontractor	META Services, Inc.
Address	2701 N. 16th Street #316, Phoenix 85006
Telephone Number	602-650-1212
Ownership	Nonprofit
Specific Management Service (including Delegated Administrative Functions)	Training and coaching to providers in GSA 2
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Team of Mentoring and Training Staff 175 hours
Compensation Arrangement including expected Total Annual Compensation	Not to exceed $12,500
Plans for Monitoring	GREABHA will meet with META Services monthly to evaluate the needs of providers and to evaluate the effectiveness of the training and coaching.

GPA

LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH
GROUP PRACTICE AFFILIATES
FOR PROVISION OF SERVICES TO ARIZONA MEDICAID MEMBERS

Group Practice Affiliates "GPA" is proposing to become the Regional Behavioral Health Authority in one or more of the GSA Regions for which the State of Arizona is currently soliciting proposals. This Request for Proposals ("RFP") numbered HP532003 is issued by the Arizona Department of Health Services for provision of services to Title XIX and Title XXI Covered consumers, Developmentally Disabled Children and Adults, and Non-Title XIX and XXI Persons with Serious Mental Illness.

If GPA is awarded the contract to become the Regional Behavioral Health Authority for GSA 1, GSA 2, or GSA 4, META Services, Inc. will provide training and coaching in the planning, development, and implementation of mental health recovery principles and practices to GREABHA staff and to the providers in those regions at the direction of GPA.

1. CONTRACTOR PRINTED NAME

   META Services, Inc.

2. ADDRESS (primary address if more than one location)

   2701 N. 16th Street #316
   Phoenix, AZ

3. ZIP CODE 85006
4. COUNTY Maricopa
5. TELEPHONE 602.650.1212
6. FAX 602.650.1616
7. TAX ID# 86 0671446
8. AZ PROVIDER ID# 1204014

HOURS TO BE SUBCONTRACTED

GSA 1 – not to exceed 300

GSA 2 – not to exceed 175

GSA 4 – not to exceed 225

COMPENSATION

Not to exceed $50,000.00

MONITORING

META Services, Inc. will meet with GPA monthly to evaluate the needs of providers and to evaluate the effectiveness of training and coaching.

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GPA

ATTESTATION

META Services, Inc. has never been suspended or excluded from any Federal program.

9. PROVIDER'S SIGNATURE _____

10. DATE September 28, 2004

11. PRINTED NAME OF SIGNER Eugene Johnson

12. TITLE President/CEO

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3. Caremark/PCS

To ensure continuity of care for Arizona behavioral health recipients, GREABHA provides Pharmacy Benefit Management (PBM) services through a contract with Caremark/PCS, the same PBM vendor that currently serves the majority of behavioral health recipients in GSA 1 and GSA 2. GREABHA's parent company, Centene, has experience working with Caremark to provide specialty pharmacy services such as self-injectables or therapies that require extensive monitoring or follow-up care.

Name of Subcontractor	Caremark/PCS
Address	9501 E. Shea Blvd., Scottsdale, AZ 85260
Telephone Number	(480) 391-4600
Ownership	Publicly traded NYSE symbol CMX
Specific Management Service (including Delegated Administrative Functions)	Pharmacy claims processing and payment, pharmacy network contracting and management, rebate contracting and administration, formulary administration, drug utilization review, pharmacy help desk
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	0.5 FTE Customer Service 0.25 FTE Pharmacy Administrator 0.25 FTE Contracting Pharmacy program administration requires approximately 40 hours per week per 50,000 live both pharmacy and non-pharmacy
Compensation Arrangement including expected Total Annual Compensation	Discounted AWP plus dispensing fee per prescription. Per claim administration fee and rebate administration fee Total Annual Compensation: $2.6 million $3.67 per member per month
Plans for Monitoring	Annual delegated oversight audit including financial, operations, customer service, clinical, administrative and quality functional areas. Contract specifies deliverables from subcontractor.

CAREMARK
It all starts with care

October 6, 2004

Galit Lev-Harir
Centene Corporation

Dear Ms. Lev-Harir:

This letter is to inform you that Caremark and its Subsidiaries and facilities in the State of Arizona are all in good standing without any restriction, sanction or suspension within the scope of its business, as of this date.

Sincerely,

Richard J. Nagler
Vice President, Western Region

PHARMACY BENEFIT MANAGEMENT AGREEMENT

This **PHARMACY BENEFIT MANAGEMENT AGREEMENT** (this "Agreement") is made and entered into this _____ day of _____, 2004 by and between **CENPATICO BEHAVIORAL HEALTH**, a Delaware corporation ("HMO"), and **CAREMARK RX**, an Illinois corporation ("Manager").

RECITALS

WHEREAS, HMO is a managed care organization which arranges for the delivery of behavioral heath care services on behalf of Health Plans (as hereinafter defined), including state Medicaid and CHIP programs in the state of Wisconsin, and desires to contract with a pharmacy benefits management company for the management and delivery of pharmacy benefits to its Covered Persons (as hereinafter defined); and

WHEREAS, Manager is in the business of developing and administering systems for the delivery of pharmacy benefits and desires to contract with HMO to provide access to such systems and the management services related thereto.

NOW, THEREFORE, in consideration of the terms and conditions set forth in this Agreement, the parties hereto agree as follows:

I. DEFINITIONS

In addition to the capitalized terms defined elsewhere in this Agreement, the following terms shall have the following meanings:

1.1. **"Benefit Contracts"** means a health benefit plan that: (i) is sponsored, purchased, issued, or administered by Health Plans, (ii) contains the terms and conditions of a Covered Person's coverage, and (iii) provides pharmacy benefits either as part of the basic plan or through a rider to the plan. A Benefit Contract is also known as a certificate of coverage, summary plan description, evidence of coverage, or group services agreement.

1.2. **"Commencement Date"** the date on which Manager begins to provide services pursuant to the terms of this Agreement, which date shall be January 1, 2005, subject to State regulatory filing and/or prior approval requirements.

1.3. **"Copayment"** collectively means the charge, in addition to the premium, which a Covered Person is required to pay for certain covered services provided under the Benefit Contracts and includes copayments, coinsurance, deductibles, or other similar charges, which may be either a defined dollar amount or a percentage of eligible expenses. A Covered Person is responsible for the payment of any Copayment directly to a pharmacy at the time a prescription is dispensed.

1.4. **"Covered Person"** means an individual eligible to receive coverage for outpatient prescription pharmacy benefits as an enrollee under a Benefit Contract.

1.5. **"Covered Prescription Drug Services"** means those outpatient prescription drugs and pharmacy products, services, and supplies that are covered pursuant to the Benefit Contracts.

1.6. **"ADHS"** means the Arizona Department of Health Services.

1.7. **"Health Plans"** means any of the managed care health plans established and operated by HMO or its subsidiaries or affiliates, whether insured or self-insured, commercial or governmental program. This term includes behavioral health and state RBHA programs operated in the State of Arizona.

1.8. **"Intellectual Property"** means all patents, patents pending, trademarks, service marks, trade names, service names, slogans, registered copyrights, commercially significant unregistered copyrights, technology rights and licenses, computer software (including, without limitation, any source or object codes or related documentation), trade secrets, franchises, know-how, inventions, and all improvements to such intellectual property.

1.9. **"RBHA Management Contract"** means the written agreement entered into by Cenpatico and the Arizona Department of Health Services for the management of the Arizona Regiona Behavioral Health Association programs.

1.10. **"Medically Necessary"** shall mean the provision of a Covered Prescription Drug Service which a Covered Person requires as determined by one or more participating providers, in accordance with generally accepted medical practice standards in effect at the time of treatment and in conformity with the professional and technical standards adopted by the Quality Improvement and Utilization Management Committee(s) of HMO and its subsidiaries and not solely for the convenience of the Covered Persons.

1.11. **"Non-Covered Services"** shall mean those health care services that are not Covered Prescription Drug Services and are not benefits under the ADHS/RBHA Contract and are, therefore, the financial responsibility of the Covered Persons, or are to be paid by the ADHS fee-for-service programs.

1.12. **"Participating Pharmacy(ies)"** means a pharmacy, including a retail service pharmacy, or a pharmacist which/who has entered into an agreement with Manager under which pharmacy/pharmacist has agreed to provide Covered Prescription Drug Services to Covered Persons and to comply with (i) contractual requirements pursuant to this Agreement, and (ii) statutory and regulatory requirements.

1.13. **"Pharmacy & Therapeutics Committee"** or **"P&T Committee"** means the HMO committee that: (i) considers a prescription drug for inclusion on the HMO Preferred Drug List or other comparable formularies, and (ii) develops other criteria, procedures, and rules for the Program including, but not limited to, quantity levels and prior authorization issues.

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obligations under this Agreement, including, without limitation, a certificate of authority as a third party administrator. Manager shall promptly notify HMO of any and all licensing, administrative, or legal actions initiated against it by any government agency which has as a potential remedy the loss or limitation of any license or which is likely to result in the inability of Manager to fulfill and perform its duties under this Agreement. Manager shall be solely responsible for any fines, penalties, or other assessments imposed against it or against HMO by any state or federal regulatory authority which arise out of Manager's failure to comply with HMO's procedures for administering PBM Services. In the event a state or federal regulatory authority imposes a fine, penalty or other assessment against HMO for acts or omissions caused by Manager's failure to comply with this Agreement, Manager shall reimburse HMO in full for such fine, penalty or other assessment within ten (10) days of receiving written notice from HMO. Manager shall perform the PBM Services required under this Agreement in accordance with all applicable state and federal laws and regulations, including, without limitation, those relating to the activities of third party administrators.

2.1.4. No Conflict; Required Filings and Consents. Manager represents and warrants to HMO that the execution, delivery, and performance of this Agreement does not, and the provision of the services contemplated hereby will not: (a) conflict with the Articles of Incorporation or Bylaws or other corporate documents of Manager; (b) conflict with or violate any laws applicable to Manager or by which any of its properties is bound or affected; or (c) result in any breach of or constitute a default (or an event that with notice or lapse of time or both would become a default) under, or give to others any rights of termination, amendment, acceleration, or cancellation of, or result in the creation of a lien or encumbrance on any of the properties or assets of Manager pursuant to any note, bond, mortgage, indenture, contract, agreement, lease, license, permit, franchise, or other instrument or obligation to which Manager is a party, or by which Manager or any of its properties is bound or affected. The execution and delivery of this Agreement by Manager does not, and the performance of this Agreement by Manager and the provision of the services contemplated hereby by Manager will not, require any consent, approval, authorization or permit of, or filing with or notification to, any third party, except for certain filings required by certain state governmental entities.

2.1.5 Financial Viability. Manager represents and warrants that it has sufficient net worth and financial reserves to meet its reasonably foreseeable needs under the terms of this Agreement and the Cenpatico/ADHS Contract. Upon request by HMO, Manager shall provide HMO a copy of its most recent audited financial statements.

2.2. Representations and Warranties of HMO.

2.2.1. Organization and Qualification. HMO represents and warrants to Manager that it is a corporation duly incorporated, validly existing, and in good standing under the laws of Delaware. HMO has the corporate power and authority necessary to own and operate its properties and to carry on its business as now conducted. HMO is qualified to do business as a foreign corporation in

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every jurisdiction in which the nature of its business or its ownership of property requires it to be so qualified.

2.2.2. Corporate Authorization. HMO represents and warrants to Manager that the execution, delivery, and performance of this Agreement are within its corporate powers. All requisite authority necessary to enter into this Agreement has been obtained, and HMO has duly and validly executed and delivered this Agreement. Assuming this Agreement constitutes the valid and binding agreement of Manager, this Agreement constitutes a valid and binding agreement of HMO enforceable against HMO in accordance with its terms.

2.2.3. Regulatory Compliance. HMO represents and warrants that Health Plans are currently, and shall remain throughout the duration of this Agreement, duly licensed as required to enter into and provide benefits under the Benefit Contracts. HMO shall promptly notify Manager of any and all licensing, administrative, or legal actions initiated against it or Health Plans by any state or federal government agency which has as a potential remedy the loss or limitation of its licensure or which is likely to result in the inability of HMO to fulfill its obligations under this Agreement. HMO or Health Plans shall be solely responsible for any fines, penalties, or other assessments imposed against them by any state or federal regulatory authority which arise out of HMO's or Health Plans' acts or omissions in connection with the administration of the Benefit Contracts. HMO shall perform its duties under this Agreement in accordance with all applicable state and federal laws and regulations.

2.2.4. No Conflict; Required Filings and Consents. HMO represents and warrants to Manager that the execution, delivery, and performance of this Agreement does not, and the performance of this Agreement by HMO will not: (a) conflict with the Articles of Incorporation or Bylaws of HMO; (b) conflict with or violate any laws applicable to HMO or by which any of its properties is bound or affected; or (c) result in any breach of or constitute a default (or an event that with notice or lapse of time or both would become a default) under, or give to others any rights of termination, amendment, acceleration, or cancellation of, or result in the creation of a lien or encumbrance on any of the properties or assets of HMO pursuant to any note, bond, mortgage, indenture, contract, agreement, lease, license, permit, franchise, or other instrument or obligation to which HMO is a party, or by which HMO or any of its properties is bound or affected. The execution and delivery of this Agreement by HMO does not, and the performance of this Agreement by HMO will not, require any consent, approval, authorization or permit of, or filing with or notification to any third party, except for certain filings required by certain state governmental entities.

III. OBLIGATIONS OF MANAGER: PHARMACY BENEFIT MANAGEMENT AND SERVICES

3.1. General Manager Services. Manager shall provide to HMO the PBM Services described in this Agreement and in **Exhibit** B and C.

3.2. Retail Participating Pharmacy Network. Manager agrees to provide networks of retail Participating Pharmacies under contract with Manager to provide dispensing services to Covered Persons under the Retail Pharmacy Program. Manager agrees that HMO may

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require the termination of a specific retail pharmacy for good cause including quality of care issues. Manager shall notify HMO of any terminations in the Participating Pharmacy network. Manager shall send letters to Covered Persons who have utilized a Participating Pharmacy in the prior twelve months notifying them of the termination of such Participating Pharmacy, after receiving from HMO: (a) the addresses of the affected Covered Persons; and (b) the approval of the letters by HMO. HMO shall be responsible for the postage costs of any mailings to Covered Persons when a Participating Pharmacy is terminated at HMO's request. Manager shall be responsible for the postage costs of any mailings to Covered Persons when Participating Pharmacy is terminated at Manager's request. Manager agrees that during the term of this Agreement all Manager customized pharmacy provider agreements for such retail pharmacy network shall be assignable to HMO. Such assignment shall be made at HMO's sole discretion and at a time determined by HMO.

3.3. Pharmacy Network Information. Manager shall provide HMO with a complete list of the names, addresses, license numbers, and normal office hours of the Participating Pharmacies, together with the provider-specific information required by HMO, at the time this Agreement is signed and thereafter as such information becomes available. Manager shall provide at least ninety (90) calendar days prior written notice to HMO of the proposed termination of Participating Pharmacies if a group of 5 or more pharmacies is terminated at one time or if such termination of one or more pharmacies would result in the pharmacy network not meeting state access standards .

3.4. Consultation. Manager shall provide ongoing consultation and assistance to HMO with respect to the delivery of PBM Services to Covered Persons. The scope of such assistance shall include, without limitation, advice and recommendations regarding the PBM Services, provider network, and claims. Manager shall educate HMO's provider network regarding Manager's policies and procedures in a reasonably prudent manner.

3.5. HMO Policies. Manager shall perform the PBM Services in accordance with the standards, policies, procedures, and requirements established by HMO for such activities and in accordance with applicable state and federal law. Manager may utilize its own policies and procedures for the PBM Services, provided that such policies and procedures are consistent with the HMO standards and requirements and are provided to HMO for its review and approval.

3.6. Laws, Regulations and Licenses. Manager, at its own cost, shall: (a) maintain all federal, state, and local licenses that are materially necessary to provide PBM Services under this Agreement and the lack of which could adversely affect HMO; (b) shall comply with all applicable statutes and regulations in providing all PBM Services pursuant to this Agreement; and (c) require all Participating Pharmacies employed by or under contract with Manager to comply with (a) and (b).

3.7. Personnel and Other Resources. Manager shall provide sufficient, dedicated personnel, information systems support, and other resources, as reasonably required to successfully provide high-quality, cost-effective PBM Services for HMO pursuant to this Agreement.

3.8. Customized Installation Materials. Manager agrees to provide to HMO customized installation materials for HMO that are accurate and support the specific

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language in the Benefit Contracts. Manager is responsible for administering the Benefit Contracts accurately and in accordance with all regulatory requirements.

3.9. Communications. At HMO's option and approval, Manager shall produce brochures, and other materials for Covered Persons specific to Covered Prescription Drug Services. Manager agrees to provide an accompanying explanatory brochure and direct reimbursement claim forms for use by Covered Persons who have not received or who have lost their identification cards. Manager agrees that any materials sent to Covered Persons must be approved by HMO. HMO shall be responsible for all postage costs related to mailings to Covered Persons, except as otherwise provided in this Agreement. Manager agrees that all written communications sent to HMO Covered Persons, Participating Pharmacies, or facilities that relate in any way to HMO's Benefit Contracts must be reviewed and approved by HMO before such communications are sent out to any such individuals or groups. Manager agrees that all program communication protocols to be used with HMO Participating Pharmacies will be reviewed and approved by HMO prior to use. HMO shall approve or disapprove all such materials within a reasonable time after submission by Manager.

3.10. Eligibility and Claims Processing.

3.10.1. Eligibility. Manager shall administer the eligibility of Covered Persons according to eligibility information provided by HMO via tape or telecommunication or such other reasonably practicable method in a mutually agreeable acceptable format. Manager shall load eligibility tapes within one (1) business day and inform HMO upon completion. Manager agrees to provide toll-free access for network pharmacies to Manager's customer service department for claims processing assistance. Manager shall notify HMO immediately upon becoming aware of any discrepancies in the eligibility information.

3.10.2. Payment of Claims. Manager shall process Covered Persons' Covered Prescription Drug Services in accordance with the Benefit Contracts, Manager's standard operating procedure, and any applicable statutory and regulatory requirements governing third party administrators, including but not limited to any prompt payment of claims requirements. Claims adjudication includes, without limitation: (i) an explanation to a Covered Person of benefits describing any payment reduction or denial of the claim; (ii) a request for additional information to determine benefits; (iii) a notification that additional information is required from a provider; and (iv) payment for clean claims, as defined in any applicable law or regulation.

3.10.3. Disputes. Any disputes over claims shall be resolved prior to payment by Manager. If Manager makes an error or omission in claims processing, Manager shall be solely responsible for any related costs.

3.10.4. Postage. All postage costs related to payment or denial of direct reimbursement claims are the responsibility of Manager.

3.10.5. Claims Reports. Manager shall provide claims reports and written notice to HMO of the amount necessary to pay the fees due to Manager for claims processed, as set forth in **Exhibit A**. Manager will provide HMO with a claims

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processing fee statement pursuant to **Exhibit A**. Within 15 days after receipt of each statement from Manager, HMO shall remit payment of such fees.

3.10.6. Claims Auditing. Manager shall regularly audit its electronic and on-site claim processing activities and shall regularly audit its retail pharmacies, in accordance with Manager's standard audit procedures. Manager shall provide HMO with a report on such audits containing specific audit information and containing such other information as HMO reasonably requests. HMO shall receive one hundred percent of any such audit recoveries that were incorrectly paid pursuant to the HMO PBM Services. When any such overpayment was the result of errors or omissions by Manager, payment of such audit recovery shall include interest at the prevailing prime rate of interest for the period of time from the payment of the claim to receiving recovery from Manager.

3.10.7. Claim Appeals. In the event of a claim denial by Manager, Manager shall promptly communicate to the Covered Person the right to appeal according to the Covered Person's Benefit Contract and applicable law. Manager shall assist HMO in dealing with the Covered Person's appeal of Manager's decisions.

3.11. Covered Person Hold Harmless Provision. Manager agrees that it shall look only to the applicable Health Plan and agrees to hold Covered Persons harmless for compensation for all services provided to Covered Persons during the term of this Agreement. Under no circumstances, including but not limited to, nonpayment by Health Plan, Health Plan's insolvency or breach of this Agreement, shall Manager or any Participating Pharmacy bill, charge, collect a deposit or Surcharge from or seek compensation, remuneration, or reimbursement from, or have any recourse against, Covered Person or persons (other than Health Plan) acting on the Covered Person's behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or Copayments made in accordance with the terms of the applicable Benefit Contract, nor does this provision affect the right of Participating Pharmacy to collect fees for services to Covered Persons which do not constitute Covered Services or for which Covered Person has specifically assumed financial responsibility, in writing, prior to the time that services were rendered. Manager further agrees that this provision shall: (i) survive the termination of this Agreement, regardless of the reason for termination, and shall be for the benefit of the Covered Person; (ii) supersede any oral or written agreement now existing or hereafter entered into between Manager and a Covered Person or persons acting on the Covered Person's behalf; and (iii) be construed to inure to the benefit of Covered Persons and persons acting on the Covered Person's behalf. Any modifications, additions, or deletions to this provision shall be effective no earlier than fifteen (15) days after any applicable regulatory authority has received any required written notice of and has approved such changes.

3.12. Reports. Manager agrees to provide reports to HMO in a format and containing such information as HMO reasonably requests, including but not limited to, claims paid, claims denial, claims lag, coordination of benefits, and third-party liability reports. The reports shall contain the information set forth in **Exhibit C**. If a state fine or penalty is imposed upon HMO due to Manager's failure to provide reports on the required due date, then Manager shall reimburse HMO for the full amount of the fine and any incidental expenses.

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3.13. Coordination of Benefits. When HMO provides required information, Manager agrees to administer coordination of benefits in accordance with HMO's coordination of benefits rules and the Benefit Contracts.

3.14. Service Performance Standards. HMO and Manager shall each use good faith and reasonable commercial efforts to perform their respective duties and obligations under this Agreement in a diligent, professionally responsible, and efficient manner. The parties agree to cooperate with and assist each other as reasonably necessary in the performance of their respective duties and in developing timely responses to the needs of HMO's business. Manager shall perform the services for which it is responsible under this Agreement using the same degree of skill and care in such performance as a prudent person engaged in pharmacy benefit management services would use under substantially similar circumstances. Manager accepts the service performance standards set forth in **Exhibit** C hereto, including the fees which shall be at risk if the performance standards and guarantees are not met. Manager shall provide to HMO monthly or quarterly reports, as applicable with respect to Manager's performance, and annual statistics, within ninety (90) days of the end of the calendar year, demonstrating whether Manager met the service performance standards described in **Exhibit** C. At such time that Manager provides such reports to HMO, Manager shall reimburse HMO any monies owed because of Manager's failure to meet such service performance standards and guarantees.

3.15. Insurance. Manager shall procure by the Effective Date and shall maintain, at its own expense: (a) professional liability insurance in the amount of $5,000,000.00 per occurrence and $10,000,000.00 annual aggregate including coverage for errors and omissions; (b) general liability insurance in the amount of $1,000,000.00 per each occurrence and $3,000,000.00 annual aggregate; and (c) umbrella/excess liability insurance in the amount of $10,000,000.00 each occurrence and aggregate. HMO must be named as an "additional insured" on the policies referenced above for claims affecting HMO's interests.

3.15.1. Nature of Insurance. Manager's and its contractors' or subcontractors' insurance policies shall: (i) be issued by companies that are admitted insurers in the jurisdiction in which all or a majority of the services or products are being provided, that have an A.M. Best rating of not less than "A-", and are in a size category which is not lower than "VIII"; (ii) be primary and noncontributory with any of HMO's insurance or self-insurance; (iii) name HMO as an additional insured; and (iv) not be cancelable, non-renewable or materially changed except after not less than thirty (30) days written notice to HMO. Manager shall provide to HMO certificates of insurance evidencing the insurance coverage required by this Section.

3.15.2 Liability. None of the foregoing requirements as to the type and limits of insurance to be maintained by Manager are intended to and shall not in any manner limit or qualify the liabilities and obligations assumed by Manager under this Agreement.

3.16. Claims and Regulatory Inquiries. Manager shall, within ten (10) days, provide information to HMO regarding all non-routine inquiries by regulatory departments, pharmaceutical manufacturers, attorneys, Covered Persons, or other individuals or entities

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with respect to Manager's services pursuant to this Agreement, including, but not limited to, the denial of any claims or any causes of action.

3.17. Books and Records. Manager shall maintain adequate medical, financial, and administrative records related to PBM Services in a manner consistent with the standards of the community and in accordance with all applicable statutes and regulations, including, but not limited to, reasonable documentation of all the data of Covered Persons related to Manager's services under this Agreement to determine whether Manager is performing its obligations under the Agreement and correctly billing HMO. HMO shall have the right to review such data at reasonable times and upon reasonable notice. If any audit reveals an underpayment or overpayment by HMO to Manager, such discrepancy will be reported to Manager, and Manager will respond within forty-five (45) days. Any amounts deemed payable as a result thereof shall be promptly repaid to the appropriate party with accrued interest (whether or not this Agreement has terminated). If the parties disagree on the amount to be repaid, the matter shall be resolved in accordance with Section 11.5. This obligation shall survive the expiration or earlier termination of this Agreement.

3.18. Accreditation. Manager agrees to provide HMO with reasonable assistance and cooperation in meeting all accreditation standards, including but not limited to National Committee for Quality Assurance standards, applicable to the services provided pursuant to this Agreement.

3.19. Utilization Review. In accordance with the terms and conditions of the delegation standards attached hereto as **Exhibit** C, Manager shall, for and on behalf of HMO, establish and administer a utilization review program in connection with PBM Services provided or proposed to be provided to Members, utilizing the standards, criteria, protocols and procedures established by HMO and in accordance with the applicable requirements of state and federal law and NCQA standards. Manager agrees to abide by, and shall have each of its employees or contracted providers performing utilization review services under this Agreement sign a written statement agreeing to abide by, the following NCQA standards: (1) any and all utilization review decisions made under this Agreement shall be based only on the appropriateness of the proposed prescription drug services and the existence of coverage for such services; (2) neither contracted providers nor Manager's staff or other individuals conducting utilization review are rewarded for issuing denials of coverage; and (3) financial incentives provided to persons conducting utilization review are not used to encourage decision-making that results in under-utilization of Covered Prescription Drug Services.

3.20 Submission of Electronic Files. On a quarterly basis, Manager shall submit directly to HMO's database contractor electronic files of data maintained pursuant to this Agreement on a quarterly basis. The submission shall consist of electronic standard NCPDP claims payment files files.

IV. OBLIGATIONS OF HMO

4.1. General.

4.1.1. HMO will be the entity that contracts with Health Plans related to the services provided under this Agreement. Such agreements between HMO and Health Plans may provide for additional services by HMO and shall make

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provision for fees and other terms that HMO, in its discretion, determines to establish.

4.1.2. HMO agrees to provide information reasonably needed by Manager to administer its responsibilities under this Agreement including (a) Benefit Contracts documents; (b) timely eligibility and enrollment data on Covered Persons; (c) specific HMO customer information and needs; (d) Participating Pharmacy information when Manager's pharmacy network is not utilized or is used in addition to another participating pharmacy network; (e) patient identifiable prescription drug claims (including prescription drug claims from prior pharmacy benefit management vendors); and (f) patient identifiable medical claims reasonably necessary for Manager to implement and operate its clinical management programs for HMO. Information shall be provided in a mutually agreeable format.

4.1.3. HMO or Health Plans shall be solely responsible for drafting HMO's Benefit Contracts.

4.2. Payment to Manager. HMO shall compensate Manager for the PBM Services and the Covered Prescription Drug Services provided by Manager as described in Exhibit A to this Agreement. All payments to Manager shall be deemed final unless adjustment is requested within ninety (90) days of Manager's receipt of payment. HMO's request to recoup overpayments made to Manager, including overpayments made because of erroneous eligibility information, shall not be subject to such 90-day deadline. Except for fee-for-service (Billback) claims described in Section 2 of Exhibit A, HMO shall have no further obligation for payment related to the Covered Prescription Drug Services under its Benefit Contracts. Manager shall be at financial risk for the cost of covered prescription drug services as specified in a separate letter agreement executed by both parties hereto and which shall constitute a legally binding part of this agreement.

HMO shall remit payments to Manager on a monthly basis, by the 10th business day of each month. Payments shall be remitted via wire transfer to the account(s) designated by Manager or by other means as mutually agreed upon, provided such invoices contain all information necessary for HMO to determine its liability in the case of fee-for-service (Billback) claims and to determine the number of Covered Persons under this Agreement in the case of capitated fees. For each month for which payment is due, HMO shall be liable for payment of capitated fees to Manager for only those Covered Persons for whom HMO receives capitation from the State. Manager shall invoice such fees by the third business day of each calendar month and shall provide written detail for adjustments of fees assessed in prior months due to all eligibility status changes.

4.3. Regulatory. HMO shall (a) maintain all material federal, state, and local licenses that are reasonably required to operate its business; (b) comply with all material applicable statutes and regulations; and, (c) make reasonable commercial efforts to cause Health Plans to comply with (a) and (b).

4.4. Insurance. HMO agrees to maintain adequate insurance related to the operation of its business and its obligations under the Agreement.

4.5. Claims and Regulatory. HMO shall promptly provide information to Manager within ten (10) days about all non-routine inquiries by regulatory authorities,

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pharmaceutical manufacturers, or Covered Persons, with respect to the services provided by Manager under this Agreement.

4.6. Audits. HMO shall keep reasonable documentation of all Covered Persons related to this Agreement. Manager shall have the right to review such data at reasonable times upon reasonable notice.

V. PREFERRED DRUG LIST

5.1. Preferred Drug List. Beginning on the Commencement Date or on such later date designated by HMO and continuing through the term of this Agreement, Manager shall administer the HMO PDL or other formularies as developed by HMO from time to time pursuant to the Benefit Contracts.

5.1.1. HMO Preferred Drug List. The Preferred Drug List ("PDL") is a list that identifies those FDA approved prescription drug products that are preferred by HMO for dispensing to Covered Persons. HMO's PDL will at minimum contain the the medications listed on the ADHS/DBHS Medication listing that is in the ADHS/DBHS Provider manual and may contain additional covered medications.

5.1.1.1. HMO and its P&T Committee have complete control in deciding what prescription drugs are placed on the PDL from time to time.

5.1.1.2. Manager shall have the right to present clinical data and rationale to the P&T Committee in conjunction with its evaluation of prescription drugs, but shall not be a voting member of the P&T Committee.

5.1.2. Preferred Drug List Compliance. HMO has in effect certain Program features designed to promote prescribing of PDL drugs by participating providers, dispensing of PDL drugs by Participating Pharmacies, and awareness of the advantages of the PDL by Covered Persons. Such features include, but are not limited to, incented benefit plan designs and corresponding levels of Copayments. HMO shall notify Manager, in advance, of any proposed Program modifications that are reasonably anticipated to have a material effect on PDL compliance. Additionally, HMO shall, as its option, participate in Manager's formulary communications programs, which may include communications with HMO Covered Persons, Participating Pharmacies and/or physicians, and financial incentives to Participating Pharmacies for their participation in the PDL. Manager shall notify HMO, in advance, of all PDL communications programs. HMO shall approve and may make reasonable changes to the content of such PDL communication programs before they are provided to the above HMO groups and individuals.

5.2. PDL Rebate Program. Pursuant to agreements entered into between Manager and certain pharmaceutical manufacturers ("Manufacturer Agreements"), Manager receives PDL Rebates from certain drug manufacturers as a result of the inclusion of such manufacturer's branded products on the PDL ("PDL Rebates"). Manager also receives and retains additional rebates and/or fees from certain manufacturers which may take into account various factors, including the utilization of certain drugs within

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their respective therapeutic categories for Manager's business in aggregate as a result of various commitments, services, and programs including, but not limited to, formularies (e.g. cost effective, incentive, volume, and market-share rebates). Manager shall fully disclose to HMO all rebates that Manager receives on HMO's behalf.

5.2.1. Rebate Distribution. Manager shall in good faith calculate the portion of any such rebates received that are allocable to PBM Services provided pursuant to this Agreement. Any disagreements related to such allocation determination shall be resolved in accordance with **Section 11.5**.

5.2.2. Drug Formulary Only Administration. Manager shall, at HMO's request, provide drug formulary only rebate administration for no additional fee for pharmacy claims processed by other entities, if such business qualifies for PDL Rebates. Such entities shall comply with Manager's data format requirements and processes.

VI. CONFIDENTIALITY

6.1. Confidential and Proprietary Information. In fulfilling the objectives of this Agreement, HMO and Manager may provide to each other or learn (directly or indirectly) certain information which a party considers to be confidential or proprietary ("Confidential Information"). Confidential Information shall include, without limitation, information relating to Covered Person and provider identities; reimbursement procedures; claims adjudication procedures; software and financial systems; the specific financial sections and provisions, specific operational aspects, financial guarantees contained in this Agreement, and other information relating to each party's business which is not generally available to the public. Each party's Confidential Information shall also include confidential, proprietary information which a third party has disclosed to a party, and which such party is obligated to maintain as confidential. Notwithstanding the foregoing, Manager and HMO acknowledge the other party's obligation to provide its pharmaceutical manufacturers and customers with information generally regarding this Agreement and, consistent with the foregoing, agrees that such parties may disclose generally the terms of this Agreement.

6.1.1. Neither party shall have any obligation to disclose its Confidential Information to the other party, unless such an obligation is set forth elsewhere in this Agreement.

6.1.2. Each party agrees to maintain the secrecy of and not to use or disclose the other party's Confidential Information, except as required in order for a party to perform under this Agreement. A party may disclose the other party's Confidential Information only to the receiving party's directors, officer, employees, agents and representatives (collectively, the "Representatives"), but only if a Representative needs to know the Confidential Information in order for the receiving party to perform under this Agreement. The parties agree to inform their Representatives of the confidential nature of the disclosing party's Confidential Information, and each party shall require any Representative, who is not an employee of the receiving party to sign an appropriate confidentiality agreement to protect the disclosing party's Confidential Information from unauthorized use or disclosure. Each party shall direct its Representatives to

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treat the other party's Confidential Information confidentially and not to use it other than to perform under this Agreement. Each party shall be responsible for its Representatives' use and disclosure of the other party's Confidential Information.

6.1.3. The restrictions in this **Section 6.1** shall not apply to: (a) information which is or becomes generally available to the public, other than as a result of a disclosure by the receiving party; (b) information a party obtains from a third party which has no obligation to keep the information confidential; (c) information which a party had in its possession prior to receiving Confidential Information from the disclosing party; (d) information which is independently developed by a party without reference to the Confidential Information disclosed by the other party; or (e) information required to be disclosed by law, subject to compliance with **Section 6.1.4**.

6.1.4. The parties agree that if a party is required (by subpoena, civil investigative demand or similar process) to disclose the other party's Confidential Information, the disclosing party shall notify the other party of the request or requirement so that the other party may seek an appropriate protective order or waive compliance with the sections or provisions of this Agreement. The parties agree to exercise their commercially reasonable efforts to assist each other in obtaining a protective order or other reliable assurance that confidential treatment will be accorded the Confidential Information.

6.1.5. Manager recognizes and agrees that HMO has a valuable business relationship with each of its Covered Persons and, further, that Manager stands in a position to influence Covered Persons decisions concerning insurers. In recognition of HMO's valuable business relationships with its Covered Persons, Manager agrees that, during the term of this Agreement, and after termination of this Agreement for any reason whatsoever, Manager shall not solicit Covered Persons, directly or indirectly, to enroll in any other health insurance or health coverage or alternative health care delivery system. Manager's obligation not to solicit Covered Persons is a material inducement for Manager's engagement by HMO pursuant to this Agreement.

6.1.6. The parties acknowledge and agree that irreparable injury will result to the other party in the event of a party's breach of these covenants, that a material inducement for the parties engagement by the other party are the covenants set forth in this **Section 6.1**, and that monetary damages in an action at law would not provide an adequate remedy in the event of a breach of this **Section 6.1**. The parties further acknowledge and agree that the covenants set forth in this **Section 6.1** are necessary for the protection of each party's legitimate business and professional duties, ethical obligations, and interests, and are reasonable in scope and content. Accordingly, in the event of either party's breach of this **Section 6.1**, or any part of this **Section 6.1**, this **Section 6.1** may be enforced by the obtaining of an injunction to restrain the violation thereof by the breaching party and all persons acting for or with such party.

6.1.7. Upon termination of this Agreement each party will immediately discontinue use of the other party's Confidential Information, and shall return the other party's Confidential Information to it, or destroy the other party's

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Confidential Information in its possession or control. However, each party may retain the other party's Confidential Information to the extent such Confidential Information has been used in or integrated into reports, studies, analyses, compilations or other documents in the receiving party's possession or control. Any oral Information will continue to be subject to the terms of this letter agreement. The parties agree that the Confidentiality obligations of this **Article VI** shall survive termination of this Agreement.

6.2. Privacy of Individually Identifiable Health Information. HMO and Manager will maintain the privacy and confidentiality of all individually identifiable protected health Information (PHI) regarding Covered Persons in accordance with all applicable statutes and regulations. In addition, Manager will:

6.2.1. Not use or further disclose the Protected Information other than as permitted or required by this Agreement or as required by law;

6.2.2. Use appropriate safeguards to prevent use or disclosure of the Protected Information other than as provided by this Agreement;

6.2.3. Report to HMO any use or disclosure of the Protected Information not provided for by this Agreement of which it becomes aware;

6.2.4. Ensure that any agents, including a subcontractor, to whom Manager provides Protected Information received from, or created or received by Manager on behalf of, HMO agrees to the same restrictions and conditions that apply to Manager with respect to such Protected Information;

6.2.5. Make available to Covered Persons Protected Information in accordance with those provisions of the Health Insurance Portability and Accountability Act ("HIPAA") relating to a Covered Person's right to access his or her health information;

6.2.6. Make available to Covered Persons Protected Information for amendment and incorporate any amendments to Protected Information in accordance with the HIPAA provisions providing therefor;

6.2.7. Make available to Covered Persons the information required to provide an accounting of disclosures in accordance with the HIPAA provisions providing therefor;

6.2.8. Make its internal practices, books, and records relating to the use and disclosure of Protected Information received from, or created or received by Manager on behalf of, HMO available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining HMO's compliance with this subsection; and

6.2.9. At termination of this Agreement, if feasible, return or destroy all Protected Information received from, or created or received by Manager on behalf of, HMO that Manager still maintains in any form and retain no copies of such Protected Information or, if such return or destruction is not feasible, extend the protections of this Agreement to the Protected Information and limit further

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uses and disclosures to those purposes that make the return or destruction of the Protected Information feasible.

Manager and HMO shall require all employees to comply with this subsection. Manager agrees that all Covered Person information provided to Manager by HMO belongs exclusively to HMO.

6.3. HMO's Database. Subject to **Section 6.4** below, Manager agrees that all data of HMO and its affiliates, including but not limited to Covered Person, customer, and provider related data, which is in Manager's possession, whether obtained by Manager in the course of providing services for HMO or as a result of a data transfer between HMO and Manager, belongs solely to HMO. Manager has the right to possess and use such data only to the extent permitted by contracts between the parties or as otherwise provided in this Agreement, subject to applicable legal restrictions. All information contained in HMO's database and systems belongs exclusively to HMO. Manager shall not have direct access to HMO's database and systems without signing a separate agreement with HMO. Manager and HMO recognize and agree that only information necessary for Manager performance under the Agreement shall be supplied by HMO to Manager, and Manager agrees that such data belongs exclusively to HMO.

6.4. Manager Use of Data. Notwithstanding the foregoing provisions of this **Article VI**, Manager may incorporate prescription data into Manager's prescription database when that database is used by Manager or provided to others for research, statistical, marketing, sales tracking or similar purposes. Manager agrees that if such prescription data is identifiable as to (a) Covered Persons, (b) employers and/or customers, and/or (d) HMO, such identifiable information will be deleted or encrypted before it is provided to others. This section only applies to Manager's use of prescription data and does not apply to medical data.

6.5. Pharmaceutical Agreements. Manager's agreements with pharmaceutical manufacturers are subject to confidentiality agreements. Any audit of Manager's agreements with pharmaceutical manufacturers conducted pursuant to this Agreement, shall be conducted by a third party public accounting firm reasonably acceptable to Manager whose audit department is a separate stand alone function of its business, subject to execution of a confidentiality agreement, and shall include only those portions of such pharmaceutical manufacturer agreements as necessary to determine Manager's compliance with **Article VI** in respect to PDL Rebates.

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VII. INTELLECTUAL PROPERTY

7.1. Manager's Property. Any Intellectual Property developed solely by Manager without using HMO's Confidential Information shall remain the property of Manager. HMO's right to use such Manager Intellectual Property shall be limited to those permitted by this Agreement or as otherwise agreed to in writing by the parties.

7.2. HMO's Property. Any Intellectual Property developed solely by HMO, without utilizing Manager's Confidential Information shall remain the property of HMO. Manager's right to use such Intellectual Property shall be limited to those permitted by this Agreement or as otherwise agreed to in writing by the parties.

7.3. Joint Property. The parties agree that any Intellectual Property or work product: (a) created jointly by the parties; or (b) created by Manager under this Agreement; or (c) created by Manager upon HMO's request (the "Work Product"), shall be the joint property of Manager and HMO.

7.4. Name, Symbol, and Service Mark. Manager and HMO agree that each party may use the other party's name in its discussions with prospective clients and in marketing and promotional materials, directories, and other communications. Each party shall provide to the other party a copy of any written materials containing the other party's name and shall obtain the prior written consent to such use from the other party. No use of the registered service marks of Manager or HMO by the other is permitted without prior written consent.

VIII. INDEMNIFICATION

8.1. By HMO. HMO agrees to indemnify and hold Manager, its subsidiaries and affiliates, and their respective officers, directors, agents, and employees harmless from and against any and all liabilities, losses, proceedings, actions, damages, claims, or expenses of any kind, including reasonable attorneys' fees, which result from (a) a breach by HMO of any of its obligations under this Agreement or (b) the negligent or willful acts or omissions by HMO, its agents, directors, officers, or employees, in connection with the representations, duties, and obligations of HMO under this Agreement.

8.2. By Manager. Manager agrees to indemnify and hold HMO, its subsidiaries and affiliates, and their respective officers, directors, agents, and employees harmless from and against any and all liabilities, losses, proceedings, actions, damages, claims, or expenses of any kind, including reasonable attorneys' fees, which result from (a) a breach by Manager of any of its obligations under this Agreement or (b) the negligent or willful acts or omissions by Manager, its agents, directors, officers, or employees, in connection with the representations, duties, and obligations of Manager under this Agreement.

IX. TERM AND TERMINATION

9.1. Term. The term of this Agreement is for the period of one year, commencing on the Commencement Date, unless terminated earlier as outlined in this **Article IX**. This Agreement shall automatically renew for successive one-year periods, unless terminated pursuant to this **Article IX**.

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9.2. Termination. This Agreement may be terminated as follows:

9.2.1. By either party at the end of any term, without cause, by providing at least ninety (90) days prior written notice of termination to the other party.

9.2.2. At any time by the mutual written consent of the parties.

9.2.3. By either party at any time, for cause, by providing sixty (60) days prior written notice to the other party upon the breach by such party of any material term, covenant, or condition of this Agreement, unless such breach is cured to the reasonable satisfaction of the terminating party within such sixty (60) day notice period.

9.2.4. Immediately by HMO, by providing notice to Manager, upon the expiration, non-renewal, or revocation of any license, certificate, approval, or authorization of Manager to perform any or all of the PBM Services.

9.2.5. By either party, effective immediately upon provision of written notice to the other party, if the other party has become insolvent or has been dissolved or liquidated, makes a general assignment for the benefit of creditors, or has a receiver appointed for a substantial portion of its assets.

9.2.6. Automatically and without any notice or other action on the part of either party if either party files, or has filed against it, a petition in bankruptcy and such petition is not dismissed within 60 days of the filing, unless the party which is not subject to such petition elects to waive such termination prior to the expiration of such 60 day period.

9.2.7. By either party immediately due to loss of insurance or inability to self-insure as required under this Agreement.

9.3. Information to Covered Persons. Manager acknowledges the right of HMO to inform Covered Persons of Manager's termination.

9.4. End of Term or Termination. In the event this Agreement is terminated for any reason prior to its expiration or upon the end of the term, Manager and HMO shall cooperate reasonably with each other for up to a six (6) month period following such termination or expiration to effect a quality, cost-effective and smooth transition of HMO's business previously operated or managed by Manager to HMO or HMO's designee.

9.5. Effect of Termination. Any termination of this Agreement shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Termination of this Agreement shall not release Manager or its Participating Pharmacies from their obligations to continue to provide PBM Services and Covered Prescription Drug Services for which compensation has been received prior to the effective date of termination.

9.6. Continuity of Care. Upon termination of this Agreement for any reason other than a quality of care issue, Manager and HMO shall comply with any applicable

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requirements for continuity of care as set forth in Wisconsin Insurance statutes Section 609.24.

X. ADHS CONTRACT REQUIREMENTS

10.1. Compliance with ADHS Contract. Manager shall abide by all applicable provisions of the ADHS Contract. Manager's compliance with the ADHS Contract specifically includes but is not limited to:

10.2. State Approval. This Agreement is subject to the prior review and approval by ADHS. HMO shall submit and obtain this approval prior to the Commencement Date.

10.3. Arizona Licensed Pharmacy Administrator. Manager shall use only an Arizona licensed pharmacist to oversee the Contractors medication services per the ADHS Contract.

10.4. Legal Liability. Nothing in this Agreement shall affect the legal liability of HMO in accordance with the ADHS Contract.

10.5. Quality Data. Manager shall participate in and contribute required data to HMO Quality Assessment/Performance Improvement programs, as defined in and required by ADHS Contract.

10.6. Pharmacy Encounter Data. Manager shall submit to HMO pharmacy encounter data in the format specified by HMO so that HMO can meet the State of Arizona ADHS contract specifications.

10.7. Non-discrimination. Manager shall comply with all non-discrimination requirements in ADHS Contract.

10.8. Access to and Confidentiality of Pharmacy Records. Manager shall provide to representatives of HMO, as well as duly authorized agents or representatives of ADHS and the federal Department of Health and Human Services, access to its premises and its contract and/or pharmacy records.

10.9. Referrals. Manager shall clearly specify referral approval requirements to its Participating Pharmacies and in any provider contracts.

10.10. Payment for Services. Manager shall not bill a RBHA Covered Person for Medically Necessary pharmacy services covered under the ADHS Contract and provided during the Covered Person's period of enrollment.

10.11. Grievances. Manager shall forward to HMO applicable medical records pertaining to grievances, within fifteen (15) working days of HMO's request. If Manager does not meet the 15-day requirement, Manager must explain the delay and indicate when the medical records will be provided.

10.12. Non-payment of Providers. Manager shall abide by the terms of the ADHS Contract regarding appeals to HMO and to ADHS for non-payment of providers.

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XI. GENERAL PROVISIONS

11.1. Notices. All notices or other communications required or permitted hereunder shall be in writing and shall be delivered personally, by commercial overnight delivery service, by facsimile or sent by certified, registered or express air mail, postage prepaid, and shall be deemed given when so delivered personally, by overnight delivery service or by facsimile, or if mailed, five days after the date of mailing, addressed as follows:

If to Manager:	If to HMO:
Caremark Rx Contract Services 2211 Sanders Road Northbrook, IL 60062 Attention: President	Cenpatico Behavioral Health 823 Congress Ave., Suite 600 Austin, TX 78701 Attention: President & CEO

or to such other address or to such other person as may be designated by written notice given from time to time during the term of the Agreement by one party to the other.

11.2. Force Majeure. Noncompliance with the obligations of this Agreement due to force majeure, laws or regulations of any government, war, civil commotion, destruction of production facilities and materials, fire, earthquake or storm, labor disturbances, shortage of materials, failure of public utilities or common carriers, and any other causes beyond the reasonable control of the applicable party, shall not constitute breach of contract.

11.3. Assignment. HMO may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with HMO; provided, however, that any such entity is reasonably able to perform any responsibilities which it assumes. HMO may assign its rights and responsibilities in such a way that both HMO and Assignee share in the rights and responsibilities that, prior to such assignment, were solely those of HMO. Manager may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with such party; provided, however, that any such entity is reasonably able to perform any responsibilities which it assumes. Manager and HMO each acknowledge that persons and entities under contract with such party, or in the case of HMO, Health Plans, may perform certain administrative services under this Agreement. Other than above, HMO and Manager agree that they shall not assign any of the rights and responsibilities under this Agreement without the prior written consent of the other party.

11.4. Amendment. Any amendments to this Agreement shall require written approval of the parties.

11.5. Dispute Resolution. In the event of a dispute arising out of this Agreement, the parties shall first attempt in good faith to resolve the dispute through informal discussions between themselves. Any claim, controversy, dispute or disagreement between the parties hereto which the parties are unable to resolve informally shall be resolved by binding arbitration by a single arbitrator in accordance with the Commercial Arbitration Rules of the American Arbitration Association (the "AAA") and administration of the

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arbitration shall be performed by AAA or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures of the AAA will be utilized. Arbitration hearings shall be held in Austin, TX or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by applicable law. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a district court of Missouri including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by applicable law, except that punitive damages shall not be awarded. The parties shall divide equally the expenses of the AAA and the arbitrator, but the arbitrator may assess all such costs and expenses to the non-prevailing party in the arbitrator's award. The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to applicable law.

11.6. Relationship Between HMO and Manager. The relationship between HMO and Manager is solely that of independent contractors, and nothing in this Agreement or otherwise will be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

11.7. Severability. If any provision of this Agreement shall be determined by any court of competent jurisdiction or arbitrator to be invalid and unenforceable to any extent under the law of any relevant jurisdiction, the remainder of this Agreement shall not be affected thereby, and each remaining provision shall be valid and shall be enforced to the fullest extent permitted by law.

11.8. Headings. The headings of the various sections herein are for convenience of reference only and shall not define, limit, or otherwise affect any of the terms or sections or provisions hereof.

11.9. Counterparts. This Agreement may be executed in one (1) or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

11.10. Governing Law. This Agreement shall be governed by and construed in accordance with applicable Illinois law without giving effect to conflict of law principles.

11.11. Entire Agreement. This Agreement and its Appendix, Exhibits, and Attachments constitute the entire Agreement between the parties with regard to the subject matter hereof and supercede any and all prior agreements, oral or written, between the parties with regard to the subject matter of this Agreement.

11.12. Regulatory Approval. The parties agree and acknowledge that the terms of this Agreement may be subject to review by state regulators.

11.13. Approvals. Approvals required under this agreement shall not be unreasonably delayed or withheld.

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11.14. No Third Party Beneficiaries. Nothing in this Agreement shall create or be deemed to create any third party beneficiary rights in any person or entity not a party to this Agreement.

11.15. Additional Agreements. Upon request, Manager agrees to enter into an additional separate agreement with any HMO affiliate receiving services hereunder reflecting the services received and obligations of such affiliate.

[SIGNATURE PAGE FOLLOWS]

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first set forth above.

CENPATICO BEHAVIORAL HEALTH 823 CONGRESS AVE., SUITE 600 AUSTIN, TX 78701	**CAREMARK RX** 2211 Sanders Rd. Northbrook, IL 60062
By:_____ Name: _____ Title: _____	By:_____ Name: _____ Title: _____

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EXHIBIT A
Financial Arrangements

"Average Wholesale Price" or **"AWP"** means the average wholesale price of the Covered Prescription Drug Services dispensed, utilizing the current price list in a nationally recognized pricing source, which Manager uses for all of its other customers, or, if Manager uses more than one source, then the source used for HMO shall be the source mutually agreed to by the parties. Under the Retail Pharmacy Program, AWP is based on the package size submitted.

"Maximum Allowable Cost" or **"MAC"** means the maximum acceptable cost of a generic product as determined from time to time by Manager. Manager shall provide its MAC list and prices to HMO upon request. Manager represents that its MAC pricing is generally no higher than HCFA MAC pricing and covenants that it shall give HMO written notice when any MAC price shall exceed the HCFA MAC price, which notice shall include the reasons for the discrepancy, if known, and the projected length of time that the MAC price will likely exceed the HCFA MAC price (if reasonable to estimate).

2. Charges for Covered Prescription Drug Services.

The following formulas shall be used to determine (a) the prices Manager shall pay for Covered Prescription Drug Services that are included as Covered Prescription Drug Services:

Lesser of Manager's actual payment or AWP minus 14% plus $2.00 dispensing fee for brands.

For generics, MAC plus $2.00 or AWP-20% plus $2.00 (whichever is actually paid to the dispensing pharmacy).
Plus, in each case (brands and generics), $0.35 administrative fee per paid claim.

4. Changes to the PDL.

Except as required by the ADHS or as mandated by applicable law, no changes to the PDL or Benefit Design (Exhibit D) will be implemented unless and until the change is agreed to by Manager and HMO.

5. Additional Administrative Fees.

HMO shall pay Manager for additional PBM Services HMO utilizes as follows:

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Exhibit B
PBM Services

The services listed below will be performed by Manager for behavioral health and ADHS Contract business. HMO can request the discontinuation of any service listed below and/or may perform any services listed below internally at HMO. Manager acknowledges that, from time to time, it will modify the services on this Agreement or add new services to be more effective. Such modified or new services will be provided to HMO.

1. **Claims Processing**
   - Electronic processing in-network
   - Paper claims processing in-network and out-of-network
   - Coordination of benefits administration
   - Twelve month on-line claims history retention
   - Monitor Participating Pharmacy compliance
   - On-line viewing access to claims history

2. **Eligibility Management**
   - Administration of eligibility submitted by multiple sources per tape or electronically with variable HMO formats with reasonable notice of changes to such formats
   - Load eligibility tapes within one (1) business day and inform HMO upon completion
   - Toll-free access to Manager's help desk for eligibility/claims processing assistance
   - Administration of paper adds/deletes/changes
   - 24 hour eligibility/claims processing support

3. **Benefits Management/Utilization Management**
   - Administration of benefits submitted electronically or by tape or by paper
   - Administration of paper adds/deletes/changes

4. **Pharmacy Network Management**
   - Establish, license-verification, contract, and maintain Participating Pharmacy networks for HMO
   - Develop and distribute communications to Participating Pharmacies following review by HMO

5. **Call Center Services**
   - 24 hour, seven day a week live customer service
   - Toll-free telephone access to Customer Service for the Program for use by Covered Persons, benefits personnel, pharmacists and physicians

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EXHIBIT C
Performance Standards and Requirements for PBM Services

1. Network Pharmacy License Verification

Activities include, but are not limited to, the following:

(a) Verification of active pharmacy licenses for all Participating Pharmacies;
(b) Verification of current Wisconsin Medicaid certification; and
(c) Provision of policies and procedures for reducing, suspending, or terminating pharmacy privileges.

INDICATOR	DUE DATE
Verify active pharmacy licenses and Wisconsin Medicaid certification for all Participating Pharmacies.	Once every three years.
Provide policies and procedures for reducing, suspending, or terminating pharmacy privileges.	Initial and forward any revisions made within 30 days of revision, or send a letter postmarked by January 31st of each year verifying no revisions have been made in the previous year.
Pharmacies terminated or disciplined	For termination of pharmacies: As per Section 3.3 of this agreement. For termination of pharmacists: 30 business days after the close of each quarter.
Complete pharmacy network.	15th of each month (per ADHS requirements).

2. Quality Improvement

Quality Improvement ("QI") activities may include, but are not limited to, the following:

(a) Planned monitoring of previously identified issues, including tracking and trending of issues over time;
(b) Customer service indicators such as call monitoring (for both Covered Person and provider calls) shall be reported and include, but are not limited to: number of calls, calls answered, calls abandoned, abandonment rate, and average time on hold;
(c) A process by which findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QI activity are documented and reported to the appropriate individuals of Manager and HMO;
(d) Coordination of QI activities are coordinated with other performance monitoring activities;

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(e) Identify important areas for improvement and set meaningful priorities through annual physician and pharmacy surveys;
(f) A process for monitoring pharmacy access and availability; and
(g) A process that uses measurements, QI data collection, and analysis to track quality improvement, takes action to improve quality and assesses the effectiveness of these actions through systematic follow-up.

INDICATOR	DUE DATE
Submission of policies and procedures.	Initial and forward any revisions made within 30 days of revision, or send letter postmarked by February 28th of each year verifying no revisions have been made in the previous year.
Submission of Manager QI work plan and Manager QI program description.	Annually by February 28th.
Submission of the QI program evaluation of the prior year.	Annually by February 28th.
Copies of all QI meeting minutes included in the quarterly report.	60 days after close of the quarter.

3. Utilization Management/Appeals

Utilization management activities include the following:

(a) Prior authorization;
(b) Concurrent review; and
(c) Retrospective review.

INDICATOR	DUE DATE
Submission of annual utilization written plan.	Annually by February 28th.
Submission of annual utilization management program evaluation.	Annually by February 28th.
Monthly reports.	15th day following the end of the previous month.
Quarterly Executive Summary Reports.	60th day following the end of the previous quarter.

4. Complaints/Appeals/Grievances

Complaint, appeal, and grievance activities include the following:

(a) Registering and responding to complaints, appeals, and grievances;
(b) Documentation of substance of complaints, appeals, grievances, and actions taken; and
(c) Aggregation and analysis of complaint and grievance data.

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INDICATOR	DUE DATE
Electronic submission of policies and procedures.	Initial and forward any revisions made within 30 days of the revision, or send a postmarked letter by February 28th of each year verifying no revisions have been made in the previous year.
Submission of complaint and grievance activity by the 15th day following the end of the month.	15th day following the end of the previous month.

5. Claims Administration

Claims administration activities include the following:

(a) Development and submission to HMO of Manager's documented claims processing program that, at a minimum, satisfies the standards and procedures required by Manager's claims processing policies and procedures and the requirements under the Medicaid/BadgerCare HMO Contract. The documentation shall be provided by Manager to HMO for review and approval, on or before the Commencement Date, at any time thereafter upon HMO's request, and whenever a material modification to such documented claims processing program is made by Manager. All claims processing related delegated duties shall be performed by Manager in strict compliance with Manager's written clean claims processing program, and subsequently paid as approved by HMO.

(b) Manager represents and warrants that Manager's claims processing program will be administered in accordance with Manager's claims processing program standards and procedures established in accordance with state and federal laws and shall include, but is not limited to, the following:

(1) Verification of eligibility;
(2) Verification of authorization (if applicable);
(3) Verification of payee;
(4) Application of benefits in accordance with Benefit Contracts;
(5) Payment in accordance with provider contract terms;
(6) Appropriate level of medical review;
(7) Timely payment for "clean" claims in accordance with pharmacy contract terms, or within 30 days for non-contracted providers.

INDICATOR	DUE DATE
Electronic submission of all HMO pharmacy claims.	15th day following the end of the previous month.

7. Subcontracting

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All Manager's subcontracting arrangements for delegation of any portion of the PBM Services to another entity requires prior written approval of HMO. If Manager, with HMO's prior written approval, partners with another entity to perform any portion of the PBM Services, Manager shall provide documentation and demonstrate oversight of such entity by Manager to include:

(a) An executed agreement, including what is to be delegated and made available to HMO;
(b) The responsibilities of Manager and subcontractor;
(c) The process by which Manager evaluates the subcontract;
(d) The remedies, including revocation of the delegation available to Manager if the subcontractor does not fulfill its obligation;
(e) Evaluation of the subcontractor's capacity to perform the delegated activities prior to the execution of the contract;
(f) Annual evaluation of performance in accordance with HMO's accreditation and regulatory and statutory standards;
(g) The role of Manager and any subcontractor under this Agreement limited to performing certain delegated functions of HMO, using standards approved by HMO and which are in compliance with applicable statutes and rules.

HMO retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by HMO. Further, HMO retains the right to modify, rescind, or terminate at any time any one or all delegated activities under this amendment, regardless of any sub-delegation that may be approved.

8. Reporting Requirements

All reports specified by ADHS will be provided per specifications. The following table of standard reports may or may not be required by ADHS:

All Hedis and detailed reports will be submitted in test format initially for verification of set up and data pull by the HMO.

REPORTS	DUE DATE
Hedis (Beta-Blockers)	Quarterly
Hedis (Asthma)	Quarterly
Hedis (Diabetic Care-Oral Hypoglycemics/Insulin)	Quarterly
Hedis (Out-patient Drug Utilization)	Quarterly
Hedis (Anti-depressants)	Quarterly
Detailed Prenatal Vitamin Report	Bi-Weekly
Detailed ADHD Medication Reports	Monthly
Detailed Antibiotic Utilization	Monthly
Detailed HIV Medication Utilization	Monthly
Smoking Cessation	Monthly
Pharmacy Network List	Monthly
Executive Profile (electronic, as currently submitted)*	Monthly
Executive Summary (electronic, as currently submitted)*	Monthly
BioScrip Reporting (per BioScrip contract)	Quarterly
P & T Document Support	Quarterly

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2020R Group utilization summary	Monthly
3010R Therapeutic class profile summary	Monthly
3070R Drug cost ranking summary	Monthly
3140R Drug Therapeutic class usage ranking summary	Monthly
5050R Prescriber utilization summary ranked by volume	Monthly
Hedis (Eligibility report)	Quarterly
Hedis (Utilization report)	Quarterly
Hedis (HIV report)	Quarterly
Monthly Claims Data – agreed upon format	Monthly
Monthly PA Denials and approvals	Monthly
TPL Reporting	Quarterly

8. Corrective Action Plan

(a) If HMO receives information through its monitoring plan and/or audit processes that Manager or its subcontractors are not operating in accordance with this Agreement or federal or state requirements, and is operating in a condition that renders the continuance of its business hazardous to Covered Persons, HMO will request a written and signed Corrective Action Plan (CAP) from Manager. Each CAP shall include, but is not limited to, the following:

(1) Expected, measurable results indicating completion of the CAP;
(2) Detailed action plan to complete activities required by the CAP; and
(3) Due date for completion of CAP.

(b) Submission of the CAP shall be made by Manager to HMO within two (2) weeks of the notification with a written explanation of:

(1) Manager noncompliance with the CAP written agreement; or
(2) The existence of the condition that renders the continuance of Manager's business hazardous to Covered Persons.

(c) Implementation of the CAP shall be completed within thirty (30) days of Manager's receipt of written approval of the proposed CAP by HMO, unless an alternative completion period is approved by HMO in writing. The CAP shall accomplish the written expected results and such results must be validated by a HMO audit within the stated time frame. Failure of the Manager or any of its subcontractors to comply with this provision may result at HMO's discretion, in the suspension or revocation of PBM Services delegation.

(d) HMO will cooperate with Manager or its subcontractors to correct any failure by Manager to comply with the ADHS regulatory requirements relating to any contractual matters.

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EXHIBIT D

Benefit Contract Design

[INSERT FROM CENPATICO/ADHS]

1

EXHIBIT E

Preferred Drug List ("PDL")

[To be inserted by CENPATICO on or after the Commencement Date]

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4. Medical Verification Solutions, LLC (MVS)

GREABHA will perform delegation oversight of the Primary Source Verification (PSV) functions delegated to MVS. MVS is certified by NCQA in all elements of PVS in their function as a Credentialing Verification Organization (CVO).

Name of Subcontractor	Medical Verification Solutions (MVS)
Address	6700 Jefferson Blvd NE Building B, Suite 4 Albuquerque, NM 87109
Telephone Number	505-468-0504
Ownership	Owned by The Medical Reliance Group, a privately held organization
Specific Management Service (including Delegated Administrative Functions)	• Primary source verification of the credentials of clinical professionals who apply for membership in GREABHA's provider network, including verification of licensure, educational history, and any sanctions or limitations on behavioral health providers' clinical practice • Provide routine reports to GREABHA on all primary source verifications performed
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Dependent on the number of providers in GSA 2 who will need credentialing
Compensation Arrangement including expected Total Annual Compensation	Initial Credentialing, Price Per File: $55 Re-credentialing, Price Per File: $50 Total Annual Compensation is dependent on the number of providers in GSA 2 who will need credentialing
Plans for Monitoring	Initial and Annual Delegation Audit

MVS
Medical Verification Solutions
A Member of the Medical Reliance Group

6700 Jefferson Blvd. NE
Building B, Suite 4
Albuquerque, NM 87109
Phone: 505.468.0504
Fax: 505.468.0554
Toll Free: 800.677.0944

MEDICAL VERIFICATION SOLUTIONS

Subcontractor Attestation

I the undersigned hereby attest that Medical Verification Solutions, a subsidiary of the Medical Reliance Group, has never been suspended or excluded from any federal program.

Kristi J. Beck, Chief Operating Officer

9-27-04
Date

MEDICAL VERIFICATION SOLUTIONS, LLC

CREDENTIALS VERIFICATION SERVICES AGREEMENT

This Services Agreement (the "Agreement") is entered into as of July August 1, 2004 (the "Effective Date"), by and between MEDICAL VERIFICATION SOLUTIONS, LLC, a Michigan limited liability company ("MVS"), and CENTENE CORPORATION a Healthcare Organization (the "Healthcare Organization").

RECITALS

A. The Healthcare Organization is required by law to verify the credentials of the heath care professionals who provide certain healthcare services to or on behalf of the Healthcare Organization.

B. MVS provides certain credentials verification services on behalf of the healthcare organizations.

B. The Healthcare Organization wishes to secure such services of MVS and MVS wishes to provide such services upon terms and conditions more fully described in this Agreement.

AGREEMENT

NOW, THEREFORE, in consideration of mutual covenants and promises contained in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties, intending to be legally bound, agree as follows:

1. SERVICES

1.1 Scope of the Services. Subject to the terms and conditions of this Agreement, MVS will perform the credentials verification services authorized by the Healthcare Organization and set forth on Exhibit A attached hereto and incorporated by reference herein (collectively, the "Services"), upon receipt of an application form in accordance with JCAHO or NCQA or other applicable agency or organization, as designated by the Healthcare Organization and further defined in the Scope of Services. Additional services may be added from time to time by execution of an addendum to such exhibit, which services are incorporated by reference into this Agreement and will become part of the Services. The Services will be provided by MVS within an agreed upon time schedule in order to collect, verify, maintain and provide data and information needed by the Healthcare Organization to evaluate Applicants and comply with state and federal laws.

1.2 Deliverables. MVS will deliver its work product (regardless as to whether for an initial credentialing or a recredentialing, the "Credentials Verification Report") to the Healthcare Organization in the form of the electronic report format available from MVS and with content as specified in the Credentials Verification Report Summary form (substantially in the form of Exhibit C) with supporting documents (e.g. the verified items), and/or in a materially similar electronic format as may be changed from time to time as may be necessary to, amongst other

reasons, comply with appropriate regulations and accreditation standards. Notwithstanding the foregoing, nothing contained in this Agreement will be deemed to require MVS to provide to the Healthcare Organization any information that is protected by the confidentiality provisions of any applicable federal, state, or other peer review protection law, or any related rule, regulation or judicial decision.

1.3 Performance of the Services.

(a) MVS will abide by all applicable federal and state legal requirements with respect to maintaining the confidentiality of information in connection with the Services.

(b) As a business associate of the Healthcare Organization, MVS will abide by the privacy and security requirements of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) and with all of the terms and conditions of Exhibit D, which is attached hereto.

(c) In the event MVS discovers facts or encounters circumstances impairing its ability to perform the Services with respect to a particular Applicant(s), MVS will promptly advise the Healthcare Organization and, at the discretion of the Healthcare Organization will make accommodations to rectify those inhibiting facts or circumstances

(d) During the term of this Agreement, the Healthcare Organization may, at the Healthcare Organization's expense, review the activities of MVS, as they relate to the provision of Services for the Healthcare Organization, on an annual basis. MVS will cooperate with the Healthcare Organization's auditors in connection with these reviews; *provided, however*, that the Healthcare Organization will give MVS reasonable prior notice of each review and the Healthcare Organization will conduct each such review in a manner that does not unreasonably interfere with the ongoing activities of MVS.

1.4 Healthcare Organization Responsibilities. To assist MVS in the performance of its responsibilities under this Agreement, the Healthcare Organization agrees to perform the following duties:

(a) To complete the National Practitioner Data Bank ("NPDB") form and to designate MVS as its querying agent.

(b) To provide all reasonably needed information (including that outlined in Exhibit A), and assistance in communication, or execution of any additional documents, and other reasonably necessary coordination, in cooperation with MVS's credentials verification activities and timetables so that MVS may best adhere to a consistent and efficient schedule for the provision of the Services.

(c) To oversee the contracted Services in accordance with the Healthcare Organization's federal, state and accreditation requirements and guidelines.

(d) To verify that the Services provided by MVS comply with and fulfill all aspects of Healthcare Organization's by-laws and other such applicable guidelines and regulations.

(e) To notify MVS, in writing, with regard to any operational matter not acceptable to the Healthcare Organization. MVS will acknowledge in writing to the Healthcare Organization its receipt of such written notice within seven business days following such receipt. MVS will thereafter, but in no event later than 60 days after its receipt of such written notice, take every reasonable action necessary to correct such matter.

(f) To utilize MVS as the Healthcare Organization's sole solution for the provision of the contracted Services.

1.5 Commitments of Timeliness and Accuracy.

(a) Subject to the provisions of this Agreement, MVS guarantees the following:

(i) *On-Time Commitment*. Subject to Section 1.5(a)(ii), MVS will deliver each Credentials Verification Report to the Healthcare Organization within 21 calendar days of the that date on which MVS receives a fully executed and accurate Application and associated Attestation (the "Full Attestation Receipt Date").

(ii) *Accuracy Commitment*. MVS further guarantees that the information contained within a Credentials Verification Report Summary shall be without material error. This guarantee, as outlined in this Section 1.5(a)(ii) (the "Accuracy Commitment"), shall not apply in those cases where MVS has determined in good faith that: x) the information provided on the Application was inaccurate, incomplete, or materially misleading; or y) the information provided by any verification source was inaccurate, incomplete, or materially misleading (the "Inaccurate Sources Exclusion").

(b) In the case where either the On-Time Commitment or the Accuracy Commitment (as provided in Section 1.5(a) above) is not upheld by MVS, Healthcare Organization shall have no obligation to pay for Services associated with the processing and provision of the applicable Credentials Verification Report. The relief provided hereunder shall be Healthcare Organization's sole recourse against MVS.

2. MVS STATUS, PROVIDER DECISIONS

2.1 Independent Contractor Status. MVS is an independent contractor performing certain data collection and verification services for the Healthcare Organization and is not an employee, representative, officer, or partner of the Healthcare Organization. Except as expressly set forth in this Agreement, MVS has no power or authority to act for, represent, or bind the Healthcare Organization in any manner. Nothing contained in this Agreement will be deemed to create any

relationship between the parties other than that of a principal and independent contractor. MVS is not an "independent review body" as that term is used in HCQIA, nor is it a "review organization".

2.2 Healthcare Organization Provider Decisions. The Healthcare Organization will be solely responsible for decisions regarding the granting, revoking, denying, terminating, suspending, restricting or otherwise conditioning contracted physician appointments, privileges, and participation status, and for all reporting required by federal or state law, or accreditation entities relating to such action. MVS will have no authority, nor represent itself as having any authority, with respect thereto.

3. TERM AND TERMINATION

3.1 Term. This Agreement will commence on the Effective Date and will remain in effect for two years following the Effective Date, unless sooner terminated as herein provided; provided, however, that the term will be automatically renewed for subsequent one-year periods unless either party gives written notice of its desire not to renew the term at least 60 days prior to the end of the then current one-year period, at which point the term will expire at the conclusion of such one-year period. This contract may be terminated for no cause at any time by either party with a written 60 day notice.

3.2 Termination. This Agreement will terminate upon occurrence of any of the following events:

(a) Failure to pay MVS its fees when due which remains uncured for a period of 10 days after receipt by the Healthcare Organization of written notice of such breach;

(b) A material breach of the Agreement (other than for failure to pay) which remains uncured for a period of 30 days after receipt of written notice specifying the breach, with reasonable opportunity for cure having been afforded the notified party;

(c) Either party is adjudged bankrupt, makes a general assignment for the benefit of creditors, seeks reorganization under bankruptcy or insolvency laws, or a proceeding relating to bankruptcy or insolvency laws is commenced against the other party.

3.3 Survival. Notwithstanding anything to the contrary contained in this Agreement, the provisions of Sections 5, 6, 8 and 9 will survive any termination, expiration or cancellation of this Agreement, regardless of the basis for such termination or cancellation.

4. PAYMENT FOR THE SERVICES

The Healthcare Organization will pay MVS for the Services in accordance with the reimbursement and payment schedule set forth on Exhibit B (respective of the services for which Healthcare Organization has authorized) attached hereto and incorporated herein by reference, which may be revised from time to time as mutually agreed by the parties.

5. RIGHTS, USE, AND OWNERSHIP

5.1 MVS will grant to Healthcare Organization the right to use, copy, and maintain MVS Intellectual Property (herein defined) and data that has been fully paid for by Healthcare Organization and provided to or collected by MVS for Healthcare Organization for the purposes of Healthcare Organization's: i) credentialing, regulatory, and quality management; ii) internal or external evaluations; and iii) other purposes that do not violate the provisions of this Agreement.

5.2 MVS is the sole owner of all MVS-created deliverables and all U.S. copyrights and other intellectual property rights in those MVS-created deliverables; data collection, analysis, and review tools; and data processing and management systems or processes, including all tangible and intangible items, processes, or information incorporated therein (the "MVS Intellectual Property"). If any such MVS-created deliverables or other MVS Intellectual Property may, by operation of law, be considered "works made for hire" (or if ownership of all right, title and interest of the U.S. copyrights therein will not otherwise vest exclusively in MVS), the Healthcare Organization will be deemed to have automatically assigned, without further consideration, the ownership of all U.S. copyrights therein to MVS, its successors and assigns. MVS, its successors and assigns will then have the right to obtain and hold in its or their own name copyrights, registrations and any other protection available in the foregoing. The Healthcare Organization agrees that it will not market, parcel, distribute, sell or otherwise communicate the MVS Intellectual Property without the express written consent of MVS.

6. PROPRIETARY INFORMATION

6.1 Definition. The parties acknowledge that MVS owns and may develop proprietary information during the course of the Agreement, which is privileged and confidential. MVS will use the proprietary information in the discharge of its contracted-for obligations to the Healthcare Organization. "Proprietary information" includes trade secrets and computer programs and software (including source codes), processes, technical information, know-how, plans, specifications, identity of Healthcare Organizations and suppliers, financial information, and other proprietary or confidential information related to the Services and business affairs of MVS which is treated by MVS as confidential; *provided, however*, that proprietary information will not include (a) information known by the Healthcare Organization prior to the Effective Date, or which is in the public domain at the time of disclosure, or which is disclosed to the Healthcare Organization through a third party; (b) all information on the Credentials Verification Report forms, or the documents and information upon which such information is based.

6.2 Use, Disclosure. The parties agree that MVS will disclose proprietary information to the Healthcare Organization only to the extent that such information is necessary to conduct the Services. With respect to any proprietary information disclosed by MVS to the Healthcare Organization in the course of or in connection with this Agreement, the Healthcare Organization will not use, copy, reveal, report, publish, transfer or otherwise disclose such information to any person, company or other entity, without the prior written consent of MVS, and the proprietary information will not be utilized for the detriment or intended detriment of the supplier of the information including the solicitation of any of that party's Healthcare Organizations, leads or employees. Upon expiration or earlier termination of this Agreement, the Healthcare Organization will return to MVS all proprietary information in its possession. The parties acknowledge that no license is created by the use of the proprietary information.

6.3 Equitable Relief. Since a remedy at law for any breach or attempted breach of the provisions of this Section 6 will be inadequate, either party hereto will be entitled to specific performance and injunctive or other equitable relief in case of any such breach or attempted breach, in addition to any remedies available at law.

7. DISPUTE RESOLUTION

7.1 Duty to Negotiate in Good Faith. If a party has reason to believe the existence of a dispute in connection with this Agreement and the Services provided hereunder, it will give written notice to the other party, describing the dispute and a proposed resolution. The parties will then meet as soon as practicable thereafter and negotiate in good faith to resolve the dispute.

7.2 Mediation. If the dispute cannot be resolved by negotiation within 30 days of notice of a dispute having been given as described above, unless otherwise agreed to by the parties in writing, the parties will be obligated to submit the dispute to a mediator.

7.3 Binding Arbitration. If the dispute cannot be resolved by way of direct negotiation or mediation within 60 days of notice of a dispute having been given as described above, the dispute will be decided by arbitration, which will be conducted by a single arbitrator and, except as otherwise expressly provided herein, in accordance with the commercial arbitration rules of the American Arbitration Association or the American Health Lawyers Association. The arbitration will be conducted in Ingham County, Michigan, unless the parties in the proceeding mutually agree otherwise. In the event that there will be more than one dispute to be arbitrated, the parties agree that all pending disputes will be consolidated to the extent feasible. Within 30 days of the hearing, the arbitrator will render a decision concerning all contested issues considered during the arbitration and the arbitrator will notify the parties in writing of his or her decision, setting forth the arbitrator's findings of fact and conclusions of law and the dollar amount, if any, awarded. Unless the parties mutually agree otherwise, the arbitrator may fix his or her compensation. The fees of the American Arbitration Association or the American Health Lawyers Association and of the arbitrator will be paid equally by the parties, unless the arbitrator determines that a particular party has prevailed on all major substantive issues presented, in which case the fees and costs will be paid by the party not so prevailing. This agreement to arbitrate will be specifically enforceable under the Michigan Arbitration law. The arbitrator's decision will be final, and judgment, including specific enforcement of the decision, may be entered upon the decision in any court of competent jurisdiction in accordance with applicable law. The amount of any dollar award, including applicable fees and costs of the prevailing party, will be paid in cash by the party not so prevailing to the prevailing party, within 10 days following the date of such award. In the event that payment is not made within the time period provided herein, the prevailing party will have the right to commence an action, at law or in equity, in any state or federal court in the State of Michigan to have the decision of the arbitrator enforced. In the event such an action is filed, the costs of such action (including reasonable attorneys' fees) will be borne by the party against whom such performance is sought. A pending arbitration will not extend the term of this Agreement or affect any termination provided for hereunder. All statutes of limitations will be tolled from the date of giving notice of the intention to submit to arbitration and for 90 days after the delivery of the arbitrator's written determination.

7.4 Certain Exclusions. The binding arbitration procedure, described in Section 7.3 above, will not apply to any claims between the parties arising out of third party claims asserting professional negligence, and the parties are not precluded from asserting claims against each other based on contribution, indemnity, breach of contract, or other legal theories, by way of cross-claim or third-party complaint in any circuit court action, commenced by a third party, which alleges professional negligence against either or both of the parties to this Agreement. In the event of a dispute, which is not subject to arbitration, each party hereto consents and agrees that any litigation arising therefrom will be commenced and maintained exclusively in the state and federal courts of competent jurisdiction located in Ingham County, Michigan.

7.5 Equitable Relief. To the extent that arbitrator acting under the applicable rules of the American Arbitration Association or the American Health Lawyers Association and pursuant to Michigan law does not have legal jurisdiction and authority to impose injunctive or other equitable relief, a party seeking the same will be entitled to pursue the same through court litigation. Such action may be pursued during, after or in lieu of arbitration. Any such action will be pursued only in the state or federal courts with requisite jurisdiction located in Ingham County, Michigan.

8. INDEMNIFICATION

8.1 Indemnification of MVS. The Healthcare Organization will indemnify and hold MVS and its officers, directors, employees, agents, consultants, affiliates, and representatives harmless from and against any and all actions, suits, proceedings, liabilities, losses, damages, judgments, fines, amounts paid in settlement, losses, costs and expenses which may arise out of acts or omissions of the Healthcare Organization or its officers, directors, employees, agents, consultants, affiliates, and representatives in the performance of the Healthcare Organization's responsibilities under this Agreement or which may arise out of any action taken by the Healthcare Organization or decision made by the Healthcare Organization regarding medical staff appointments or privileges, participation status or disciplinary matters, whether in contract, tort, or otherwise. Without limiting the generality of the foregoing, MVS will have no liability for any claims relating to the issuance of, denial of, or claims made to, any insurance coverage(s) for, from, or to the Healthcare Organization, regardless of the form of the claim, and this indemnification provision will likewise apply to any such claims.

8.2 Indemnification of the Healthcare Organization. MVS will indemnify and hold the Healthcare Organization and its officers, directors, employees, agents, consultants, affiliates, and representatives harmless from and against any and all actions, suits, proceedings, liabilities, losses, damages, judgments, fines, amounts paid in settlement, losses, costs and expenses which may arise out of acts or omissions of MVS and MVS's officers, directors, employees, agents, consultants, affiliates, and representatives in the performance of its or their responsibilities under this Agreement.

9. LIMITATION OF LIABILITY

Except as to the damages, amounts and/or costs provided in Sections 7 and 8 above, in no event will either party here to be liable under this agreement to the other party for any special consequential punitive, reliance or incidental damages, including lost profits or revenues of such party, whether or not such damages were foreseeable.

10. MISCELLANEOUS

10.1 Certain Definitions. The following terms will have the following respective meanings:

"Applicant" means a qualified Physician or Licensed Health Care Practitioner who is applying for an appointment or reappointment to the Medical Staff or health plan panel, and the receipt of Privileges at the Member's organization.

"Application" means a form (whether existing in electronic or paper format) to be supplied by MVS on which all necessary information may be acquired by MVS from Applicant needed by MVS to perform the credentialing and recredentialing Services of this Agreement.

"Attestation" means the attestment of an Applicant to the accuracy of the content provided by the Applicant within their Application.

"Board of Medical Examiners" means the board established pursuant to the statute set forth in Appendix D.

"Continuous File Maintenance" means the process of verifying certain information as it expires and providing this verification to the Healthcare Organization within 30 days of the expiration date of the information.

"HCQIA" means the Health Care Quality Improvement Act of 1986, Title IV of Public Law 99-660, as amended (42 U.S.C. 11101 et seq.).

"JCAHO" means Joint Commission for Accreditation of Healthcare Organizations, which provides accreditation for hospitals and other health care organizations.

"Licensed Health Care Practitioner" means an individual who is licensed or otherwise authorized by the laws of the state or states set forth in Appendix D to provide health care services.

"Medical Staff" means a group of Physicians and, if applicable, other Licensed Health Care Practitioners who provide medical and other health care services to patients and who are required to acquire privileges or health plan panel membership.

"National Practitioner Data Bank" or "NPDB" means the national practitioner data bank authorized and created by HCQIA.

"NCQA" means the National Commission for Quality Assurance, which provides accreditation for Managed Care Organizations ("MCO's") and certification of Credentials Verification Organizations ("CVO's").

"Physician" means a doctor of medicine (M.D.) or Osteopathy (D.O.) or a doctor of dental surgery (D.D.S.) or medical dentistry (D.M.D.) legally authorized to practice medicine and surgery or dentistry in state or states identified in Appendix C.

"Privileges" means clinical privileges, membership on the Medical Staff, or membership on a health plan panel, and other circumstances pertaining to the furnishing of medical care under which a Physician or other Licensed Health Care Practitioner is permitted to furnish such care by the Healthcare Organization.

"Credentialing Requests" means the provision of a formal request (as submitted via electronic means, facsimile, telephone, or by paper copy) by Healthcare Organization for MVS to initiate the process by which a Credentials Verification Report may be delivered by MVS to Healthcare Organization.

10.2 Mutual Agreement Not to Solicit Employees. During the term of this Agreement and for a period of two years thereafter, neither party will, either directly or indirectly, on its own behalf or on behalf of others, solicit, divert or hire away, or attempt to solicit, divert, or hire away, any person employed by the other party, whether or not such employee is a full-time employee or a temporary employee of, consultant to, or independent contractor to such other party and whether or not such employment or engagement is pursuant to written agreement and whether or not such employment or engagement is for a determined period or is at will.

10.3 Notices. All notices, consents, waivers and other communications under this Agreement must be in writing and will be deemed to have been duly given when (a) delivered by hand (with written confirmation of receipt), (b) sent by facsimile or electronic mail (with written confirmation of receipt), provided that a copy is mailed by registered mail, return receipt requested, or (c) when received by the addressee, if sent by a nationally recognized overnight delivery service (receipt requested), in each case to the appropriate addresses and facsimile numbers set forth on the signature page below (or to such other addresses and facsimile numbers as a party may designate by notice to the other party).

10.4 Entire Agreement and Modification.

(a) This Agreement, together with all referenced and attached exhibits, contains the entire agreement between the parties hereto, supersedes all prior agreements, arrangements, or understandings between the parties and constitutes a complete and exclusive statement of the terms of the agreement between the parties with respect to its subject matter. This Agreement may not be modified or amended except by a written agreement duly signed by persons authorized to act on behalf of the party to be charged with the amendment.

(b) Notwithstanding the foregoing, subject to the following procedure, the Exhibits to this Agreement will be deemed to be automatically amended in order to permit MVS and the Healthcare Organization to comply with any applicable amendments to HCQIA, the Guidebook, any related changes in state and federal regulations promulgated pursuant to such acts, NCQA, or in order to comply with changes of policy or procedures required by MVS for the operation its systems used in connection with the Services.

(i) MVS will give written notice to the Healthcare Organization of regulatory changes or changes in MVS policy or procedures which are applicable to the Healthcare Organization ("Notices"). The Notice will include revised Exhibits to this Agreement, as applicable, setting forth the revisions required by changes in statutes, regulations or MVS policy and procedure.

(ii) The Healthcare Organization may, within 60 days of receipt of the Notice and revised Exhibits, give notice of termination of the Agreement pursuant to Section 3 hereof. The Healthcare Organization must comply with the Notice during any period in which the changes are effective and before this Agreement is terminated.

(iii) If notice of termination is not given by the Healthcare Organization as set forth above, the Healthcare Organization will accept, initial and return the revised Exhibits to MVS, which will become effective as of the later of the date so accepted or 30 days following the date of the Notice.

10.5 Assignments, Successors and Third-Party Rights. Neither party may assign any of its rights under this Agreement without prior written consent of the other party; provided, however, such consent will not be necessary in connection with an assignment on the part of MVS of this Agreement to an affiliate of MVS as a part of any reorganization or corporate restructuring of MVS. Subject to the preceding sentence, this Agreement will apply to, be binding in all respect upon and inure to the benefit of the respective successors and permitted assigns of the parties. Nothing expressed or referred to in this Agreement will be construed to give any person other than the parties to this Agreement any legal or equitable right, remedy or claim under or with respect to this Agreement or any provision of this Agreement. This Agreement and all of its provisions and conditions are for the sole and exclusive benefit of the parties to this Agreement and their successors and permitted assigns.

10.6 Severability. If any provision of this Agreement is held invalid or unenforceable by any court of competent jurisdiction or an arbitrator pursuant to Section 7.3 hereof, the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable.

10.7 Section Headings, Construction. The headings of sections in this Agreement are provided for convenience only and will not affect its construction or interpretation. All words used in this Agreement will be construed to be of such gender or number as the circumstances require. Unless otherwise expressly provided, the word "including" does not limit the words or terms preceding it.

10.8 Governing Law. This Agreement will be governed by and interpreted pursuant to the laws of the State of Michigan without regard to conflicts of laws principles.

10.9 Counterparts. This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and delivered by their duly authorized officers or agents as set forth below.

MEDICAL VERIFICATION SOLUTIONS, LLC
"MVS"

Date: _____

By: _____
Name: Kristi Beck
Title: Chief Operating Officer

Address:
3410 Belle Chase Way, Suite 600
Lansing, Michigan 48911
Tel: 800-677-0944
Fax: 517-702-4000
Email: kbeck@mvshome.com

CENTENE CORPORATION
"Healthcare Organization"

Date: _____

By: _____
Name: Aron Halfin
Title: Vice President of Clinical Operations

Address:
823 Congress Avenue
Suite 600
Austin, Texas 78701
Tel: 512-406-7200
Fax: _____
Email: ahalfin@centene.com

EXHIBIT A

SCOPE OF SERVICES

1. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by JCAHO criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) Board certification
   (c) Medical/dental/podiatry or other professional education and training obtained
   (d) DEA and CSR certificate
   (e) Hospital affiliation/work history for previous 5 years
   (f) Professional liability insurance for previous 5 years
   (g) Malpractice claims history for previous 5 years (via confirmation with insurance provider or NPDB query)
   (h) Medicaid/Medicare sanctions (via NPDB query)
   (i) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (j) Minimum of two professional references
   (k) Other information, specified as follows:_____
   _____
   _____

2. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by NCQA criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) Board certification (or)
   (c) Medical/dental/podiatry residency training or highest level of education or training obtained
   (d) DEA or CSR certificate
   (e) Professional liability insurance (copy of the policy cover page)
   (f) Malpractice claims history for previous 5 years (via confirmation with insurance provider or NPDB query)
   (g) Work history that has been provided by the Applicant (5 years as evident via application, curriculum vitae, or resume; verification not required)
   (h) Medicaid/Medicare sanctions (via NPDB query) for a period of 3 years

(i) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)

(j) Other information, specified as follows:_____

_____

_____

Signed Attestation that addresses:

reasons for any inability to perform the essential functions of the position, with or without accommodation

lack of present illegal drug use

history of loss of license and felony convictions

history of loss or limitation of privileges or disciplinary activity

current malpractice insurance coverage

the correctness and completeness of the application.

3. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by URAC criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

(a) Licensure in the applicable state or states [State *licensure* information, including current *license(s)* and history of *licensure* in all jurisdictions;]

(b) DEA or CSR certificate

(c) Board certification

(d) Professional liability insurance (copy of the policy cover page)

(e) NPDB query [Professional liability claims history]

(f) Other information, specified as follows:_____

_____

_____

The following items will be obtained via a completed Application, release, and Attestation:

(a) History of education and professional training, including *board certification* status;

(b) Work history for at least the last five years (or since last credentialed by the *organization*);

(c) Listing of all sanctions or penalties imposed by hospitals, licensing boards, government entities, and managed care organizations;

(d) Documentation of any voluntary or involuntary relinquishment of privileges to practice in a *facility* or jurisdiction;

(e) Hospital affiliations or privileges, if applicable;

(f) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the *practitioner's* ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;

(g) A signed and dated statement attesting that the information submitted with the application is complete and accurate to the *practitioner's* knowledge; **and**

(l) A signed and dated statement authorizing the *organization* to collect any information necessary to verify the information in the credentialing application.

4. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by JCAHO criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) DEA and CSR certificate
   (c) Hospital affiliation/work history for previous 2 years
   (d) Professional liability insurance for previous 2 years
   (e) Malpractice claims history for previous 2 years (via confirmation with insurance provider or NPDB query)
   (f) Medicaid/Medicare sanctions (via NPDB query)
   (g) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (h) Minimum of two professional references
   (i) Other information, specified as follows:_____
   _____
   _____

5. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by NCQA criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) DEA or CSR certificate
   (c) Professional liability insurance (copy of the policy cover page or declaration in application)
   (d) Malpractice claims history for previous 3 years (via NPDB query)
   (e) Medicaid/Medicare sanctions for a period of 3 years (via NPDB query)
   (f) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 3 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (g) Other information, specified as follows:_____
   _____
   _____

Signed Attestation that addresses:

reasons for any inability to perform the essential functions of the position, with or without accommodation

lack of present illegal drug use

history of loss of license and felony convictions in the past 3 years

history of loss or limitation of privileges or disciplinary activity in the past 3 years

current malpractice insurance coverage

the correctness and completeness of the application.

6. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by URAC criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

(a) Licensure in the applicable state or states [State *licensure* information, including current *license(s)* and history of *licensure* in all jurisdictions;]
(b) DEA or CSR certificate
(c) Professional liability insurance (copy of the policy cover page)
(d) NPDB query [Professional liability claims history]

Other information, specified as follows:_____

_____

The following items will be obtained via a completed Application, release, and Attestation:

(a) Listing of all sanctions or penalties imposed by hospitals, licensing boards, government entities, and managed care organizations during the past 3 years;
(b) Documentation of any voluntary or involuntary relinquishment of privileges to practice in a *facility* or jurisdiction during the past 3 years;
(c) Current hospital affiliations or privileges, if applicable;
(d) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the *practitioner's* ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;
(e) A signed and dated statement attesting that the information submitted with the application is complete and accurate to the *practitioner's* knowledge; **and**
(f) A signed and dated statement authorizing the *organization* to collect any information necessary to verify the information in the credentialing application.

7. Upon MVS' receipt of the data outlining, in sufficient detail (see Section 3(b) below), the Healthcare Organization's care provider network (the "Care Provider Network"), MVS shall initiate a process designed to maintain as current the credential verification records pertaining to the members of the Care Provider Network (the "Credentials Monitoring Process").

(a) The credentialing data maintained through the execution of the Credentials Monitoring Process shall include:
   i. Licensure;
   ii. Board certification;
   iii. DEA and/or CSR certificate; and
   iv. Professional liability insurance.

1

(b) The data and materials that Healthcare Organization shall provide to MVS to identify and initiate the Credentials Monitoring Process for each member of the Care Provider Network shall be:

i. Member's name, professional degree, address, and phone number;
ii. State licensure number and expiration date;
iii. Board certification and expiration date;
iv. CSR certificate number and expiration date;
v. DEA certificate number, expiration date, and physical copy; and
vi. Professional liability insurance carrier and policy number.

8. Upon MVS' receipt of the data outlining, in sufficient detail (see Section 4(b) below), the Healthcare Organization's care provider network (the "Care Provider Network"), MVS shall initiate a process of monitoring for sanctions pertaining to the members of the Care Provider Network (the "Sanctions Monitoring Process") on a monthly basis.

(c) The sanctions data monitored through the execution of the Sanctions Monitoring Process shall include:

i. Medicaid sanctions;
ii. Medicare sanctions;
iii. State sanctions; and
iv. Limitations of licensure.

(d) The data and materials that Healthcare Organization shall provide to MVS to identify and initiate the Sanctions Monitoring Process for each member of the Care Provider Network shall be:

i. Member's name, professional degree, address, and phone number;
ii. Date of birth;
iii. Social Security number; and
iv. State licensure number.

9. If the Healthcare Organization requires additional information from the Applicant which is not contained on the application form or within the materials provided to MVS by the Healthcare Organization, the Healthcare Organization will mail directly to the Applicant whatever additional information the Healthcare Organization requires. A copy of the application form required by the Healthcare Organization is attached this Scope of Services.

10. For all Applications completed under this Agreement, MVS will collect all data required to meet both NCQA and URAC standards, as detailed above.

11. The Healthcare Organization hereby designates the following staff member as the recipient of the information provided to the Healthcare Organization under this Agreement, including responses from the National Practitioner Data Bank (NPDB) (provide the name of the specific job title of the person to whom MVS is to provide information):

Name: Aron Halfin
Address: 823 Congress Avenue
Suite 600

1

Austin, TX 78701
Telephone:512-406-7200

Effective Date: August 1, 2004

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EXHIBIT B

PAYMENT/FEE SCHEDULE & TERMS

Summary MVS Fee Schedule For Initial and Recredentialing Verifications	
	NCQA Profile
Initial Credentialing	
Pricing per File:	$55.00
Recredentialing	
Pricing per File:	$50.00

Table B-1: Summary Fee Schedule For Initial and Recredentialing Verifications

Summary MVS Fee Schedule For Bundled Sanction Monitoring and Credentials Monitoring	
Element:	**Sanction & Credential Monitoring**
License Sanctions and Limitations	✓
Medicare / Medicaid Sanctions	✓
Valid License	✓
Valid DEA	✓
Valid CSR	✓
Board Certification	✓
Malpractice Insurance	✓
Malpractice Claims History through NPDB	✓
Pricing per Practitioner per Year:	$43.00

Table B-2: Summary Fee Schedule For Sanction and Credentials Monitoring

	60 Day Guarantee	45 Day Guarantee	30 Day Guarantee	15 Day Guarantee	2 Day Guarantee
Initial Credentialing					
Expedited Fees:	No Additional Charge	25% Additional Charge	50% Additional Charge	75% Additional Charge	150% Additional Charge
Recredentialing					
Expedited Fees:	No Additional Charge	25% Additional Charge	50% Additional Charge	75% Additional Charge	150% Additional Charge

Table B-3: Summary Fee Schedule For Expedited Files

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1. Fees.

   a. Credential Verifications: The fees (the "Credentialing Verification Fees") due to MVS from Healthcare Organization for each initial and recredentialing verification requested by the Healthcare Organization shall be as outlined in Table B-1 (Summary Fee Schedule For Initial and Recredentialing Verifications), as may be adjusted by expedition requests as outlined in Table B-3. In the case that Healthcare Organization requests the provision of a Credentialing or Recredentialing report within a period of time less than 60 calendar days (the "Expedited Request"), the respective Credentialing Verification Fees shall be adjusted by the addition of that amount outlined within Table B-3 (the "Expedite Fee").

   b. Credentials & Sanction Monitoring: The fees (the "Monitoring Fees") due to MVS from Healthcare Organization for Credentials and Sanctions Monitoring shall be calculated by multiplying the number of members within the Care Provider Network by the fees outlined in Table B-2 (Summary MVS Fee Schedule For Bundled Sanction Monitoring and Credentials Monitoring). The Monitoring Fees shall be invoiced in advance on a quarterly basis.

2. Invoicing.

   a. Monthly Invoicing: MVS will, on a monthly basis, provide an invoice outlining in reasonable detail the fees due to MVS by Healthcare Organization for the following:
      i. Initial Verifications;
      ii. Recredentialing Verifications; and
      iii. Pass-Through Fees.

   b. Quarterly Invoicing: MVS will, on a quarterly basis, provide an invoice outlining in reasonable detail the fees due to MVS by Healthcare Organization for one quarter of the projected annual price (in advance) for Sanctions and Credentials Monitoring indicated for the respective quarterly period and in accordance with the pricing on Table B-2. MVS shall make adjustments in arrears (and invoice for such adjustments) for any additions to the Healthcare Organizations provider network as submitted by the Healthcare Organizations or that become known to MVS during the respective quarterly period.

3. Payment Term. Payment is due within 15 days from the date of receipt of an invoice by the Healthcare Organization (the "Due Date").

4. Late Charges. If any undisputed fee for services by MVS is not paid within 10 days after the Due Date, interest will accrue from such Due Date at a rate equal to two percent (2%) per month. The Healthcare Organization will pay such interest upon demand by MVS, and such interest charge will be in addition to the amounts otherwise charged by MVS for its services. The amount of interest payable pursuant to this provision will not exceed the maximum effective rate of interest permitted to be paid under the laws of the State of Michigan. If such amounts result in an effective rate of interest in excess of such maximum effective rate of interest, then the amount payable pursuant to this provision will be reduced to the highest amount permitted under the laws of the State of Michigan.

5. Pass Through Fees. Certain components of the service processes generate expenses from third-parties. These expenses are passed through to Healthcare Organization at cost (the "Pass-Through Fees"). A non-exhaustive list of typical Pass-Through Fees is provided below in Table B-4. This list may change from time to time and is independent of MVS. MVS shall invoice Healthcare Organization for such Pass-Through Fees as outlined in Paragraph 2 of this Exhibit B. Upon request from the Healthcare Organization, MVS shall provide, in reasonable detail, information outlining the Pass-Through Fees.

Typical Pass-Through Fees Associated with Credential Verifications	
Verification Source	**Pass-Through Fees**
Educational Commission for Foreign Medical Schools (ECFMG)	$ 25.00
National Practitioner Data Bank (NPDB)	$4.25
Healthcare Integrity and Protection Data Bank (HIPDB)	$4.25
DPM Board Certification	$25.00
American Medical Association (AMA) Profile	$26.00
American Nursing Credentialing Center (ANCC)	$10.00
DO Board Certification	$10.00
DC license	$5.00
OD License	$15.00
Various Insurance Companies	$20.00
Various Universities	$20.00
Various Medical Centers	$20.00

Table B-4: Typical Pass-Through Fees Associated with Credential Verifications

6. Cancellations. If an initial or recredentialing verification request is canceled (directly or indirectly by any means or necessity) by the Healthcare Organization within two business days of the date of the original request (a "Early Cancellation") shall result in a cancellation fee of $25 (the "Early Cancellation Fee"), in addition to any Pass-Through Fees incurred, being charged as the only Credentialing Verification Fees for such initial or recredentialing verification request. Any initial or recredentialing verification request that is canceled (directly or indirectly by any means or necessity) by the Healthcare Organization more than two business days after the date of the original request (a "Late Cancellation") shall result the charging of the full amount of the Credentialing Verification Fees, and any Pass-Through Fees incurred, as if the request were completed in a timely and accurate fashion. In the case of any cancellation in which the original request by the Healthcare Organization was for such request to be handled in an expedited fashion (the "Expedition Cancellation"), the aforementioned cancellation fees (whether Early Cancellation or Late Cancellation, as the case may be) shall be adjusted as outlined within Table B-3 above. MVS is not responsible for determining whether any (e.g. repeated, changed, or otherwise) submissions of initial or recredentialing verification requests by the Healthcare Organization are appropriate, needed, or otherwise. Hence, any cancellation (or change which shall be interpreted as a cancellation followed by a re-submission) necessitated by such submissions are treated as cancellation as described within this Paragraph 6.

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7. Fee Adjustments. To accommodate changes in labor, data processing, and other operating expenses that may occur from time to time, MVS reserves the right to make adjustments to the fees upon 30 days prior written notice to Healthcare Organization. Such fees may be adjusted no more frequently than once per annual period.

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EXHIBIT C

SAMPLE CREDENTIALS VERIFICATION REPORT FORM

MVS
Medical Verification Solutions
A division of the Medical Reliance Group

Practitioner Summary

Prepared for <<Client>>

<<RequestType>> of <<NameLast>>, <<NameFirst>> <<NameMI>>, <<Degree>>

Social Security Number:	<<SSN>>	**Report Date:**	<<CompletionDate>>
Date of Birth:	<<DOB>>	**Attestation Date:**	<<AttestationDate>>
		Quality Control Date:	<<AttestationDate>>

Addresses

<<AddressDescription>>

<<Organization>>
<<Address1>>, <<Address2>>
<<City>>, <<State>>, <<Zip>>

Phone:	<<Phone>>
Fax:	<<Fax>>
Email:	<<Email>>
Contact:	<<Contact>>

Education and Training

<<Institution Name>>

Education Type:	<<EducationType>>
Degree/Training Type:	<<DegreeType>>
Attendance Dates:	<<StartDate>> to <<EndDate>>
Degree/Training Completion:	<<Completion>>
Verification Date:	<<VerDate>>

Work History

Organization	Start Date	End Date	Verification Date
<<InstitutionName>>	<<StartDate>>	<<EndDate>>	<<VerDate>>

Work History Gaps	Start Date	End Date	Verification Date
<<GapDescription>>	<<StartDate>>	<<EndDate>>	<<VerDate>>

Speciality & Board Certification

Type	Board Certification Date	Expiration Date	Verification Date
<<Specialty>>	<<CertDate>>	<<ExpDate>>	<<VerDate>>

Page 1 MVS

MVS Service Agreement
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<<RequestType>> of <<NameLast>>, <<NameFirst>> <<NameMI>>, <<Degree>>

Social Security Number:	<<SSN>>	**Report Date:**	<<CompletionDate>>
Date of Birth:	<<DOB>>	**Attestation Date:**	<<AttestationDate>>
		Quality Control Date:	<<AttestationDate>>

Sanctions

Data Source	Verification Date	Findings
<<DataSourceName>>	<<VerDate>>	<<Finding>>

Page 3

MVS

EXHIBIT D

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum amends and is made part of the Credentials Verification Services Agreement (the "Agreement") by and between Healthcare Organization ("Covered Entity") and Medical Verification Services, LLC ("Business Associate").

Covered Entity and Business Associate mutually agree to modify the Agreement to incorporate the terms of this Addendum to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing privacy regulations at 45 CFR Parts 160-164 ("HIPAA Privacy Rule"). The parties acknowledge and agree that if any of the terms and conditions set forth in this Addendum are in conflict with or in addition to the terms and conditions set forth in the Agreement, then this Addendum will control in connection with the request, use, or disclosure of Protected Health Information ("PHI"), as that term is defined in Section 1(c) of this Addendum.

1) Definitions. For purposes of this Section, the following terms will have the indicated meanings:

   a) *Affiliated Entity*. "Affiliated Entity" will mean an entity under common control or common ownership.

   b) *HIPAA Regulations*. "HIPAA Regulations" will mean the regulations promulgated by the Secretary of Health and Human Services under the authority of Title II, Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-191)

   c) *Protected Health Information*. "Protected Health Information" will have the meaning set forth in 45 CFR § 164.501, as amended from time to time. Generally, this term means individually identifiable health information including all information, data and materials, including demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2) Protected Health Information.

   a) *Permitted Uses and Disclosures*. Business Associate agrees to use or disclose PHI it creates for or receives from Covered Entity only as follows:

      i *Functions and Activities on Covered Entity's Behalf*. Business Associate is permitted to use and disclose PHI it creates for or receives from Covered Entity in order to provide services as described in the Agreement, provided that such use or disclosure would not violate the HIPAA Privacy Rule if done by Covered Entity.

      ii *Business Associate's Operations – Use of PHI*. Business Associate is permitted by this Addendum to use PHI it creates for or receives from Covered Entity if such use is essential

for Business Associate's proper management and administration, or is essential to carry out Business Associate's legal responsibilities.

iii *Business Associate's Operations – Disclosure of PHI*. Business Associate is permitted by this Addendum to disclose PHI it creates for or receives from Covered Entity if such disclosure is essential for Business Associate's proper management and administration, or is essential to carry out Business Associate's legal responsibilities, provided that such disclosure would be permitted under state and federal confidentiality laws if done by Covered Entity, and only if the following conditions are met: (1) the disclosure is required by law; or (2) Business Associate obtains reasonable assurances in writing from any person or organization to which Business Associate will disclose such PHI that the person or organization will hold such PHI as confidential, and will only use or further disclose such PHI as required by law, or for the purpose for which the Business Associate disclosed such PHI to the person or organization. The person or organization shall promptly notify the Business Associate (who shall in turn promptly notify Covered Entity) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI has been breached.

iv *Minimum Necessary Standard*. In performing the functions and activities on Covered Entity's behalf as set forth above, Business Associate agrees to use, disclose or request only the minimum necessary PHI to accomplish the purpose of the use, disclosure or request.

b) *Certain Representations and Warranties*. Business Associate represents and warrants that to the extent that Business Associate is provided with any Protected Health Information, Business Associate will:

i Not use or further disclose the information other than as specifically set forth in this Business Associate Addendum;

ii Not use or further disclose the Protected Health Information in a manner that would violate the requirements of any state or federal law including the provisions of the HIPAA Regulations;

iii Use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for in this Business Associate Addendum;

iv Report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Business Associate Addendum of which Business Associate may become aware;

v Ensure that any agents, including subcontractors, to whom Business Associate provides Protected Health Information received from Covered Entity or Affiliated Entities agrees to the same restrictions and conditions that apply to Business Associate with respect to such Protected Health Information;

vi Make the Protected Health Information available in accordance with the HIPAA Regulations;

vii Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the HIPAA Regulations;

viii Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Covered Entity available to the Secretary of Health and Human Services for purposes of determining the Covered Entity's compliance with the HIPAA Regulations;

ix Return or destroy all Protected Health Information received from the Covered Entity which Business Associate maintains in any form at the termination of this Business Associate Addendum; and

x Incorporate any amendments or corrections to the Protected Health Information which may be requested pursuant to the HIPAA Regulations.

3) Audit Rights. In order to allow Covered Entity to certify its compliance with the HIPAA Regulations, Business Associate will permit Covered Entity, at Covered Entity's expense and on five (5) days prior notice, to audit Business Associate's business systems and services, with specific emphasis on Business Associate's compliance with the provisions of this Section. Such audit, which may be conducted by Covered Entity's personnel under obligations of confidentiality or by an independent auditing firm, will not interfere unreasonably with Business Associate's business activities, and will be conducted no more than once per calendar year, unless Covered Entity has received a request from the Secretary of Health and Human Services, or unless a previous audit has disclosed a material issue indicating non-conformance to the provisions of this Business Associate Addendum. Covered Entity will use information received during an audit solely for the purposes of the Agreement and will otherwise maintain the confidentiality of such information.

4) Breach. In addition to any other rights Covered Entity may have in this Business Associate Addendum, the Agreement or by operation of law, Covered Entity may immediately terminate this Business Associate Addendum and the Agreement, if Business Associate breaches this Business Associate Addendum.

5) Third Party Rights. The terms of this Business Associate Addendum are not intended nor should they be construed to grant any rights to parties other than Business Associate and Covered Entity.

6) Applicable Law and Forum. This Business Associate Addendum will be interpreted and construed in accordance with the laws of the State of Michigan. Any dispute arising under this agreement will be resolved pursuant to the Dispute Resolution provisions of Section 7 of the Agreement.

7) Waiver. No delay or omission on the part of either party in exercising any right hereunder will operate as a waiver of such right or of any other right under this Business Associate Addendum. A waiver on any one occasion will not be construed as a bar to or waiver of any right or remedy on any further occasion. The election of either party of a particular remedy on default will not be exclusive of any other remedy, and all rights and remedies of the parties hereto will be cumulative.

8) Amendments. Any amendment to this Business Associate Addendum will not be binding on either

of the parties to this Business Associate Addendum unless such amendment is in writing and executed by the party against whom enforcement is sought.

9) Notices. Any notices required or permitted under this Business Associate Addendum will be in writing and delivered in person or sent by registered or certified mail, return receipt requested, proper postage prepaid, properly addressed to the address of the addressee set forth above or to such other more recent address of the addressee of which the sending party has received written notice.

10) Binding Effect. Entry into the Agreement constitutes entry into this Business Associate Addendum and no separate signatures or executions are required.

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MVS Service Agreement
Exhibit E - Page 1 of 1

MVS Base Agreement (Centene Corporation) v2.0.01

Initials: MVS _____ HP _____

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i. Management Services Subcontracts – GSA 4

To facilitate implementation and to fulfill the requirements in the Arizona RFP, GREABHA has contracted with four organizations:

- The Southwest Network
- META Services
- Caremark, Inc.
- Medical Verification Solutions, LLC (MVS)

The requested information regarding these three organizations is provided below.

1. The Southwest Network

The Southwest Network has a proven track record of leadership and innovation in the implementation of the Arizona principles.

Name of Subcontractor	The Southwest Network
Address	3707 N. 7th Street #200, Phoenix 85014
Telephone Number	602-266-8402
Ownership	Nonprofit
Specific Management Service (including Delegated Administrative Functions)	Training and coaching to providers in GSA 4
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Team of Mentoring and Training Staff 175 hours
Compensation Arrangement including expected Total Annual Compensation	Not to exceed $17,500
Plans for Monitoring	GREABHA will meet with The Southwest Network monthly to evaluate the needs of providers and to evaluate the effectiveness of the training and coaching.

09/28/2004 15:07 DESERT SPRINGS → 13147254658 NO.228 P002
09/28/2004 14:56 NO.486 P02

GPA
FOCUSED BEHAVIORAL SOLUTIONS

LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH GROUP PRACTICE AFFILIATES FOR PROVISION OF SERVICES TO ARIZONA MEDICAID MEMBERS

Group Practice Affiliates, "GPA" is proposing to become the Regional Behavioral Health Authority in one or more of the GSA Regions for which the State of Arizona is currently soliciting proposals. This Request for Proposals ("RFP"), Numbered HP532003, is issued by the Arizona Department of Health Services for provision of services to Title XIX and Title XXI Covered consumers, Developmentally Disabled Children and Adults, and Non-Title XIX and XXI Persons with a Serious Mental Illness.

If GPA is awarded the contract to become the Regional Behavioral Health Authority for GSA 1, GSA 2, or GSA 4, Southwest Network will provide training and coaching to the providers in those regions at the direction of GPA.

1. CONTRACTOR PRINTED NAME

The Southwest Network

2. ADDRESS (primary address if more than one location)

3707 N. 7th Street #200, Phoenix, AZ

3. ZIP CODE 85014 4. COUNTY Maricopa

5. TELEPHONE (602) 2010-8402 6. FAX (602) 264-0887

7. TAX ID# 86-0966400 8. AZ PROVIDER ID# 5452416

HOURS TO BE SUBCONTRACTED

GSA 1 350

GSA 2 175

GSA 4 175

COMPENSATION

Not to exceed $70,000

MONITORING

Southwest Network will meet with GPA monthly to evaluate the needs of providers and to evaluate the effectiveness of training and coaching.

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09/28/2004 15:07 DESERT SPRINGS → 13147254658 NO.228 P003
09/28/2004 14:56 NO.486 P03

GPA
FOCUSED BEHAVIORAL SOLUTIONS

ATTESTATION

Southwest Network has never been suspended or excluded from any Federal program.

9. PROVIDER'S SIGNATURE

10. DATE 9/28/04

11. PRINTED NAME OF SIGNER Jeff Jorde

12. TITLE President/CEO

1

2. META Services, Inc.

META Services has a proven track record of leadership and innovation in the implementation of the Arizona principles.

Name of Subcontractor	META Services, Inc.
Address	2701 N. 16th Street #316, Phoenix 85006
Telephone Number	602-650-1212
Ownership	Non-profit
Specific Management Service (including Delegated Administrative Functions)	Training and coaching to providers in GSA 4
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Team of Mentoring and Training Staff 225 hours
Compensation Arrangement including expected Total Annual Compensation	Not to exceed $16,100
Plans for Monitoring	GREABHA will meet with META Services monthly to evaluate the needs of providers and to evaluate the effectiveness of the training and coaching.

GPA

LETTER OF INTENT TO ENTER INTO CONTRACT NEGOTIATIONS WITH
GROUP PRACTICE AFFILIATES
FOR PROVISION OF SERVICES TO ARIZONA MEDICAID MEMBERS

Group Practice Affiliates "GPA" is proposing to become the Regional Behavioral Health Authority in one or more of the GSA Regions for which the State of Arizona is currently soliciting proposals. This Request for Proposals ("RFP") numbered HP532003 is issued by the Arizona Department of Health Services for provision of services to Title XIX and Title XXI Covered consumers, Developmentally Disabled Children and Adults, and Non-Title XIX and XXI Persons with Serious Mental Illness.

If GPA is awarded the contract to become the Regional Behavioral Health Authority for GSA 1, GSA 2, or GSA 4, META Services, Inc. will provide training and coaching in the planning, development, and implementation of mental health recovery principles and practices to GREABHA staff and to the providers in those regions at the direction of GPA.

1. CONTRACTOR PRINTED NAME

   META Services, Inc.

2. ADDRESS (primary address if more than one location)

   2701 N. 16th Street #316
   Phoenix, AZ

3. ZIP CODE 85006
4. COUNTY Maricopa
5. TELEPHONE 602.650.1212
6. FAX 602.650.1616
7. TAX ID# 86 0671446
8. AZ PROVIDER ID# 1204014

HOURS TO BE SUBCONTRACTED

GSA 1 – not to exceed 300

GSA 2 – not to exceed 175

GSA 4 – not to exceed 225

COMPENSATION

Not to exceed $50,000.00

MONITORING

META Services, Inc. will meet with GPA monthly to evaluate the needs of providers and to evaluate the effectiveness of training and coaching.

1

GPA

ATTESTATION

META Services, Inc. has never been suspended or excluded from any Federal program.

9. PROVIDER'S SIGNATURE _____

10. DATE September 28, 2004

11. PRINTED NAME OF SIGNER Eugene Johnson

12. TITLE President/CEO

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3. Caremark/PCS

To ensure continuity of care for Arizona behavioral health recipients, GREABHA provides Pharmacy Benefit Management (PBM) services through a contract with Caremark/PCS, the same PBM vendor that currently serves the majority of behavioral health recipients in GSA 1 and GSA 2. GREABHA's parent company, Centene, has experience working with Caremark to provide specialty pharmacy services such as self-injectables or therapies that require extensive monitoring or follow-up care.

Name of Subcontractor	Caremark/PCS
Address	9501 E. Shea Blvd., Scottsdale, AZ 85260
Telephone Number	(480) 391-4600
Ownership	Publicly traded NYSE symbol CMX
Specific Management Service (including Delegated Administrative Functions)	Pharmacy claims processing and payment, pharmacy network contracting and management, rebate contracting and administration, formulary administration, drug utilization review, pharmacy help desk
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	0.75 FTE Customer Service 0.25 FTE Pharmacy Administrator 0.25 FTE Contracting Pharmacy program administration requires approximately 40 hours per week per 50,000 live both pharmacy and non-pharmacy
Compensation Arrangement including expected Total Annual Compensation	Discounted AWP plus dispensing fee per prescription. Per claim administration fee and rebate administration fee Total Annual Compensation: $2.4 million $3.25 per member per month
Plans for Monitoring	Annual delegated oversight audit including financial, operations, customer service, clinical, administrative and quality functional areas. Contract specifies deliverables from subcontractor.

CAREMARK
It all starts with care

October 6, 2004

Galit Lev-Harir
Centene Corporation

Dear Ms. Lev-Harir:

This letter is to inform you that Caremark and its Subsidiaries and facilities in the State of Arizona are all in good standing without any restriction, sanction or suspension within the scope of its business, as of this date.

Sincerely,

Richard J. Nagler
Vice President, Western Region

PHARMACY BENEFIT MANAGEMENT AGREEMENT

This **PHARMACY BENEFIT MANAGEMENT AGREEMENT** (this "Agreement") is made and entered into this _____ day of _____, 2004 by and between **CENPATICO BEHAVIORAL HEALTH**, a Delaware corporation ("HMO"), and **CAREMARK RX**, an Illinois corporation ("Manager").

RECITALS

WHEREAS, HMO is a managed care organization which arranges for the delivery of behavioral heath care services on behalf of Health Plans (as hereinafter defined), including state Medicaid and CHIP programs in the state of Wisconsin, and desires to contract with a pharmacy benefits management company for the management and delivery of pharmacy benefits to its Covered Persons (as hereinafter defined); and

WHEREAS, Manager is in the business of developing and administering systems for the delivery of pharmacy benefits and desires to contract with HMO to provide access to such systems and the management services related thereto.

NOW, THEREFORE, in consideration of the terms and conditions set forth in this Agreement, the parties hereto agree as follows:

I. DEFINITIONS

In addition to the capitalized terms defined elsewhere in this Agreement, the following terms shall have the following meanings:

1.1. **"Benefit Contracts"** means a health benefit plan that: (i) is sponsored, purchased, issued, or administered by Health Plans, (ii) contains the terms and conditions of a Covered Person's coverage, and (iii) provides pharmacy benefits either as part of the basic plan or through a rider to the plan. A Benefit Contract is also known as a certificate of coverage, summary plan description, evidence of coverage, or group services agreement.

1.2. **"Commencement Date"** the date on which Manager begins to provide services pursuant to the terms of this Agreement, which date shall be January 1, 2005, subject to State regulatory filing and/or prior approval requirements.

1.3. **"Copayment"** collectively means the charge, in addition to the premium, which a Covered Person is required to pay for certain covered services provided under the Benefit Contracts and includes copayments, coinsurance, deductibles, or other similar charges, which may be either a defined dollar amount or a percentage of eligible expenses. A Covered Person is responsible for the payment of any Copayment directly to a pharmacy at the time a prescription is dispensed.

1.4. **"Covered Person"** means an individual eligible to receive coverage for outpatient prescription pharmacy benefits as an enrollee under a Benefit Contract.

1.5. **"Covered Prescription Drug Services"** means those outpatient prescription drugs and pharmacy products, services, and supplies that are covered pursuant to the Benefit Contracts.

1.6. **"ADHS"** means the Arizona Department of Health Services.

1.7. **"Health Plans"** means any of the managed care health plans established and operated by HMO or its subsidiaries or affiliates, whether insured or self-insured, commercial or governmental program. This term includes behavioral health and state RBHA programs operated in the State of Arizona.

1.8. **"Intellectual Property"** means all patents, patents pending, trademarks, service marks, trade names, service names, slogans, registered copyrights, commercially significant unregistered copyrights, technology rights and licenses, computer software (including, without limitation, any source or object codes or related documentation), trade secrets, franchises, know-how, inventions, and all improvements to such intellectual property.

1.9. **"RBHA Management Contract"** means the written agreement entered into by Cenpatico and the Arizona Department of Health Services for the management of the Arizona Regiona Behavioral Health Association programs.

1.10. **"Medically Necessary"** shall mean the provision of a Covered Prescription Drug Service which a Covered Person requires as determined by one or more participating providers, in accordance with generally accepted medical practice standards in effect at the time of treatment and in conformity with the professional and technical standards adopted by the Quality Improvement and Utilization Management Committee(s) of HMO and its subsidiaries and not solely for the convenience of the Covered Persons.

1.11. **"Non-Covered Services"** shall mean those health care services that are not Covered Prescription Drug Services and are not benefits under the ADHS/RBHA Contract and are, therefore, the financial responsibility of the Covered Persons, or are to be paid by the ADHS fee-for-service programs.

1.12. **"Participating Pharmacy(ies)"** means a pharmacy, including a retail service pharmacy, or a pharmacist which/who has entered into an agreement with Manager under which pharmacy/pharmacist has agreed to provide Covered Prescription Drug Services to Covered Persons and to comply with (i) contractual requirements pursuant to this Agreement, and (ii) statutory and regulatory requirements.

1.13. **"Pharmacy & Therapeutics Committee"** or **"P&T Committee"** means the HMO committee that: (i) considers a prescription drug for inclusion on the HMO Preferred Drug List or other comparable formularies, and (ii) develops other criteria, procedures, and rules for the Program including, but not limited to, quantity levels and prior authorization issues.

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obligations under this Agreement, including, without limitation, a certificate of authority as a third party administrator. Manager shall promptly notify HMO of any and all licensing, administrative, or legal actions initiated against it by any government agency which has as a potential remedy the loss or limitation of any license or which is likely to result in the inability of Manager to fulfill and perform its duties under this Agreement. Manager shall be solely responsible for any fines, penalties, or other assessments imposed against it or against HMO by any state or federal regulatory authority which arise out of Manager's failure to comply with HMO's procedures for administering PBM Services. In the event a state or federal regulatory authority imposes a fine, penalty or other assessment against HMO for acts or omissions caused by Manager's failure to comply with this Agreement, Manager shall reimburse HMO in full for such fine, penalty or other assessment within ten (10) days of receiving written notice from HMO. Manager shall perform the PBM Services required under this Agreement in accordance with all applicable state and federal laws and regulations, including, without limitation, those relating to the activities of third party administrators.

2.1.4. No Conflict; Required Filings and Consents. Manager represents and warrants to HMO that the execution, delivery, and performance of this Agreement does not, and the provision of the services contemplated hereby will not: (a) conflict with the Articles of Incorporation or Bylaws or other corporate documents of Manager; (b) conflict with or violate any laws applicable to Manager or by which any of its properties is bound or affected; or (c) result in any breach of or constitute a default (or an event that with notice or lapse of time or both would become a default) under, or give to others any rights of termination, amendment, acceleration, or cancellation of, or result in the creation of a lien or encumbrance on any of the properties or assets of Manager pursuant to any note, bond, mortgage, indenture, contract, agreement, lease, license, permit, franchise, or other instrument or obligation to which Manager is a party, or by which Manager or any of its properties is bound or affected. The execution and delivery of this Agreement by Manager does not, and the performance of this Agreement by Manager and the provision of the services contemplated hereby by Manager will not, require any consent, approval, authorization or permit of, or filing with or notification to, any third party, except for certain filings required by certain state governmental entities.

2.1.5 Financial Viability. Manager represents and warrants that it has sufficient net worth and financial reserves to meet its reasonably foreseeable needs under the terms of this Agreement and the Cenpatico/ADHS Contract. Upon request by HMO, Manager shall provide HMO a copy of its most recent audited financial statements.

2.2. Representations and Warranties of HMO.

2.2.1. Organization and Qualification. HMO represents and warrants to Manager that it is a corporation duly incorporated, validly existing, and in good standing under the laws of Delaware. HMO has the corporate power and authority necessary to own and operate its properties and to carry on its business as now conducted. HMO is qualified to do business as a foreign corporation in

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every jurisdiction in which the nature of its business or its ownership of property requires it to be so qualified.

2.2.2. Corporate Authorization. HMO represents and warrants to Manager that the execution, delivery, and performance of this Agreement are within its corporate powers. All requisite authority necessary to enter into this Agreement has been obtained, and HMO has duly and validly executed and delivered this Agreement. Assuming this Agreement constitutes the valid and binding agreement of Manager, this Agreement constitutes a valid and binding agreement of HMO enforceable against HMO in accordance with its terms.

2.2.3. Regulatory Compliance. HMO represents and warrants that Health Plans are currently, and shall remain throughout the duration of this Agreement, duly licensed as required to enter into and provide benefits under the Benefit Contracts. HMO shall promptly notify Manager of any and all licensing, administrative, or legal actions initiated against it or Health Plans by any state or federal government agency which has as a potential remedy the loss or limitation of its licensure or which is likely to result in the inability of HMO to fulfill its obligations under this Agreement. HMO or Health Plans shall be solely responsible for any fines, penalties, or other assessments imposed against them by any state or federal regulatory authority which arise out of HMO's or Health Plans' acts or omissions in connection with the administration of the Benefit Contracts. HMO shall perform its duties under this Agreement in accordance with all applicable state and federal laws and regulations.

2.2.4. No Conflict; Required Filings and Consents. HMO represents and warrants to Manager that the execution, delivery, and performance of this Agreement does not, and the performance of this Agreement by HMO will not: (a) conflict with the Articles of Incorporation or Bylaws of HMO; (b) conflict with or violate any laws applicable to HMO or by which any of its properties is bound or affected; or (c) result in any breach of or constitute a default (or an event that with notice or lapse of time or both would become a default) under, or give to others any rights of termination, amendment, acceleration, or cancellation of, or result in the creation of a lien or encumbrance on any of the properties or assets of HMO pursuant to any note, bond, mortgage, indenture, contract, agreement, lease, license, permit, franchise, or other instrument or obligation to which HMO is a party, or by which HMO or any of its properties is bound or affected. The execution and delivery of this Agreement by HMO does not, and the performance of this Agreement by HMO will not, require any consent, approval, authorization or permit of, or filing with or notification to any third party, except for certain filings required by certain state governmental entities.

III. OBLIGATIONS OF MANAGER: PHARMACY BENEFIT MANAGEMENT AND SERVICES

3.1. General Manager Services. Manager shall provide to HMO the PBM Services described in this Agreement and in **Exhibit** B and C.

3.2. Retail Participating Pharmacy Network. Manager agrees to provide networks of retail Participating Pharmacies under contract with Manager to provide dispensing services to Covered Persons under the Retail Pharmacy Program. Manager agrees that HMO may

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require the termination of a specific retail pharmacy for good cause including quality of care issues. Manager shall notify HMO of any terminations in the Participating Pharmacy network. Manager shall send letters to Covered Persons who have utilized a Participating Pharmacy in the prior twelve months notifying them of the termination of such Participating Pharmacy, after receiving from HMO: (a) the addresses of the affected Covered Persons; and (b) the approval of the letters by HMO. HMO shall be responsible for the postage costs of any mailings to Covered Persons when a Participating Pharmacy is terminated at HMO's request. Manager shall be responsible for the postage costs of any mailings to Covered Persons when Participating Pharmacy is terminated at Manager's request. Manager agrees that during the term of this Agreement all Manager customized pharmacy provider agreements for such retail pharmacy network shall be assignable to HMO. Such assignment shall be made at HMO's sole discretion and at a time determined by HMO.

3.3. Pharmacy Network Information. Manager shall provide HMO with a complete list of the names, addresses, license numbers, and normal office hours of the Participating Pharmacies, together with the provider-specific information required by HMO, at the time this Agreement is signed and thereafter as such information becomes available. Manager shall provide at least ninety (90) calendar days prior written notice to HMO of the proposed termination of Participating Pharmacies if a group of 5 or more pharmacies is terminated at one time or if such termination of one or more pharmacies would result in the pharmacy network not meeting state access standards .

3.4. Consultation. Manager shall provide ongoing consultation and assistance to HMO with respect to the delivery of PBM Services to Covered Persons. The scope of such assistance shall include, without limitation, advice and recommendations regarding the PBM Services, provider network, and claims. Manager shall educate HMO's provider network regarding Manager's policies and procedures in a reasonably prudent manner.

3.5. HMO Policies. Manager shall perform the PBM Services in accordance with the standards, policies, procedures, and requirements established by HMO for such activities and in accordance with applicable state and federal law. Manager may utilize its own policies and procedures for the PBM Services, provided that such policies and procedures are consistent with the HMO standards and requirements and are provided to HMO for its review and approval.

3.6. Laws, Regulations and Licenses. Manager, at its own cost, shall: (a) maintain all federal, state, and local licenses that are materially necessary to provide PBM Services under this Agreement and the lack of which could adversely affect HMO; (b) shall comply with all applicable statutes and regulations in providing all PBM Services pursuant to this Agreement; and (c) require all Participating Pharmacies employed by or under contract with Manager to comply with (a) and (b).

3.7. Personnel and Other Resources. Manager shall provide sufficient, dedicated personnel, information systems support, and other resources, as reasonably required to successfully provide high-quality, cost-effective PBM Services for HMO pursuant to this Agreement.

3.8. Customized Installation Materials. Manager agrees to provide to HMO customized installation materials for HMO that are accurate and support the specific

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language in the Benefit Contracts. Manager is responsible for administering the Benefit Contracts accurately and in accordance with all regulatory requirements.

3.9. Communications. At HMO's option and approval, Manager shall produce brochures, and other materials for Covered Persons specific to Covered Prescription Drug Services. Manager agrees to provide an accompanying explanatory brochure and direct reimbursement claim forms for use by Covered Persons who have not received or who have lost their identification cards. Manager agrees that any materials sent to Covered Persons must be approved by HMO. HMO shall be responsible for all postage costs related to mailings to Covered Persons, except as otherwise provided in this Agreement. Manager agrees that all written communications sent to HMO Covered Persons, Participating Pharmacies, or facilities that relate in any way to HMO's Benefit Contracts must be reviewed and approved by HMO before such communications are sent out to any such individuals or groups. Manager agrees that all program communication protocols to be used with HMO Participating Pharmacies will be reviewed and approved by HMO prior to use. HMO shall approve or disapprove all such materials within a reasonable time after submission by Manager.

3.10. Eligibility and Claims Processing.

3.10.1. Eligibility. Manager shall administer the eligibility of Covered Persons according to eligibility information provided by HMO via tape or telecommunication or such other reasonably practicable method in a mutually agreeable acceptable format. Manager shall load eligibility tapes within one (1) business day and inform HMO upon completion. Manager agrees to provide toll-free access for network pharmacies to Manager's customer service department for claims processing assistance. Manager shall notify HMO immediately upon becoming aware of any discrepancies in the eligibility information.

3.10.2. Payment of Claims. Manager shall process Covered Persons' Covered Prescription Drug Services in accordance with the Benefit Contracts, Manager's standard operating procedure, and any applicable statutory and regulatory requirements governing third party administrators, including but not limited to any prompt payment of claims requirements. Claims adjudication includes, without limitation: (i) an explanation to a Covered Person of benefits describing any payment reduction or denial of the claim; (ii) a request for additional information to determine benefits; (iii) a notification that additional information is required from a provider; and (iv) payment for clean claims, as defined in any applicable law or regulation.

3.10.3. Disputes. Any disputes over claims shall be resolved prior to payment by Manager. If Manager makes an error or omission in claims processing, Manager shall be solely responsible for any related costs.

3.10.4. Postage. All postage costs related to payment or denial of direct reimbursement claims are the responsibility of Manager.

3.10.5. Claims Reports. Manager shall provide claims reports and written notice to HMO of the amount necessary to pay the fees due to Manager for claims processed, as set forth in **Exhibit A**. Manager will provide HMO with a claims

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processing fee statement pursuant to **Exhibit A**. Within 15 days after receipt of each statement from Manager, HMO shall remit payment of such fees.

3.10.6. Claims Auditing. Manager shall regularly audit its electronic and on-site claim processing activities and shall regularly audit its retail pharmacies, in accordance with Manager's standard audit procedures. Manager shall provide HMO with a report on such audits containing specific audit information and containing such other information as HMO reasonably requests. HMO shall receive one hundred percent of any such audit recoveries that were incorrectly paid pursuant to the HMO PBM Services. When any such overpayment was the result of errors or omissions by Manager, payment of such audit recovery shall include interest at the prevailing prime rate of interest for the period of time from the payment of the claim to receiving recovery from Manager.

3.10.7. Claim Appeals. In the event of a claim denial by Manager, Manager shall promptly communicate to the Covered Person the right to appeal according to the Covered Person's Benefit Contract and applicable law. Manager shall assist HMO in dealing with the Covered Person's appeal of Manager's decisions.

3.11. Covered Person Hold Harmless Provision. Manager agrees that it shall look only to the applicable Health Plan and agrees to hold Covered Persons harmless for compensation for all services provided to Covered Persons during the term of this Agreement. Under no circumstances, including but not limited to, nonpayment by Health Plan, Health Plan's insolvency or breach of this Agreement, shall Manager or any Participating Pharmacy bill, charge, collect a deposit or Surcharge from or seek compensation, remuneration, or reimbursement from, or have any recourse against, Covered Person or persons (other than Health Plan) acting on the Covered Person's behalf for services provided pursuant to this Agreement. This provision shall not prohibit collection of supplemental charges or Copayments made in accordance with the terms of the applicable Benefit Contract, nor does this provision affect the right of Participating Pharmacy to collect fees for services to Covered Persons which do not constitute Covered Services or for which Covered Person has specifically assumed financial responsibility, in writing, prior to the time that services were rendered. Manager further agrees that this provision shall: (i) survive the termination of this Agreement, regardless of the reason for termination, and shall be for the benefit of the Covered Person; (ii) supersede any oral or written agreement now existing or hereafter entered into between Manager and a Covered Person or persons acting on the Covered Person's behalf; and (iii) be construed to inure to the benefit of Covered Persons and persons acting on the Covered Person's behalf. Any modifications, additions, or deletions to this provision shall be effective no earlier than fifteen (15) days after any applicable regulatory authority has received any required written notice of and has approved such changes.

3.12. Reports. Manager agrees to provide reports to HMO in a format and containing such information as HMO reasonably requests, including but not limited to, claims paid, claims denial, claims lag, coordination of benefits, and third-party liability reports. The reports shall contain the information set forth in **Exhibit C**. If a state fine or penalty is imposed upon HMO due to Manager's failure to provide reports on the required due date, then Manager shall reimburse HMO for the full amount of the fine and any incidental expenses.

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3.13. Coordination of Benefits. When HMO provides required information, Manager agrees to administer coordination of benefits in accordance with HMO's coordination of benefits rules and the Benefit Contracts.

3.14. Service Performance Standards. HMO and Manager shall each use good faith and reasonable commercial efforts to perform their respective duties and obligations under this Agreement in a diligent, professionally responsible, and efficient manner. The parties agree to cooperate with and assist each other as reasonably necessary in the performance of their respective duties and in developing timely responses to the needs of HMO's business. Manager shall perform the services for which it is responsible under this Agreement using the same degree of skill and care in such performance as a prudent person engaged in pharmacy benefit management services would use under substantially similar circumstances. Manager accepts the service performance standards set forth in **Exhibit** C hereto, including the fees which shall be at risk if the performance standards and guarantees are not met. Manager shall provide to HMO monthly or quarterly reports, as applicable with respect to Manager's performance, and annual statistics, within ninety (90) days of the end of the calendar year, demonstrating whether Manager met the service performance standards described in **Exhibit** C. At such time that Manager provides such reports to HMO, Manager shall reimburse HMO any monies owed because of Manager's failure to meet such service performance standards and guarantees.

3.15. Insurance. Manager shall procure by the Effective Date and shall maintain, at its own expense: (a) professional liability insurance in the amount of $5,000,000.00 per occurrence and $10,000,000.00 annual aggregate including coverage for errors and omissions; (b) general liability insurance in the amount of $1,000,000.00 per each occurrence and $3,000,000.00 annual aggregate; and (c) umbrella/excess liability insurance in the amount of $10,000,000.00 each occurrence and aggregate. HMO must be named as an "additional insured" on the policies referenced above for claims affecting HMO's interests.

3.15.1. Nature of Insurance. Manager's and its contractors' or subcontractors' insurance policies shall: (i) be issued by companies that are admitted insurers in the jurisdiction in which all or a majority of the services or products are being provided, that have an A.M. Best rating of not less than "A-", and are in a size category which is not lower than "VIII"; (ii) be primary and noncontributory with any of HMO's insurance or self-insurance; (iii) name HMO as an additional insured; and (iv) not be cancelable, non-renewable or materially changed except after not less than thirty (30) days written notice to HMO. Manager shall provide to HMO certificates of insurance evidencing the insurance coverage required by this Section.

3.15.2 Liability. None of the foregoing requirements as to the type and limits of insurance to be maintained by Manager are intended to and shall not in any manner limit or qualify the liabilities and obligations assumed by Manager under this Agreement.

3.16. Claims and Regulatory Inquiries. Manager shall, within ten (10) days, provide information to HMO regarding all non-routine inquiries by regulatory departments, pharmaceutical manufacturers, attorneys, Covered Persons, or other individuals or entities

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with respect to Manager's services pursuant to this Agreement, including, but not limited to, the denial of any claims or any causes of action.

3.17. Books and Records. Manager shall maintain adequate medical, financial, and administrative records related to PBM Services in a manner consistent with the standards of the community and in accordance with all applicable statutes and regulations, including, but not limited to, reasonable documentation of all the data of Covered Persons related to Manager's services under this Agreement to determine whether Manager is performing its obligations under the Agreement and correctly billing HMO. HMO shall have the right to review such data at reasonable times and upon reasonable notice. If any audit reveals an underpayment or overpayment by HMO to Manager, such discrepancy will be reported to Manager, and Manager will respond within forty-five (45) days. Any amounts deemed payable as a result thereof shall be promptly repaid to the appropriate party with accrued interest (whether or not this Agreement has terminated). If the parties disagree on the amount to be repaid, the matter shall be resolved in accordance with Section 11.5. This obligation shall survive the expiration or earlier termination of this Agreement.

3.18. Accreditation. Manager agrees to provide HMO with reasonable assistance and cooperation in meeting all accreditation standards, including but not limited to National Committee for Quality Assurance standards, applicable to the services provided pursuant to this Agreement.

3.19. Utilization Review. In accordance with the terms and conditions of the delegation standards attached hereto as **Exhibit** C, Manager shall, for and on behalf of HMO, establish and administer a utilization review program in connection with PBM Services provided or proposed to be provided to Members, utilizing the standards, criteria, protocols and procedures established by HMO and in accordance with the applicable requirements of state and federal law and NCQA standards. Manager agrees to abide by, and shall have each of its employees or contracted providers performing utilization review services under this Agreement sign a written statement agreeing to abide by, the following NCQA standards: (1) any and all utilization review decisions made under this Agreement shall be based only on the appropriateness of the proposed prescription drug services and the existence of coverage for such services; (2) neither contracted providers nor Manager's staff or other individuals conducting utilization review are rewarded for issuing denials of coverage; and (3) financial incentives provided to persons conducting utilization review are not used to encourage decision-making that results in under-utilization of Covered Prescription Drug Services.

3.20 Submission of Electronic Files. On a quarterly basis, Manager shall submit directly to HMO's database contractor electronic files of data maintained pursuant to this Agreement on a quarterly basis. The submission shall consist of electronic standard NCPDP claims payment files files.

IV. OBLIGATIONS OF HMO

4.1. General.

4.1.1. HMO will be the entity that contracts with Health Plans related to the services provided under this Agreement. Such agreements between HMO and Health Plans may provide for additional services by HMO and shall make

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provision for fees and other terms that HMO, in its discretion, determines to establish.

4.1.2. HMO agrees to provide information reasonably needed by Manager to administer its responsibilities under this Agreement including (a) Benefit Contracts documents; (b) timely eligibility and enrollment data on Covered Persons; (c) specific HMO customer information and needs; (d) Participating Pharmacy information when Manager's pharmacy network is not utilized or is used in addition to another participating pharmacy network; (e) patient identifiable prescription drug claims (including prescription drug claims from prior pharmacy benefit management vendors); and (f) patient identifiable medical claims reasonably necessary for Manager to implement and operate its clinical management programs for HMO. Information shall be provided in a mutually agreeable format.

4.1.3. HMO or Health Plans shall be solely responsible for drafting HMO's Benefit Contracts.

4.2. Payment to Manager. HMO shall compensate Manager for the PBM Services and the Covered Prescription Drug Services provided by Manager as described in Exhibit A to this Agreement. All payments to Manager shall be deemed final unless adjustment is requested within ninety (90) days of Manager's receipt of payment. HMO's request to recoup overpayments made to Manager, including overpayments made because of erroneous eligibility information, shall not be subject to such 90-day deadline. Except for fee-for-service (Billback) claims described in Section 2 of Exhibit A, HMO shall have no further obligation for payment related to the Covered Prescription Drug Services under its Benefit Contracts. Manager shall be at financial risk for the cost of covered prescription drug services as specified in a separate letter agreement executed by both parties hereto and which shall constitute a legally binding part of this agreement.

HMO shall remit payments to Manager on a monthly basis, by the 10th business day of each month. Payments shall be remitted via wire transfer to the account(s) designated by Manager or by other means as mutually agreed upon, provided such invoices contain all information necessary for HMO to determine its liability in the case of fee-for-service (Billback) claims and to determine the number of Covered Persons under this Agreement in the case of capitated fees. For each month for which payment is due, HMO shall be liable for payment of capitated fees to Manager for only those Covered Persons for whom HMO receives capitation from the State. Manager shall invoice such fees by the third business day of each calendar month and shall provide written detail for adjustments of fees assessed in prior months due to all eligibility status changes.

4.3. Regulatory. HMO shall (a) maintain all material federal, state, and local licenses that are reasonably required to operate its business; (b) comply with all material applicable statutes and regulations; and, (c) make reasonable commercial efforts to cause Health Plans to comply with (a) and (b).

4.4. Insurance. HMO agrees to maintain adequate insurance related to the operation of its business and its obligations under the Agreement.

4.5. Claims and Regulatory. HMO shall promptly provide information to Manager within ten (10) days about all non-routine inquiries by regulatory authorities,

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pharmaceutical manufacturers, or Covered Persons, with respect to the services provided by Manager under this Agreement.

4.6. Audits. HMO shall keep reasonable documentation of all Covered Persons related to this Agreement. Manager shall have the right to review such data at reasonable times upon reasonable notice.

V. PREFERRED DRUG LIST

5.1. Preferred Drug List. Beginning on the Commencement Date or on such later date designated by HMO and continuing through the term of this Agreement, Manager shall administer the HMO PDL or other formularies as developed by HMO from time to time pursuant to the Benefit Contracts.

5.1.1. HMO Preferred Drug List. The Preferred Drug List ("PDL") is a list that identifies those FDA approved prescription drug products that are preferred by HMO for dispensing to Covered Persons. HMO's PDL will at minimum contain the the medications listed on the ADHS/DBHS Medication listing that is in the ADHS/DBHS Provider manual and may contain additional covered medications.

5.1.1.1. HMO and its P&T Committee have complete control in deciding what prescription drugs are placed on the PDL from time to time.

5.1.1.2. Manager shall have the right to present clinical data and rationale to the P&T Committee in conjunction with its evaluation of prescription drugs, but shall not be a voting member of the P&T Committee.

5.1.2. Preferred Drug List Compliance. HMO has in effect certain Program features designed to promote prescribing of PDL drugs by participating providers, dispensing of PDL drugs by Participating Pharmacies, and awareness of the advantages of the PDL by Covered Persons. Such features include, but are not limited to, incented benefit plan designs and corresponding levels of Copayments. HMO shall notify Manager, in advance, of any proposed Program modifications that are reasonably anticipated to have a material effect on PDL compliance. Additionally, HMO shall, as its option, participate in Manager's formulary communications programs, which may include communications with HMO Covered Persons, Participating Pharmacies and/or physicians, and financial incentives to Participating Pharmacies for their participation in the PDL. Manager shall notify HMO, in advance, of all PDL communications programs. HMO shall approve and may make reasonable changes to the content of such PDL communication programs before they are provided to the above HMO groups and individuals.

5.2. PDL Rebate Program. Pursuant to agreements entered into between Manager and certain pharmaceutical manufacturers ("Manufacturer Agreements"), Manager receives PDL Rebates from certain drug manufacturers as a result of the inclusion of such manufacturer's branded products on the PDL ("PDL Rebates"). Manager also receives and retains additional rebates and/or fees from certain manufacturers which may take into account various factors, including the utilization of certain drugs within

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their respective therapeutic categories for Manager's business in aggregate as a result of various commitments, services, and programs including, but not limited to, formularies (e.g. cost effective, incentive, volume, and market-share rebates). Manager shall fully disclose to HMO all rebates that Manager receives on HMO's behalf.

5.2.1. Rebate Distribution. Manager shall in good faith calculate the portion of any such rebates received that are allocable to PBM Services provided pursuant to this Agreement. Any disagreements related to such allocation determination shall be resolved in accordance with **Section 11.5**.

5.2.2. Drug Formulary Only Administration. Manager shall, at HMO's request, provide drug formulary only rebate administration for no additional fee for pharmacy claims processed by other entities, if such business qualifies for PDL Rebates. Such entities shall comply with Manager's data format requirements and processes.

VI. CONFIDENTIALITY

6.1. Confidential and Proprietary Information. In fulfilling the objectives of this Agreement, HMO and Manager may provide to each other or learn (directly or indirectly) certain information which a party considers to be confidential or proprietary ("Confidential Information"). Confidential Information shall include, without limitation, information relating to Covered Person and provider identities; reimbursement procedures; claims adjudication procedures; software and financial systems; the specific financial sections and provisions, specific operational aspects, financial guarantees contained in this Agreement, and other information relating to each party's business which is not generally available to the public. Each party's Confidential Information shall also include confidential, proprietary information which a third party has disclosed to a party, and which such party is obligated to maintain as confidential. Notwithstanding the foregoing, Manager and HMO acknowledge the other party's obligation to provide its pharmaceutical manufacturers and customers with information generally regarding this Agreement and, consistent with the foregoing, agrees that such parties may disclose generally the terms of this Agreement.

6.1.1. Neither party shall have any obligation to disclose its Confidential Information to the other party, unless such an obligation is set forth elsewhere in this Agreement.

6.1.2. Each party agrees to maintain the secrecy of and not to use or disclose the other party's Confidential Information, except as required in order for a party to perform under this Agreement. A party may disclose the other party's Confidential Information only to the receiving party's directors, officer, employees, agents and representatives (collectively, the "Representatives"), but only if a Representative needs to know the Confidential Information in order for the receiving party to perform under this Agreement. The parties agree to inform their Representatives of the confidential nature of the disclosing party's Confidential Information, and each party shall require any Representative, who is not an employee of the receiving party to sign an appropriate confidentiality agreement to protect the disclosing party's Confidential Information from unauthorized use or disclosure. Each party shall direct its Representatives to

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treat the other party's Confidential Information confidentially and not to use it other than to perform under this Agreement. Each party shall be responsible for its Representatives' use and disclosure of the other party's Confidential Information.

6.1.3. The restrictions in this **Section 6.1** shall not apply to: (a) information which is or becomes generally available to the public, other than as a result of a disclosure by the receiving party; (b) information a party obtains from a third party which has no obligation to keep the information confidential; (c) information which a party had in its possession prior to receiving Confidential Information from the disclosing party; (d) information which is independently developed by a party without reference to the Confidential Information disclosed by the other party; or (e) information required to be disclosed by law, subject to compliance with **Section 6.1.4**.

6.1.4. The parties agree that if a party is required (by subpoena, civil investigative demand or similar process) to disclose the other party's Confidential Information, the disclosing party shall notify the other party of the request or requirement so that the other party may seek an appropriate protective order or waive compliance with the sections or provisions of this Agreement. The parties agree to exercise their commercially reasonable efforts to assist each other in obtaining a protective order or other reliable assurance that confidential treatment will be accorded the Confidential Information.

6.1.5. Manager recognizes and agrees that HMO has a valuable business relationship with each of its Covered Persons and, further, that Manager stands in a position to influence Covered Persons decisions concerning insurers. In recognition of HMO's valuable business relationships with its Covered Persons, Manager agrees that, during the term of this Agreement, and after termination of this Agreement for any reason whatsoever, Manager shall not solicit Covered Persons, directly or indirectly, to enroll in any other health insurance or health coverage or alternative health care delivery system. Manager's obligation not to solicit Covered Persons is a material inducement for Manager's engagement by HMO pursuant to this Agreement.

6.1.6. The parties acknowledge and agree that irreparable injury will result to the other party in the event of a party's breach of these covenants, that a material inducement for the parties engagement by the other party are the covenants set forth in this **Section 6.1**, and that monetary damages in an action at law would not provide an adequate remedy in the event of a breach of this **Section 6.1**. The parties further acknowledge and agree that the covenants set forth in this **Section 6.1** are necessary for the protection of each party's legitimate business and professional duties, ethical obligations, and interests, and are reasonable in scope and content. Accordingly, in the event of either party's breach of this **Section 6.1**, or any part of this **Section 6.1**, this **Section 6.1** may be enforced by the obtaining of an injunction to restrain the violation thereof by the breaching party and all persons acting for or with such party.

6.1.7. Upon termination of this Agreement each party will immediately discontinue use of the other party's Confidential Information, and shall return the other party's Confidential Information to it, or destroy the other party's

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Confidential Information in its possession or control. However, each party may retain the other party's Confidential Information to the extent such Confidential Information has been used in or integrated into reports, studies, analyses, compilations or other documents in the receiving party's possession or control. Any oral Information will continue to be subject to the terms of this letter agreement. The parties agree that the Confidentiality obligations of this **Article VI** shall survive termination of this Agreement.

6.2. Privacy of Individually Identifiable Health Information. HMO and Manager will maintain the privacy and confidentiality of all individually identifiable protected health Information (PHI) regarding Covered Persons in accordance with all applicable statutes and regulations. In addition, Manager will:

6.2.1. Not use or further disclose the Protected Information other than as permitted or required by this Agreement or as required by law;

6.2.2. Use appropriate safeguards to prevent use or disclosure of the Protected Information other than as provided by this Agreement;

6.2.3. Report to HMO any use or disclosure of the Protected Information not provided for by this Agreement of which it becomes aware;

6.2.4. Ensure that any agents, including a subcontractor, to whom Manager provides Protected Information received from, or created or received by Manager on behalf of, HMO agrees to the same restrictions and conditions that apply to Manager with respect to such Protected Information;

6.2.5. Make available to Covered Persons Protected Information in accordance with those provisions of the Health Insurance Portability and Accountability Act ("HIPAA") relating to a Covered Person's right to access his or her health information;

6.2.6. Make available to Covered Persons Protected Information for amendment and incorporate any amendments to Protected Information in accordance with the HIPAA provisions providing therefor;

6.2.7. Make available to Covered Persons the information required to provide an accounting of disclosures in accordance with the HIPAA provisions providing therefor;

6.2.8. Make its internal practices, books, and records relating to the use and disclosure of Protected Information received from, or created or received by Manager on behalf of, HMO available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining HMO's compliance with this subsection; and

6.2.9. At termination of this Agreement, if feasible, return or destroy all Protected Information received from, or created or received by Manager on behalf of, HMO that Manager still maintains in any form and retain no copies of such Protected Information or, if such return or destruction is not feasible, extend the protections of this Agreement to the Protected Information and limit further

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uses and disclosures to those purposes that make the return or destruction of the Protected Information feasible.

Manager and HMO shall require all employees to comply with this subsection. Manager agrees that all Covered Person information provided to Manager by HMO belongs exclusively to HMO.

6.3. HMO's Database. Subject to **Section 6.4** below, Manager agrees that all data of HMO and its affiliates, including but not limited to Covered Person, customer, and provider related data, which is in Manager's possession, whether obtained by Manager in the course of providing services for HMO or as a result of a data transfer between HMO and Manager, belongs solely to HMO. Manager has the right to possess and use such data only to the extent permitted by contracts between the parties or as otherwise provided in this Agreement, subject to applicable legal restrictions. All information contained in HMO's database and systems belongs exclusively to HMO. Manager shall not have direct access to HMO's database and systems without signing a separate agreement with HMO. Manager and HMO recognize and agree that only information necessary for Manager performance under the Agreement shall be supplied by HMO to Manager, and Manager agrees that such data belongs exclusively to HMO.

6.4. Manager Use of Data. Notwithstanding the foregoing provisions of this **Article VI**, Manager may incorporate prescription data into Manager's prescription database when that database is used by Manager or provided to others for research, statistical, marketing, sales tracking or similar purposes. Manager agrees that if such prescription data is identifiable as to (a) Covered Persons, (b) employers and/or customers, and/or (d) HMO, such identifiable information will be deleted or encrypted before it is provided to others. This section only applies to Manager's use of prescription data and does not apply to medical data.

6.5. Pharmaceutical Agreements. Manager's agreements with pharmaceutical manufacturers are subject to confidentiality agreements. Any audit of Manager's agreements with pharmaceutical manufacturers conducted pursuant to this Agreement, shall be conducted by a third party public accounting firm reasonably acceptable to Manager whose audit department is a separate stand alone function of its business, subject to execution of a confidentiality agreement, and shall include only those portions of such pharmaceutical manufacturer agreements as necessary to determine Manager's compliance with **Article VI** in respect to PDL Rebates.

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VII. INTELLECTUAL PROPERTY

7.1. Manager's Property. Any Intellectual Property developed solely by Manager without using HMO's Confidential Information shall remain the property of Manager. HMO's right to use such Manager Intellectual Property shall be limited to those permitted by this Agreement or as otherwise agreed to in writing by the parties.

7.2. HMO's Property. Any Intellectual Property developed solely by HMO, without utilizing Manager's Confidential Information shall remain the property of HMO. Manager's right to use such Intellectual Property shall be limited to those permitted by this Agreement or as otherwise agreed to in writing by the parties.

7.3. Joint Property. The parties agree that any Intellectual Property or work product: (a) created jointly by the parties; or (b) created by Manager under this Agreement; or (c) created by Manager upon HMO's request (the "Work Product"), shall be the joint property of Manager and HMO.

7.4. Name, Symbol, and Service Mark. Manager and HMO agree that each party may use the other party's name in its discussions with prospective clients and in marketing and promotional materials, directories, and other communications. Each party shall provide to the other party a copy of any written materials containing the other party's name and shall obtain the prior written consent to such use from the other party. No use of the registered service marks of Manager or HMO by the other is permitted without prior written consent.

VIII. INDEMNIFICATION

8.1. By HMO. HMO agrees to indemnify and hold Manager, its subsidiaries and affiliates, and their respective officers, directors, agents, and employees harmless from and against any and all liabilities, losses, proceedings, actions, damages, claims, or expenses of any kind, including reasonable attorneys' fees, which result from (a) a breach by HMO of any of its obligations under this Agreement or (b) the negligent or willful acts or omissions by HMO, its agents, directors, officers, or employees, in connection with the representations, duties, and obligations of HMO under this Agreement.

8.2. By Manager. Manager agrees to indemnify and hold HMO, its subsidiaries and affiliates, and their respective officers, directors, agents, and employees harmless from and against any and all liabilities, losses, proceedings, actions, damages, claims, or expenses of any kind, including reasonable attorneys' fees, which result from (a) a breach by Manager of any of its obligations under this Agreement or (b) the negligent or willful acts or omissions by Manager, its agents, directors, officers, or employees, in connection with the representations, duties, and obligations of Manager under this Agreement.

IX. TERM AND TERMINATION

9.1. Term. The term of this Agreement is for the period of one year, commencing on the Commencement Date, unless terminated earlier as outlined in this **Article IX**. This Agreement shall automatically renew for successive one-year periods, unless terminated pursuant to this **Article IX**.

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9.2. Termination. This Agreement may be terminated as follows:

9.2.1. By either party at the end of any term, without cause, by providing at least ninety (90) days prior written notice of termination to the other party.

9.2.2. At any time by the mutual written consent of the parties.

9.2.3. By either party at any time, for cause, by providing sixty (60) days prior written notice to the other party upon the breach by such party of any material term, covenant, or condition of this Agreement, unless such breach is cured to the reasonable satisfaction of the terminating party within such sixty (60) day notice period.

9.2.4. Immediately by HMO, by providing notice to Manager, upon the expiration, non-renewal, or revocation of any license, certificate, approval, or authorization of Manager to perform any or all of the PBM Services.

9.2.5. By either party, effective immediately upon provision of written notice to the other party, if the other party has become insolvent or has been dissolved or liquidated, makes a general assignment for the benefit of creditors, or has a receiver appointed for a substantial portion of its assets.

9.2.6. Automatically and without any notice or other action on the part of either party if either party files, or has filed against it, a petition in bankruptcy and such petition is not dismissed within 60 days of the filing, unless the party which is not subject to such petition elects to waive such termination prior to the expiration of such 60 day period.

9.2.7. By either party immediately due to loss of insurance or inability to self-insure as required under this Agreement.

9.3. Information to Covered Persons. Manager acknowledges the right of HMO to inform Covered Persons of Manager's termination.

9.4. End of Term or Termination. In the event this Agreement is terminated for any reason prior to its expiration or upon the end of the term, Manager and HMO shall cooperate reasonably with each other for up to a six (6) month period following such termination or expiration to effect a quality, cost-effective and smooth transition of HMO's business previously operated or managed by Manager to HMO or HMO's designee.

9.5. Effect of Termination. Any termination of this Agreement shall have no effect upon the rights and obligations of the parties arising out of any transactions occurring prior to the effective date of such termination. Termination of this Agreement shall not release Manager or its Participating Pharmacies from their obligations to continue to provide PBM Services and Covered Prescription Drug Services for which compensation has been received prior to the effective date of termination.

9.6. Continuity of Care. Upon termination of this Agreement for any reason other than a quality of care issue, Manager and HMO shall comply with any applicable

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requirements for continuity of care as set forth in Wisconsin Insurance statutes Section 609.24.

X. ADHS CONTRACT REQUIREMENTS

10.1. Compliance with ADHS Contract. Manager shall abide by all applicable provisions of the ADHS Contract. Manager's compliance with the ADHS Contract specifically includes but is not limited to:

10.2. State Approval. This Agreement is subject to the prior review and approval by ADHS. HMO shall submit and obtain this approval prior to the Commencement Date.

10.3. Arizona Licensed Pharmacy Administrator. Manager shall use only an Arizona licensed pharmacist to oversee the Contractors medication services per the ADHS Contract.

10.4. Legal Liability. Nothing in this Agreement shall affect the legal liability of HMO in accordance with the ADHS Contract.

10.5. Quality Data. Manager shall participate in and contribute required data to HMO Quality Assessment/Performance Improvement programs, as defined in and required by ADHS Contract.

10.6. Pharmacy Encounter Data. Manager shall submit to HMO pharmacy encounter data in the format specified by HMO so that HMO can meet the State of Arizona ADHS contract specifications.

10.7. Non-discrimination. Manager shall comply with all non-discrimination requirements in ADHS Contract.

10.8. Access to and Confidentiality of Pharmacy Records. Manager shall provide to representatives of HMO, as well as duly authorized agents or representatives of ADHS and the federal Department of Health and Human Services, access to its premises and its contract and/or pharmacy records.

10.9. Referrals. Manager shall clearly specify referral approval requirements to its Participating Pharmacies and in any provider contracts.

10.10. Payment for Services. Manager shall not bill a RBHA Covered Person for Medically Necessary pharmacy services covered under the ADHS Contract and provided during the Covered Person's period of enrollment.

10.11. Grievances. Manager shall forward to HMO applicable medical records pertaining to grievances, within fifteen (15) working days of HMO's request. If Manager does not meet the 15-day requirement, Manager must explain the delay and indicate when the medical records will be provided.

10.12. Non-payment of Providers. Manager shall abide by the terms of the ADHS Contract regarding appeals to HMO and to ADHS for non-payment of providers.

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XI. GENERAL PROVISIONS

11.1. Notices. All notices or other communications required or permitted hereunder shall be in writing and shall be delivered personally, by commercial overnight delivery service, by facsimile or sent by certified, registered or express air mail, postage prepaid, and shall be deemed given when so delivered personally, by overnight delivery service or by facsimile, or if mailed, five days after the date of mailing, addressed as follows:

If to Manager:	If to HMO:
Caremark Rx Contract Services 2211 Sanders Road Northbrook, IL 60062 Attention: President	Cenpatico Behavioral Health 823 Congress Ave., Suite 600 Austin, TX 78701 Attention: President & CEO

or to such other address or to such other person as may be designated by written notice given from time to time during the term of the Agreement by one party to the other.

11.2. Force Majeure. Noncompliance with the obligations of this Agreement due to force majeure, laws or regulations of any government, war, civil commotion, destruction of production facilities and materials, fire, earthquake or storm, labor disturbances, shortage of materials, failure of public utilities or common carriers, and any other causes beyond the reasonable control of the applicable party, shall not constitute breach of contract.

11.3. Assignment. HMO may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by or under common control with HMO; provided, however, that any such entity is reasonably able to perform any responsibilities which it assumes. HMO may assign its rights and responsibilities in such a way that both HMO and Assignee share in the rights and responsibilities that, prior to such assignment, were solely those of HMO. Manager may assign all or any of its rights and responsibilities under this Agreement to any entity controlling, controlled by, or under common control with such party; provided, however, that any such entity is reasonably able to perform any responsibilities which it assumes. Manager and HMO each acknowledge that persons and entities under contract with such party, or in the case of HMO, Health Plans, may perform certain administrative services under this Agreement. Other than above, HMO and Manager agree that they shall not assign any of the rights and responsibilities under this Agreement without the prior written consent of the other party.

11.4. Amendment. Any amendments to this Agreement shall require written approval of the parties.

11.5. Dispute Resolution. In the event of a dispute arising out of this Agreement, the parties shall first attempt in good faith to resolve the dispute through informal discussions between themselves. Any claim, controversy, dispute or disagreement between the parties hereto which the parties are unable to resolve informally shall be resolved by binding arbitration by a single arbitrator in accordance with the Commercial Arbitration Rules of the American Arbitration Association (the "AAA") and administration of the

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arbitration shall be performed by AAA or such other arbitration service as the parties may agree in writing. The parties will endeavor to mutually agree to the appointment of the arbitrator, but if such agreement cannot be reached within thirty (30) days following the date demand for arbitration is made, the arbitrator appointment procedures of the AAA will be utilized. Arbitration hearings shall be held in Austin, TX or at such other location as the parties may agree in writing. Civil discovery may be taken in such arbitration as provided by applicable law. The arbitrator selected shall have the power to control the timing, scope and manner of the taking of discovery and shall further have the same powers to enforce the parties' respective duties concerning discovery as would a district court of Missouri including, but not limited to, the imposition of sanctions. The arbitrator shall have the power to grant all remedies provided by applicable law, except that punitive damages shall not be awarded. The parties shall divide equally the expenses of the AAA and the arbitrator, but the arbitrator may assess all such costs and expenses to the non-prevailing party in the arbitrator's award. The arbitrator shall prepare in writing an award that includes the legal and factual reasons for the decision. The arbitrator shall not have the power to commit errors of law or legal reasoning, and the award may be vacated or corrected pursuant to applicable law.

11.6. Relationship Between HMO and Manager. The relationship between HMO and Manager is solely that of independent contractors, and nothing in this Agreement or otherwise will be construed or deemed to create any other relationship, including one of employment, agency or joint venture.

11.7. Severability. If any provision of this Agreement shall be determined by any court of competent jurisdiction or arbitrator to be invalid and unenforceable to any extent under the law of any relevant jurisdiction, the remainder of this Agreement shall not be affected thereby, and each remaining provision shall be valid and shall be enforced to the fullest extent permitted by law.

11.8. Headings. The headings of the various sections herein are for convenience of reference only and shall not define, limit, or otherwise affect any of the terms or sections or provisions hereof.

11.9. Counterparts. This Agreement may be executed in one (1) or more counterparts, each of which shall be deemed an original but all of which together shall constitute one and the same instrument.

11.10. Governing Law. This Agreement shall be governed by and construed in accordance with applicable Illinois law without giving effect to conflict of law principles.

11.11. Entire Agreement. This Agreement and its Appendix, Exhibits, and Attachments constitute the entire Agreement between the parties with regard to the subject matter hereof and supercede any and all prior agreements, oral or written, between the parties with regard to the subject matter of this Agreement.

11.12. Regulatory Approval. The parties agree and acknowledge that the terms of this Agreement may be subject to review by state regulators.

11.13. Approvals. Approvals required under this agreement shall not be unreasonably delayed or withheld.

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11.14. No Third Party Beneficiaries. Nothing in this Agreement shall create or be deemed to create any third party beneficiary rights in any person or entity not a party to this Agreement.

11.15. Additional Agreements. Upon request, Manager agrees to enter into an additional separate agreement with any HMO affiliate receiving services hereunder reflecting the services received and obligations of such affiliate.

[SIGNATURE PAGE FOLLOWS]

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IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first set forth above.

CENPATICO BEHAVIORAL HEALTH 823 CONGRESS AVE., SUITE 600 AUSTIN, TX 78701	**CAREMARK RX** 2211 Sanders Rd. Northbrook, IL 60062
By:_____ Name: _____ Title: _____	By:_____ Name: _____ Title: _____

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EXHIBIT A
Financial Arrangements

"Average Wholesale Price" or **"AWP"** means the average wholesale price of the Covered Prescription Drug Services dispensed, utilizing the current price list in a nationally recognized pricing source, which Manager uses for all of its other customers, or, if Manager uses more than one source, then the source used for HMO shall be the source mutually agreed to by the parties. Under the Retail Pharmacy Program, AWP is based on the package size submitted.

"Maximum Allowable Cost" or **"MAC"** means the maximum acceptable cost of a generic product as determined from time to time by Manager. Manager shall provide its MAC list and prices to HMO upon request. Manager represents that its MAC pricing is generally no higher than HCFA MAC pricing and covenants that it shall give HMO written notice when any MAC price shall exceed the HCFA MAC price, which notice shall include the reasons for the discrepancy, if known, and the projected length of time that the MAC price will likely exceed the HCFA MAC price (if reasonable to estimate).

2. Charges for Covered Prescription Drug Services.

The following formulas shall be used to determine (a) the prices Manager shall pay for Covered Prescription Drug Services that are included as Covered Prescription Drug Services:

Lesser of Manager's actual payment or AWP minus 14% plus $2.00 dispensing fee for brands.

For generics, MAC plus $2.00 or AWP-20% plus $2.00 (whichever is actually paid to the dispensing pharmacy).

Plus, in each case (brands and generics), $0.35 administrative fee per paid claim.

4. Changes to the PDL.

Except as required by the ADHS or as mandated by applicable law, no changes to the PDL or Benefit Design (Exhibit D) will be implemented unless and until the change is agreed to by Manager and HMO.

5. Additional Administrative Fees.

HMO shall pay Manager for additional PBM Services HMO utilizes as follows:

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Exhibit B
PBM Services

The services listed below will be performed by Manager for behavioral health and ADHS Contract business. HMO can request the discontinuation of any service listed below and/or may perform any services listed below internally at HMO. Manager acknowledges that, from time to time, it will modify the services on this Agreement or add new services to be more effective. Such modified or new services will be provided to HMO.

1. **Claims Processing**
   - Electronic processing in-network
   - Paper claims processing in-network and out-of-network
   - Coordination of benefits administration
   - Twelve month on-line claims history retention
   - Monitor Participating Pharmacy compliance
   - On-line viewing access to claims history

2. **Eligibility Management**
   - Administration of eligibility submitted by multiple sources per tape or electronically with variable HMO formats with reasonable notice of changes to such formats
   - Load eligibility tapes within one (1) business day and inform HMO upon completion
   - Toll-free access to Manager's help desk for eligibility/claims processing assistance
   - Administration of paper adds/deletes/changes
   - 24 hour eligibility/claims processing support

3. **Benefits Management/Utilization Management**
   - Administration of benefits submitted electronically or by tape or by paper
   - Administration of paper adds/deletes/changes

4. **Pharmacy Network Management**
   - Establish, license-verification, contract, and maintain Participating Pharmacy networks for HMO
   - Develop and distribute communications to Participating Pharmacies following review by HMO

5. **Call Center Services**
   - 24 hour, seven day a week live customer service
   - Toll-free telephone access to Customer Service for the Program for use by Covered Persons, benefits personnel, pharmacists and physicians

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EXHIBIT C
Performance Standards and Requirements for PBM Services

1. Network Pharmacy License Verification

Activities include, but are not limited to, the following:

(a) Verification of active pharmacy licenses for all Participating Pharmacies;
(b) Verification of current Wisconsin Medicaid certification; and
(c) Provision of policies and procedures for reducing, suspending, or terminating pharmacy privileges.

INDICATOR	DUE DATE
Verify active pharmacy licenses and Wisconsin Medicaid certification for all Participating Pharmacies.	Once every three years.
Provide policies and procedures for reducing, suspending, or terminating pharmacy privileges.	Initial and forward any revisions made within 30 days of revision, or send a letter postmarked by January 31st of each year verifying no revisions have been made in the previous year.
Pharmacies terminated or disciplined	For termination of pharmacies: As per Section 3.3 of this agreement. For termination of pharmacists: 30 business days after the close of each quarter.
Complete pharmacy network.	15th of each month (per ADHS requirements).

2. Quality Improvement

Quality Improvement ("QI") activities may include, but are not limited to, the following:

(a) Planned monitoring of previously identified issues, including tracking and trending of issues over time;
(b) Customer service indicators such as call monitoring (for both Covered Person and provider calls) shall be reported and include, but are not limited to: number of calls, calls answered, calls abandoned, abandonment rate, and average time on hold;
(c) A process by which findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of QI activity are documented and reported to the appropriate individuals of Manager and HMO;
(d) Coordination of QI activities are coordinated with other performance monitoring activities;

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(e) Identify important areas for improvement and set meaningful priorities through annual physician and pharmacy surveys;
(f) A process for monitoring pharmacy access and availability; and
(g) A process that uses measurements, QI data collection, and analysis to track quality improvement, takes action to improve quality and assesses the effectiveness of these actions through systematic follow-up.

INDICATOR	DUE DATE
Submission of policies and procedures.	Initial and forward any revisions made within 30 days of revision, or send letter postmarked by February 28th of each year verifying no revisions have been made in the previous year.
Submission of Manager QI work plan and Manager QI program description.	Annually by February 28th.
Submission of the QI program evaluation of the prior year.	Annually by February 28th.
Copies of all QI meeting minutes included in the quarterly report.	60 days after close of the quarter.

3. Utilization Management/Appeals

Utilization management activities include the following:

(a) Prior authorization;
(b) Concurrent review; and
(c) Retrospective review.

INDICATOR	DUE DATE
Submission of annual utilization written plan.	Annually by February 28th.
Submission of annual utilization management program evaluation.	Annually by February 28th.
Monthly reports.	15th day following the end of the previous month.
Quarterly Executive Summary Reports.	60th day following the end of the previous quarter.

4. Complaints/Appeals/Grievances

Complaint, appeal, and grievance activities include the following:

(a) Registering and responding to complaints, appeals, and grievances;
(b) Documentation of substance of complaints, appeals, grievances, and actions taken; and
(c) Aggregation and analysis of complaint and grievance data.

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INDICATOR	DUE DATE
Electronic submission of policies and procedures.	Initial and forward any revisions made within 30 days of the revision, or send a postmarked letter by February 28th of each year verifying no revisions have been made in the previous year.
Submission of complaint and grievance activity by the 15th day following the end of the month.	15th day following the end of the previous month.

5. Claims Administration

Claims administration activities include the following:

(a) Development and submission to HMO of Manager's documented claims processing program that, at a minimum, satisfies the standards and procedures required by Manager's claims processing policies and procedures and the requirements under the Medicaid/BadgerCare HMO Contract. The documentation shall be provided by Manager to HMO for review and approval, on or before the Commencement Date, at any time thereafter upon HMO's request, and whenever a material modification to such documented claims processing program is made by Manager. All claims processing related delegated duties shall be performed by Manager in strict compliance with Manager's written clean claims processing program, and subsequently paid as approved by HMO.

(b) Manager represents and warrants that Manager's claims processing program will be administered in accordance with Manager's claims processing program standards and procedures established in accordance with state and federal laws and shall include, but is not limited to, the following:

(1) Verification of eligibility;
(2) Verification of authorization (if applicable);
(3) Verification of payee;
(4) Application of benefits in accordance with Benefit Contracts;
(5) Payment in accordance with provider contract terms;
(6) Appropriate level of medical review;
(7) Timely payment for "clean" claims in accordance with pharmacy contract terms, or within 30 days for non-contracted providers.

INDICATOR	DUE DATE
Electronic submission of all HMO pharmacy claims.	15th day following the end of the previous month.

7. Subcontracting

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All Manager's subcontracting arrangements for delegation of any portion of the PBM Services to another entity requires prior written approval of HMO. If Manager, with HMO's prior written approval, partners with another entity to perform any portion of the PBM Services, Manager shall provide documentation and demonstrate oversight of such entity by Manager to include:

(a) An executed agreement, including what is to be delegated and made available to HMO;
(b) The responsibilities of Manager and subcontractor;
(c) The process by which Manager evaluates the subcontract;
(d) The remedies, including revocation of the delegation available to Manager if the subcontractor does not fulfill its obligation;
(e) Evaluation of the subcontractor's capacity to perform the delegated activities prior to the execution of the contract;
(f) Annual evaluation of performance in accordance with HMO's accreditation and regulatory and statutory standards;
(g) The role of Manager and any subcontractor under this Agreement limited to performing certain delegated functions of HMO, using standards approved by HMO and which are in compliance with applicable statutes and rules.

HMO retains the right to perform additional evaluation and oversight of the subcontractor, if deemed necessary by HMO. Further, HMO retains the right to modify, rescind, or terminate at any time any one or all delegated activities under this amendment, regardless of any sub-delegation that may be approved.

8. Reporting Requirements

All reports specified by ADHS will be provided per specifications. The following table of standard reports may or may not be required by ADHS:

All Hedis and detailed reports will be submitted in test format initially for verification of set up and data pull by the HMO.

REPORTS	DUE DATE
Hedis (Beta-Blockers)	Quarterly
Hedis (Asthma)	Quarterly
Hedis (Diabetic Care-Oral Hypoglycemics/Insulin)	Quarterly
Hedis (Out-patient Drug Utilization)	Quarterly
Hedis (Anti-depressants)	Quarterly
Detailed Prenatal Vitamin Report	Bi-Weekly
Detailed ADHD Medication Reports	Monthly
Detailed Antibiotic Utilization	Monthly
Detailed HIV Medication Utilization	Monthly
Smoking Cessation	Monthly
Pharmacy Network List	Monthly
Executive Profile (electronic, as currently submitted)*	Monthly
Executive Summary (electronic, as currently submitted)*	Monthly
BioScrip Reporting (per BioScrip contract)	Quarterly
P & T Document Support	Quarterly

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2020R Group utilization summary	Monthly
3010R Therapeutic class profile summary	Monthly
3070R Drug cost ranking summary	Monthly
3140R Drug Therapeutic class usage ranking summary	Monthly
5050R Prescriber utilization summary ranked by volume	Monthly
Hedis (Eligibility report)	Quarterly
Hedis (Utilization report)	Quarterly
Hedis (HIV report)	Quarterly
Monthly Claims Data – agreed upon format	Monthly
Monthly PA Denials and approvals	Monthly
TPL Reporting	Quarterly

8. Corrective Action Plan

(a) If HMO receives information through its monitoring plan and/or audit processes that Manager or its subcontractors are not operating in accordance with this Agreement or federal or state requirements, and is operating in a condition that renders the continuance of its business hazardous to Covered Persons, HMO will request a written and signed Corrective Action Plan (CAP) from Manager. Each CAP shall include, but is not limited to, the following:

(1) Expected, measurable results indicating completion of the CAP;
(2) Detailed action plan to complete activities required by the CAP; and
(3) Due date for completion of CAP.

(b) Submission of the CAP shall be made by Manager to HMO within two (2) weeks of the notification with a written explanation of:

(1) Manager noncompliance with the CAP written agreement; or
(2) The existence of the condition that renders the continuance of Manager's business hazardous to Covered Persons.

(c) Implementation of the CAP shall be completed within thirty (30) days of Manager's receipt of written approval of the proposed CAP by HMO, unless an alternative completion period is approved by HMO in writing. The CAP shall accomplish the written expected results and such results must be validated by a HMO audit within the stated time frame. Failure of the Manager or any of its subcontractors to comply with this provision may result at HMO's discretion, in the suspension or revocation of PBM Services delegation.

(d) HMO will cooperate with Manager or its subcontractors to correct any failure by Manager to comply with the ADHS regulatory requirements relating to any contractual matters.

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EXHIBIT D

Benefit Contract Design

[INSERT FROM CENPATICO/ADHS]

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EXHIBIT E

Preferred Drug List ("PDL")

[To be inserted by CENPATICO on or after the Commencement Date]

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4. Medical Verification Solutions, LLC (MVS)

GREABHA will perform delegation oversight of the Primary Source Verification (PVS) functions delegated to MVS. MVS is certified by NCQA in all elements of PVS in their function as a Credentialing Verification Organization (CVO).

Name of Subcontractor	Medical Verification Solutions (MVS)
Address	6700 Jefferson Blvd NE Building B, Suite 4 Albuquerque, NM 87109
Telephone Number	505-468-0504
Ownership	Owned by The Medical Reliance Group, a privately held organization
Specific Management Service (including Delegated Administrative Functions)	• Primary source verification of the credentials of clinical professionals who apply for membership in GREABHA's provider network, including verification of licensure, educational history, and any sanctions or limitations on behavioral health providers' clinical practice • Provide routine reports to GREABHA on all primary source verifications performed
Expected Positions and/or Hours that will be subcontracted on an Annual Basis	Dependent on the number of providers in GSA 4 who will need credentialing
Compensation Arrangement including expected Total Annual Compensation	Initial Credentialing, Price Per File: $55 Re-credentialing, Price Per File: $50 Total Annual Compensation is dependent on the number of providers in GSA 4 who will need credentialing
Plans for Monitoring	Initial and Annual Delegation Audit

MVS
Medical Verification Solutions
A Member of the Medical Reliance Group

6700 Jefferson Blvd. NE
Building B, Suite 4
Albuquerque, NM 87109
Phone: 505.468.0504
Fax: 505.468.0554
Toll Free: 800.677.0944

MEDICAL VERIFICATION SOLUTIONS

Subcontractor Attestation

I the undersigned hereby attest that Medical Verification Solutions, a subsidiary of the Medical Reliance Group, has never been suspended or excluded from any federal program.

Kristi J. Beck, Chief Operating Officer

9-27-04
Date

MEDICAL VERIFICATION SOLUTIONS, LLC

CREDENTIALS VERIFICATION SERVICES AGREEMENT

This Services Agreement (the "Agreement") is entered into as of July August 1, 2004 (the "Effective Date"), by and between MEDICAL VERIFICATION SOLUTIONS, LLC, a Michigan limited liability company ("MVS"), and CENTENE CORPORATION a Healthcare Organization (the "Healthcare Organization").

RECITALS

A. The Healthcare Organization is required by law to verify the credentials of the heath care professionals who provide certain healthcare services to or on behalf of the Healthcare Organization.

B. MVS provides certain credentials verification services on behalf of the healthcare organizations.

B. The Healthcare Organization wishes to secure such services of MVS and MVS wishes to provide such services upon terms and conditions more fully described in this Agreement.

AGREEMENT

NOW, THEREFORE, in consideration of mutual covenants and promises contained in this Agreement, and for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties, intending to be legally bound, agree as follows:

1. SERVICES

1.1 Scope of the Services. Subject to the terms and conditions of this Agreement, MVS will perform the credentials verification services authorized by the Healthcare Organization and set forth on Exhibit A attached hereto and incorporated by reference herein (collectively, the "Services"), upon receipt of an application form in accordance with JCAHO or NCQA or other applicable agency or organization, as designated by the Healthcare Organization and further defined in the Scope of Services. Additional services may be added from time to time by execution of an addendum to such exhibit, which services are incorporated by reference into this Agreement and will become part of the Services. The Services will be provided by MVS within an agreed upon time schedule in order to collect, verify, maintain and provide data and information needed by the Healthcare Organization to evaluate Applicants and comply with state and federal laws.

1.2 Deliverables. MVS will deliver its work product (regardless as to whether for an initial credentialing or a recredentialing, the "Credentials Verification Report") to the Healthcare Organization in the form of the electronic report format available from MVS and with content as specified in the Credentials Verification Report Summary form (substantially in the form of Exhibit C) with supporting documents (e.g. the verified items), and/or in a materially similar electronic format as may be changed from time to time as may be necessary to, amongst other

reasons, comply with appropriate regulations and accreditation standards. Notwithstanding the foregoing, nothing contained in this Agreement will be deemed to require MVS to provide to the Healthcare Organization any information that is protected by the confidentiality provisions of any applicable federal, state, or other peer review protection law, or any related rule, regulation or judicial decision.

1.3 Performance of the Services.

(a) MVS will abide by all applicable federal and state legal requirements with respect to maintaining the confidentiality of information in connection with the Services.

(b) As a business associate of the Healthcare Organization, MVS will abide by the privacy and security requirements of the Administrative Simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA) and with all of the terms and conditions of Exhibit D, which is attached hereto.

(c) In the event MVS discovers facts or encounters circumstances impairing its ability to perform the Services with respect to a particular Applicant(s), MVS will promptly advise the Healthcare Organization and, at the discretion of the Healthcare Organization will make accommodations to rectify those inhibiting facts or circumstances

(d) During the term of this Agreement, the Healthcare Organization may, at the Healthcare Organization's expense, review the activities of MVS, as they relate to the provision of Services for the Healthcare Organization, on an annual basis. MVS will cooperate with the Healthcare Organization's auditors in connection with these reviews; *provided, however*, that the Healthcare Organization will give MVS reasonable prior notice of each review and the Healthcare Organization will conduct each such review in a manner that does not unreasonably interfere with the ongoing activities of MVS.

1.4 Healthcare Organization Responsibilities. To assist MVS in the performance of its responsibilities under this Agreement, the Healthcare Organization agrees to perform the following duties:

(a) To complete the National Practitioner Data Bank ("NPDB") form and to designate MVS as its querying agent.

(b) To provide all reasonably needed information (including that outlined in Exhibit A), and assistance in communication, or execution of any additional documents, and other reasonably necessary coordination, in cooperation with MVS's credentials verification activities and timetables so that MVS may best adhere to a consistent and efficient schedule for the provision of the Services.

(c) To oversee the contracted Services in accordance with the Healthcare Organization's federal, state and accreditation requirements and guidelines.

(d) To verify that the Services provided by MVS comply with and fulfill all aspects of Healthcare Organization's by-laws and other such applicable guidelines and regulations.

(e) To notify MVS, in writing, with regard to any operational matter not acceptable to the Healthcare Organization. MVS will acknowledge in writing to the Healthcare Organization its receipt of such written notice within seven business days following such receipt. MVS will thereafter, but in no event later than 60 days after its receipt of such written notice, take every reasonable action necessary to correct such matter.

(f) To utilize MVS as the Healthcare Organization's sole solution for the provision of the contracted Services.

1.5 Commitments of Timeliness and Accuracy.

(a) Subject to the provisions of this Agreement, MVS guarantees the following:

(i) *On-Time Commitment*. Subject to Section 1.5(a)(ii), MVS will deliver each Credentials Verification Report to the Healthcare Organization within 21 calendar days of the that date on which MVS receives a fully executed and accurate Application and associated Attestation (the "Full Attestation Receipt Date").

(ii) *Accuracy Commitment*. MVS further guarantees that the information contained within a Credentials Verification Report Summary shall be without material error. This guarantee, as outlined in this Section 1.5(a)(ii) (the "Accuracy Commitment"), shall not apply in those cases where MVS has determined in good faith that: x) the information provided on the Application was inaccurate, incomplete, or materially misleading; or y) the information provided by any verification source was inaccurate, incomplete, or materially misleading (the "Inaccurate Sources Exclusion").

(b) In the case where either the On-Time Commitment or the Accuracy Commitment (as provided in Section 1.5(a) above) is not upheld by MVS, Healthcare Organization shall have no obligation to pay for Services associated with the processing and provision of the applicable Credentials Verification Report. The relief provided hereunder shall be Healthcare Organization's sole recourse against MVS.

2. MVS STATUS, PROVIDER DECISIONS

2.1 Independent Contractor Status. MVS is an independent contractor performing certain data collection and verification services for the Healthcare Organization and is not an employee, representative, officer, or partner of the Healthcare Organization. Except as expressly set forth in this Agreement, MVS has no power or authority to act for, represent, or bind the Healthcare Organization in any manner. Nothing contained in this Agreement will be deemed to create any

relationship between the parties other than that of a principal and independent contractor. MVS is not an "independent review body" as that term is used in HCQIA, nor is it a "review organization".

2.2 Healthcare Organization Provider Decisions. The Healthcare Organization will be solely responsible for decisions regarding the granting, revoking, denying, terminating, suspending, restricting or otherwise conditioning contracted physician appointments, privileges, and participation status, and for all reporting required by federal or state law, or accreditation entities relating to such action. MVS will have no authority, nor represent itself as having any authority, with respect thereto.

3. TERM AND TERMINATION

3.1 Term. This Agreement will commence on the Effective Date and will remain in effect for two years following the Effective Date, unless sooner terminated as herein provided; provided, however, that the term will be automatically renewed for subsequent one-year periods unless either party gives written notice of its desire not to renew the term at least 60 days prior to the end of the then current one-year period, at which point the term will expire at the conclusion of such one-year period. This contract may be terminated for no cause at any time by either party with a written 60 day notice.

3.2 Termination. This Agreement will terminate upon occurrence of any of the following events:

(a) Failure to pay MVS its fees when due which remains uncured for a period of 10 days after receipt by the Healthcare Organization of written notice of such breach;

(b) A material breach of the Agreement (other than for failure to pay) which remains uncured for a period of 30 days after receipt of written notice specifying the breach, with reasonable opportunity for cure having been afforded the notified party;

(c) Either party is adjudged bankrupt, makes a general assignment for the benefit of creditors, seeks reorganization under bankruptcy or insolvency laws, or a proceeding relating to bankruptcy or insolvency laws is commenced against the other party.

3.3 Survival. Notwithstanding anything to the contrary contained in this Agreement, the provisions of Sections 5, 6, 8 and 9 will survive any termination, expiration or cancellation of this Agreement, regardless of the basis for such termination or cancellation.

4. PAYMENT FOR THE SERVICES

The Healthcare Organization will pay MVS for the Services in accordance with the reimbursement and payment schedule set forth on Exhibit B (respective of the services for which Healthcare Organization has authorized) attached hereto and incorporated herein by reference, which may be revised from time to time as mutually agreed by the parties.

5. RIGHTS, USE, AND OWNERSHIP

5.1 MVS will grant to Healthcare Organization the right to use, copy, and maintain MVS Intellectual Property (herein defined) and data that has been fully paid for by Healthcare Organization and provided to or collected by MVS for Healthcare Organization for the purposes of Healthcare Organization's: i) credentialing, regulatory, and quality management; ii) internal or external evaluations; and iii) other purposes that do not violate the provisions of this Agreement.

5.2 MVS is the sole owner of all MVS-created deliverables and all U.S. copyrights and other intellectual property rights in those MVS-created deliverables; data collection, analysis, and review tools; and data processing and management systems or processes, including all tangible and intangible items, processes, or information incorporated therein (the "MVS Intellectual Property"). If any such MVS-created deliverables or other MVS Intellectual Property may, by operation of law, be considered "works made for hire" (or if ownership of all right, title and interest of the U.S. copyrights therein will not otherwise vest exclusively in MVS), the Healthcare Organization will be deemed to have automatically assigned, without further consideration, the ownership of all U.S. copyrights therein to MVS, its successors and assigns. MVS, its successors and assigns will then have the right to obtain and hold in its or their own name copyrights, registrations and any other protection available in the foregoing. The Healthcare Organization agrees that it will not market, parcel, distribute, sell or otherwise communicate the MVS Intellectual Property without the express written consent of MVS.

6. PROPRIETARY INFORMATION

6.1 Definition. The parties acknowledge that MVS owns and may develop proprietary information during the course of the Agreement, which is privileged and confidential. MVS will use the proprietary information in the discharge of its contracted-for obligations to the Healthcare Organization. "Proprietary information" includes trade secrets and computer programs and software (including source codes), processes, technical information, know-how, plans, specifications, identity of Healthcare Organizations and suppliers, financial information, and other proprietary or confidential information related to the Services and business affairs of MVS which is treated by MVS as confidential; *provided*, *however*, that proprietary information will not include (a) information known by the Healthcare Organization prior to the Effective Date, or which is in the public domain at the time of disclosure, or which is disclosed to the Healthcare Organization through a third party; (b) all information on the Credentials Verification Report forms, or the documents and information upon which such information is based.

6.2 Use, Disclosure. The parties agree that MVS will disclose proprietary information to the Healthcare Organization only to the extent that such information is necessary to conduct the Services. With respect to any proprietary information disclosed by MVS to the Healthcare Organization in the course of or in connection with this Agreement, the Healthcare Organization will not use, copy, reveal, report, publish, transfer or otherwise disclose such information to any person, company or other entity, without the prior written consent of MVS, and the proprietary information will not be utilized for the detriment or intended detriment of the supplier of the information including the solicitation of any of that party's Healthcare Organizations, leads or employees. Upon expiration or earlier termination of this Agreement, the Healthcare Organization will return to MVS all proprietary information in its possession. The parties acknowledge that no license is created by the use of the proprietary information.

6.3 Equitable Relief. Since a remedy at law for any breach or attempted breach of the provisions of this Section 6 will be inadequate, either party hereto will be entitled to specific performance and injunctive or other equitable relief in case of any such breach or attempted breach, in addition to any remedies available at law.

7. DISPUTE RESOLUTION

7.1 Duty to Negotiate in Good Faith. If a party has reason to believe the existence of a dispute in connection with this Agreement and the Services provided hereunder, it will give written notice to the other party, describing the dispute and a proposed resolution. The parties will then meet as soon as practicable thereafter and negotiate in good faith to resolve the dispute.

7.2 Mediation. If the dispute cannot be resolved by negotiation within 30 days of notice of a dispute having been given as described above, unless otherwise agreed to by the parties in writing, the parties will be obligated to submit the dispute to a mediator.

7.3 Binding Arbitration. If the dispute cannot be resolved by way of direct negotiation or mediation within 60 days of notice of a dispute having been given as described above, the dispute will be decided by arbitration, which will be conducted by a single arbitrator and, except as otherwise expressly provided herein, in accordance with the commercial arbitration rules of the American Arbitration Association or the American Health Lawyers Association. The arbitration will be conducted in Ingham County, Michigan, unless the parties in the proceeding mutually agree otherwise. In the event that there will be more than one dispute to be arbitrated, the parties agree that all pending disputes will be consolidated to the extent feasible. Within 30 days of the hearing, the arbitrator will render a decision concerning all contested issues considered during the arbitration and the arbitrator will notify the parties in writing of his or her decision, setting forth the arbitrator's findings of fact and conclusions of law and the dollar amount, if any, awarded. Unless the parties mutually agree otherwise, the arbitrator may fix his or her compensation. The fees of the American Arbitration Association or the American Health Lawyers Association and of the arbitrator will be paid equally by the parties, unless the arbitrator determines that a particular party has prevailed on all major substantive issues presented, in which case the fees and costs will be paid by the party not so prevailing. This agreement to arbitrate will be specifically enforceable under the Michigan Arbitration law. The arbitrator's decision will be final, and judgment, including specific enforcement of the decision, may be entered upon the decision in any court of competent jurisdiction in accordance with applicable law. The amount of any dollar award, including applicable fees and costs of the prevailing party, will be paid in cash by the party not so prevailing to the prevailing party, within 10 days following the date of such award. In the event that payment is not made within the time period provided herein, the prevailing party will have the right to commence an action, at law or in equity, in any state or federal court in the State of Michigan to have the decision of the arbitrator enforced. In the event such an action is filed, the costs of such action (including reasonable attorneys' fees) will be borne by the party against whom such performance is sought. A pending arbitration will not extend the term of this Agreement or affect any termination provided for hereunder. All statutes of limitations will be tolled from the date of giving notice of the intention to submit to arbitration and for 90 days after the delivery of the arbitrator's written determination.

7.4 Certain Exclusions. The binding arbitration procedure, described in Section 7.3 above, will not apply to any claims between the parties arising out of third party claims asserting professional negligence, and the parties are not precluded from asserting claims against each other based on contribution, indemnity, breach of contract, or other legal theories, by way of cross-claim or third-party complaint in any circuit court action, commenced by a third party, which alleges professional negligence against either or both of the parties to this Agreement. In the event of a dispute, which is not subject to arbitration, each party hereto consents and agrees that any litigation arising therefrom will be commenced and maintained exclusively in the state and federal courts of competent jurisdiction located in Ingham County, Michigan.

7.5 Equitable Relief. To the extent that arbitrator acting under the applicable rules of the American Arbitration Association or the American Health Lawyers Association and pursuant to Michigan law does not have legal jurisdiction and authority to impose injunctive or other equitable relief, a party seeking the same will be entitled to pursue the same through court litigation. Such action may be pursued during, after or in lieu of arbitration. Any such action will be pursued only in the state or federal courts with requisite jurisdiction located in Ingham County, Michigan.

8. INDEMNIFICATION

8.1 Indemnification of MVS. The Healthcare Organization will indemnify and hold MVS and its officers, directors, employees, agents, consultants, affiliates, and representatives harmless from and against any and all actions, suits, proceedings, liabilities, losses, damages, judgments, fines, amounts paid in settlement, losses, costs and expenses which may arise out of acts or omissions of the Healthcare Organization or its officers, directors, employees, agents, consultants, affiliates, and representatives in the performance of the Healthcare Organization's responsibilities under this Agreement or which may arise out of any action taken by the Healthcare Organization or decision made by the Healthcare Organization regarding medical staff appointments or privileges, participation status or disciplinary matters, whether in contract, tort, or otherwise. Without limiting the generality of the foregoing, MVS will have no liability for any claims relating to the issuance of, denial of, or claims made to, any insurance coverage(s) for, from, or to the Healthcare Organization, regardless of the form of the claim, and this indemnification provision will likewise apply to any such claims.

8.2 Indemnification of the Healthcare Organization. MVS will indemnify and hold the Healthcare Organization and its officers, directors, employees, agents, consultants, affiliates, and representatives harmless from and against any and all actions, suits, proceedings, liabilities, losses, damages, judgments, fines, amounts paid in settlement, losses, costs and expenses which may arise out of acts or omissions of MVS and MVS's officers, directors, employees, agents, consultants, affiliates, and representatives in the performance of its or their responsibilities under this Agreement.

9. LIMITATION OF LIABILITY

Except as to the damages, amounts and/or costs provided in Sections 7 and 8 above, in no event will either party here to be liable under this agreement to the other party for any special consequential punitive, reliance or incidental damages, including lost profits or revenues of such party, whether or not such damages were foreseeable.

10. MISCELLANEOUS

10.1 Certain Definitions. The following terms will have the following respective meanings:

"Applicant" means a qualified Physician or Licensed Health Care Practitioner who is applying for an appointment or reappointment to the Medical Staff or health plan panel, and the receipt of Privileges at the Member's organization.

"Application" means a form (whether existing in electronic or paper format) to be supplied by MVS on which all necessary information may be acquired by MVS from Applicant needed by MVS to perform the credentialing and recredentialing Services of this Agreement.

"Attestation" means the attestment of an Applicant to the accuracy of the content provided by the Applicant within their Application.

"Board of Medical Examiners" means the board established pursuant to the statute set forth in Appendix D.

"Continuous File Maintenance" means the process of verifying certain information as it expires and providing this verification to the Healthcare Organization within 30 days of the expiration date of the information.

"HCQIA" means the Health Care Quality Improvement Act of 1986, Title IV of Public Law 99-660, as amended (42 U.S.C. 11101 et seq.).

"JCAHO" means Joint Commission for Accreditation of Healthcare Organizations, which provides accreditation for hospitals and other health care organizations.

"Licensed Health Care Practitioner" means an individual who is licensed or otherwise authorized by the laws of the state or states set forth in Appendix D to provide health care services.

"Medical Staff" means a group of Physicians and, if applicable, other Licensed Health Care Practitioners who provide medical and other health care services to patients and who are required to acquire privileges or health plan panel membership.

"National Practitioner Data Bank" or "NPDB" means the national practitioner data bank authorized and created by HCQIA.

"NCQA" means the National Commission for Quality Assurance, which provides accreditation for Managed Care Organizations ("MCO's") and certification of Credentials Verification Organizations ("CVO's").

"Physician" means a doctor of medicine (M.D.) or Osteopathy (D.O.) or a doctor of dental surgery (D.D.S.) or medical dentistry (D.M.D.) legally authorized to practice medicine and surgery or dentistry in state or states identified in Appendix C.

"Privileges" means clinical privileges, membership on the Medical Staff, or membership on a health plan panel, and other circumstances pertaining to the furnishing of medical care under which a Physician or other Licensed Health Care Practitioner is permitted to furnish such care by the Healthcare Organization.

"Credentialing Requests" means the provision of a formal request (as submitted via electronic means, facsimile, telephone, or by paper copy) by Healthcare Organization for MVS to initiate the process by which a Credentials Verification Report may be delivered by MVS to Healthcare Organization.

10.2 Mutual Agreement Not to Solicit Employees. During the term of this Agreement and for a period of two years thereafter, neither party will, either directly or indirectly, on its own behalf or on behalf of others, solicit, divert or hire away, or attempt to solicit, divert, or hire away, any person employed by the other party, whether or not such employee is a full-time employee or a temporary employee of, consultant to, or independent contractor to such other party and whether or not such employment or engagement is pursuant to written agreement and whether or not such employment or engagement is for a determined period or is at will.

10.3 Notices. All notices, consents, waivers and other communications under this Agreement must be in writing and will be deemed to have been duly given when (a) delivered by hand (with written confirmation of receipt), (b) sent by facsimile or electronic mail (with written confirmation of receipt), provided that a copy is mailed by registered mail, return receipt requested, or (c) when received by the addressee, if sent by a nationally recognized overnight delivery service (receipt requested), in each case to the appropriate addresses and facsimile numbers set forth on the signature page below (or to such other addresses and facsimile numbers as a party may designate by notice to the other party).

10.4 Entire Agreement and Modification.

(a) This Agreement, together with all referenced and attached exhibits, contains the entire agreement between the parties hereto, supersedes all prior agreements, arrangements, or understandings between the parties and constitutes a complete and exclusive statement of the terms of the agreement between the parties with respect to its subject matter. This Agreement may not be modified or amended except by a written agreement duly signed by persons authorized to act on behalf of the party to be charged with the amendment.

(b) Notwithstanding the foregoing, subject to the following procedure, the Exhibits to this Agreement will be deemed to be automatically amended in order to permit MVS and the Healthcare Organization to comply with any applicable amendments to HCQIA, the Guidebook, any related changes in state and federal regulations promulgated pursuant to such acts, NCQA, or in order to comply with changes of policy or procedures required by MVS for the operation its systems used in connection with the Services.

(i) MVS will give written notice to the Healthcare Organization of regulatory changes or changes in MVS policy or procedures which are applicable to the Healthcare Organization ("Notices"). The Notice will include revised Exhibits to this Agreement, as applicable, setting forth the revisions required by changes in statutes, regulations or MVS policy and procedure.

(ii) The Healthcare Organization may, within 60 days of receipt of the Notice and revised Exhibits, give notice of termination of the Agreement pursuant to Section 3 hereof. The Healthcare Organization must comply with the Notice during any period in which the changes are effective and before this Agreement is terminated.

(iii) If notice of termination is not given by the Healthcare Organization as set forth above, the Healthcare Organization will accept, initial and return the revised Exhibits to MVS, which will become effective as of the later of the date so accepted or 30 days following the date of the Notice.

10.5 Assignments, Successors and Third-Party Rights. Neither party may assign any of its rights under this Agreement without prior written consent of the other party; provided, however, such consent will not be necessary in connection with an assignment on the part of MVS of this Agreement to an affiliate of MVS as a part of any reorganization or corporate restructuring of MVS. Subject to the preceding sentence, this Agreement will apply to, be binding in all respect upon and inure to the benefit of the respective successors and permitted assigns of the parties. Nothing expressed or referred to in this Agreement will be construed to give any person other than the parties to this Agreement any legal or equitable right, remedy or claim under or with respect to this Agreement or any provision of this Agreement. This Agreement and all of its provisions and conditions are for the sole and exclusive benefit of the parties to this Agreement and their successors and permitted assigns.

10.6 Severability. If any provision of this Agreement is held invalid or unenforceable by any court of competent jurisdiction or an arbitrator pursuant to Section 7.3 hereof, the other provisions of this Agreement will remain in full force and effect. Any provision of this Agreement held invalid or unenforceable only in part or degree will remain in full force and effect to the extent not held invalid or unenforceable.

10.7 Section Headings, Construction. The headings of sections in this Agreement are provided for convenience only and will not affect its construction or interpretation. All words used in this Agreement will be construed to be of such gender or number as the circumstances require. Unless otherwise expressly provided, the word "including" does not limit the words or terms preceding it.

10.8 Governing Law. This Agreement will be governed by and interpreted pursuant to the laws of the State of Michigan without regard to conflicts of laws principles.

10.9 Counterparts. This Agreement may be executed in one or more counterparts, each of which will be deemed to be an original copy of this Agreement and all of which, when taken together, will be deemed to constitute one and the same agreement.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and delivered by their duly authorized officers or agents as set forth below.

MEDICAL VERIFICATION SOLUTIONS, LLC
"MVS"

Date: _____

By: _____
Name: Kristi Beck
Title: Chief Operating Officer

Address:
3410 Belle Chase Way, Suite 600
Lansing, Michigan 48911
Tel: 800-677-0944
Fax: 517-702-4000
Email: kbeck@mvshome.com

CENTENE CORPORATION
"Healthcare Organization"

Date: _____

By: _____
Name: Aron Halfin
Title: Vice President of Clinical Operations

Address:
823 Congress Avenue
Suite 600
Austin, Texas 78701
Tel: 512-406-7200
Fax: _____
Email: ahalfin@centene.com

EXHIBIT A

SCOPE OF SERVICES

1. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by JCAHO criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) Board certification
   (c) Medical/dental/podiatry or other professional education and training obtained
   (d) DEA and CSR certificate
   (e) Hospital affiliation/work history for previous 5 years
   (f) Professional liability insurance for previous 5 years
   (g) Malpractice claims history for previous 5 years (via confirmation with insurance provider or NPDB query)
   (h) Medicaid/Medicare sanctions (via NPDB query)
   (i) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (j) Minimum of two professional references
   (k) Other information, specified as follows:_____
   _____
   _____

2. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by NCQA criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) Board certification (or)
   (c) Medical/dental/podiatry residency training or highest level of education or training obtained
   (d) DEA or CSR certificate
   (e) Professional liability insurance (copy of the policy cover page)
   (f) Malpractice claims history for previous 5 years (via confirmation with insurance provider or NPDB query)
   (g) Work history that has been provided by the Applicant (5 years as evident via application, curriculum vitae, or resume; verification not required)
   (h) Medicaid/Medicare sanctions (via NPDB query) for a period of 3 years

(i) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)

(j) Other information, specified as follows:_____

_____

_____

Signed Attestation that addresses:

reasons for any inability to perform the essential functions of the position, with or without accommodation

lack of present illegal drug use

history of loss of license and felony convictions

history of loss or limitation of privileges or disciplinary activity

current malpractice insurance coverage

the correctness and completeness of the application.

3. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding initial credentialing by URAC criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

(a) Licensure in the applicable state or states [State *licensure* information, including current *license(s)* and history of *licensure* in all jurisdictions;]

(b) DEA or CSR certificate

(c) Board certification

(d) Professional liability insurance (copy of the policy cover page)

(e) NPDB query [Professional liability claims history]

(f) Other information, specified as follows:_____

_____

_____

The following items will be obtained via a completed Application, release, and Attestation:

(a) History of education and professional training, including *board certification* status;

(b) Work history for at least the last five years (or since last credentialed by the *organization*);

(c) Listing of all sanctions or penalties imposed by hospitals, licensing boards, government entities, and managed care organizations;

(d) Documentation of any voluntary or involuntary relinquishment of privileges to practice in a *facility* or jurisdiction;

(e) Hospital affiliations or privileges, if applicable;

(f) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the *practitioner's* ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;

(g) A signed and dated statement attesting that the information submitted with the application is complete and accurate to the *practitioner's* knowledge; **and**

(l) A signed and dated statement authorizing the *organization* to collect any information necessary to verify the information in the credentialing application.

4. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by JCAHO criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) DEA and CSR certificate
   (c) Hospital affiliation/work history for previous 2 years
   (d) Professional liability insurance for previous 2 years
   (e) Malpractice claims history for previous 2 years (via confirmation with insurance provider or NPDB query)
   (f) Medicaid/Medicare sanctions (via NPDB query)
   (g) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 5 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (h) Minimum of two professional references
   (i) Other information, specified as follows:_____
   _____
   _____

5. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by NCQA criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

   (a) Licensure in the applicable state or states
   (b) DEA or CSR certificate
   (c) Professional liability insurance (copy of the policy cover page or declaration in application)
   (d) Malpractice claims history for previous 3 years (via NPDB query)
   (e) Medicaid/Medicare sanctions for a period of 3 years (via NPDB query)
   (f) Practice history, including sanctions, restrictions and/or limitations in the scope of practice (for a period of 3 years), as defined by the state board of medical examiners or the appropriate licensing agent (via applicable entity or NPDB query)
   (g) Other information, specified as follows:_____
   _____
   _____

Signed Attestation that addresses:

reasons for any inability to perform the essential functions of the position, with or without accommodation

lack of present illegal drug use

history of loss of license and felony convictions in the past 3 years

history of loss or limitation of privileges or disciplinary activity in the past 3 years

current malpractice insurance coverage

the correctness and completeness of the application.

6. Upon receipt of a completed Application, release, and Attestation for the provision of a Credentials Verification Report regarding recredentialing by URAC criteria (and certain modifications as identified herein under), MVS will, if applicable, primary source verify the information set forth below:

(a) Licensure in the applicable state or states [State *licensure* information, including current *license(s)* and history of *licensure* in all jurisdictions;]
(b) DEA or CSR certificate
(c) Professional liability insurance (copy of the policy cover page)
(d) NPDB query [Professional liability claims history]

Other information, specified as follows:_____

_____

The following items will be obtained via a completed Application, release, and Attestation:
(a) Listing of all sanctions or penalties imposed by hospitals, licensing boards, government entities, and managed care organizations during the past 3 years;
(b) Documentation of any voluntary or involuntary relinquishment of privileges to practice in a *facility* or jurisdiction during the past 3 years;
(c) Current hospital affiliations or privileges, if applicable;
(d) Disclosure of any physical, mental, or substance abuse problems that could, without reasonable accommodation, impede the *practitioner's* ability to provide care according to accepted standards of professional performance or pose a threat to the health or safety of patients;
(e) A signed and dated statement attesting that the information submitted with the application is complete and accurate to the *practitioner's* knowledge; **and**
(f) A signed and dated statement authorizing the *organization* to collect any information necessary to verify the information in the credentialing application.

7. Upon MVS' receipt of the data outlining, in sufficient detail (see Section 3(b) below), the Healthcare Organization's care provider network (the "Care Provider Network"), MVS shall initiate a process designed to maintain as current the credential verification records pertaining to the members of the Care Provider Network (the "Credentials Monitoring Process").

(a) The credentialing data maintained through the execution of the Credentials Monitoring Process shall include:
i. Licensure;
ii. Board certification;
iii. DEA and/or CSR certificate; and
iv. Professional liability insurance.

1

(b) The data and materials that Healthcare Organization shall provide to MVS to identify and initiate the Credentials Monitoring Process for each member of the Care Provider Network shall be:

i. Member's name, professional degree, address, and phone number;
ii. State licensure number and expiration date;
iii. Board certification and expiration date;
iv. CSR certificate number and expiration date;
v. DEA certificate number, expiration date, and physical copy; and
vi. Professional liability insurance carrier and policy number.

8. Upon MVS' receipt of the data outlining, in sufficient detail (see Section 4(b) below), the Healthcare Organization's care provider network (the "Care Provider Network"), MVS shall initiate a process of monitoring for sanctions pertaining to the members of the Care Provider Network (the "Sanctions Monitoring Process") on a monthly basis.

(c) The sanctions data monitored through the execution of the Sanctions Monitoring Process shall include:

i. Medicaid sanctions;
ii. Medicare sanctions;
iii. State sanctions; and
iv. Limitations of licensure.

(d) The data and materials that Healthcare Organization shall provide to MVS to identify and initiate the Sanctions Monitoring Process for each member of the Care Provider Network shall be:

i. Member's name, professional degree, address, and phone number;
ii. Date of birth;
iii. Social Security number; and
iv. State licensure number.

9. If the Healthcare Organization requires additional information from the Applicant which is not contained on the application form or within the materials provided to MVS by the Healthcare Organization, the Healthcare Organization will mail directly to the Applicant whatever additional information the Healthcare Organization requires. A copy of the application form required by the Healthcare Organization is attached this Scope of Services.

10. For all Applications completed under this Agreement, MVS will collect all data required to meet both NCQA and URAC standards, as detailed above.

11. The Healthcare Organization hereby designates the following staff member as the recipient of the information provided to the Healthcare Organization under this Agreement, including responses from the National Practitioner Data Bank (NPDB) (provide the name of the specific job title of the person to whom MVS is to provide information):

Name: Aron Halfin
Address: 823 Congress Avenue
Suite 600

1

Austin, TX 78701
Telephone:512-406-7200

Effective Date: August 1, 2004

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EXHIBIT B

PAYMENT/FEE SCHEDULE & TERMS

Summary MVS Fee Schedule For Initial and Recredentialing Verifications	
	NCQA Profile
Initial Credentialing	
Pricing per File:	$55.00
Recredentialing	
Pricing per File:	$50.00

Table B-1: Summary Fee Schedule For Initial and Recredentialing Verifications

Summary MVS Fee Schedule For Bundled Sanction Monitoring and Credentials Monitoring	
Element:	**Sanction & Credential Monitoring**
License Sanctions and Limitations	✓
Medicare / Medicaid Sanctions	✓
Valid License	✓
Valid DEA	✓
Valid CSR	✓
Board Certification	✓
Malpractice Insurance	✓
Malpractice Claims History through NPDB	✓
Pricing per Practitioner per Year:	$43.00

Table B-2: Summary Fee Schedule For Sanction and Credentials Monitoring

	60 Day Guarantee	45 Day Guarantee	30 Day Guarantee	15 Day Guarantee	2 Day Guarantee
Initial Credentialing					
Expedited Fees:	No Additional Charge	25% Additional Charge	50% Additional Charge	75% Additional Charge	150% Additional Charge
Recredentialing					
Expedited Fees:	No Additional Charge	25% Additional Charge	50% Additional Charge	75% Additional Charge	150% Additional Charge

Table B-3: Summary Fee Schedule For Expedited Files

1

1. Fees.

   a. Credential Verifications: The fees (the "Credentialing Verification Fees") due to MVS from Healthcare Organization for each initial and recredentialing verification requested by the Healthcare Organization shall be as outlined in Table B-1 (Summary Fee Schedule For Initial and Recredentialing Verifications), as may be adjusted by expedition requests as outlined in Table B-3. In the case that Healthcare Organization requests the provision of a Credentialing or Recredentialing report within a period of time less than 60 calendar days (the "Expedited Request"), the respective Credentialing Verification Fees shall be adjusted by the addition of that amount outlined within Table B-3 (the "Expedite Fee").

   b. Credentials & Sanction Monitoring: The fees (the "Monitoring Fees") due to MVS from Healthcare Organization for Credentials and Sanctions Monitoring shall be calculated by multiplying the number of members within the Care Provider Network by the fees outlined in Table B-2 (Summary MVS Fee Schedule For Bundled Sanction Monitoring and Credentials Monitoring). The Monitoring Fees shall be invoiced in advance on a quarterly basis.

2. Invoicing.

   a. Monthly Invoicing: MVS will, on a monthly basis, provide an invoice outlining in reasonable detail the fees due to MVS by Healthcare Organization for the following:
      i. Initial Verifications;
      ii. Recredentialing Verifications; and
      iii. Pass-Through Fees.

   b. Quarterly Invoicing: MVS will, on a quarterly basis, provide an invoice outlining in reasonable detail the fees due to MVS by Healthcare Organization for one quarter of the projected annual price (in advance) for Sanctions and Credentials Monitoring indicated for the respective quarterly period and in accordance with the pricing on Table B-2. MVS shall make adjustments in arrears (and invoice for such adjustments) for any additions to the Healthcare Organizations provider network as submitted by the Healthcare Organizations or that become known to MVS during the respective quarterly period.

3. Payment Term. Payment is due within 15 days from the date of receipt of an invoice by the Healthcare Organization (the "Due Date").

4. Late Charges. If any undisputed fee for services by MVS is not paid within 10 days after the Due Date, interest will accrue from such Due Date at a rate equal to two percent (2%) per month. The Healthcare Organization will pay such interest upon demand by MVS, and such interest charge will be in addition to the amounts otherwise charged by MVS for its services. The amount of interest payable pursuant to this provision will not exceed the maximum effective rate of interest permitted to be paid under the laws of the State of Michigan. If such amounts result in an effective rate of interest in excess of such maximum effective rate of interest, then the amount payable pursuant to this provision will be reduced to the highest amount permitted under the laws of the State of Michigan.

5. Pass Through Fees. Certain components of the service processes generate expenses from third-parties. These expenses are passed through to Healthcare Organization at cost (the "Pass-Through Fees"). A non-exhaustive list of typical Pass-Through Fees is provided below in Table B-4. This list may change from time to time and is independent of MVS. MVS shall invoice Healthcare Organization for such Pass-Through Fees as outlined in Paragraph 2 of this Exhibit B. Upon request from the Healthcare Organization, MVS shall provide, in reasonable detail, information outlining the Pass-Through Fees.

Typical Pass-Through Fees Associated with Credential Verifications	
Verification Source	**Pass-Through Fees**
Educational Commission for Foreign Medical Schools (ECFMG)	$ 25.00
National Practitioner Data Bank (NPDB)	$4.25
Healthcare Integrity and Protection Data Bank (HIPDB)	$4.25
DPM Board Certification	$25.00
American Medical Association (AMA) Profile	$26.00
American Nursing Credentialing Center (ANCC)	$10.00
DO Board Certification	$10.00
DC license	$5.00
OD License	$15.00
Various Insurance Companies	$20.00
Various Universities	$20.00
Various Medical Centers	$20.00

Table B-4: Typical Pass-Through Fees Associated with Credential Verifications

6. Cancellations. If an initial or recredentialing verification request is canceled (directly or indirectly by any means or necessity) by the Healthcare Organization within two business days of the date of the original request (a "Early Cancellation") shall result in a cancellation fee of $25 (the "Early Cancellation Fee"), in addition to any Pass-Through Fees incurred, being charged as the only Credentialing Verification Fees for such initial or recredentialing verification request. Any initial or recredentialing verification request that is canceled (directly or indirectly by any means or necessity) by the Healthcare Organization more than two business days after the date of the original request (a "Late Cancellation") shall result the charging of the full amount of the Credentialing Verification Fees, and any Pass-Through Fees incurred, as if the request were completed in a timely and accurate fashion. In the case of any cancellation in which the original request by the Healthcare Organization was for such request to be handled in an expedited fashion (the "Expedition Cancellation"), the aforementioned cancellation fees (whether Early Cancellation or Late Cancellation, as the case may be) shall be adjusted as outlined within Table B-3 above. MVS is not responsible for determining whether any (e.g. repeated, changed, or otherwise) submissions of initial or recredentialing verification requests by the Healthcare Organization are appropriate, needed, or otherwise. Hence, any cancellation (or change which shall be interpreted as a cancellation followed by a re-submission) necessitated by such submissions are treated as cancellation as described within this Paragraph 6.

7. Fee Adjustments. To accommodate changes in labor, data processing, and other operating expenses that may occur from time to time, MVS reserves the right to make adjustments to the fees upon 30 days prior written notice to Healthcare Organization. Such fees may be adjusted no more frequently than once per annual period.

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EXHIBIT C

SAMPLE CREDENTIALS VERIFICATION REPORT FORM

MVS
Medical Verification Solutions
A division of the Medical Reliance Group

Practitioner Summary

Prepared for <<Client>>

<<RequestType>> of <<NameLast>>, <<NameFirst>> <<NameMI>>, <<Degree>>

Social Security Number:	<<SSN>>	**Report Date:**	<<CompletionDate>>
Date of Birth:	<<DOB>>	**Attestation Date:**	<<AttestationDate>>
		Quality Control Date:	<<AttestationDate>>

Addresses

<<AddressDescription>>

<<Organization>>
<<Address1>>, <<Address2>>
<<City>>, <<State>>, <<Zip>>

Phone:	<<Phone>>
Fax:	<<Fax>>
Email:	<<Email>>
Contact:	<<Contact>>

Education and Training

<<Institution Name>>

Education Type:	<<EducationType>>
Degree/Training Type:	<<DegreeType>>
Attendance Dates:	<<StartDate>> to <<EndDate>>
Degree/Training Completion:	<<Completion>>
Verification Date:	<<VerDate>>

Work History

Organization	Start Date	End Date	Verification Date
<<InstitutionName>>	<<StartDate>>	<<EndDate>>	<<VerDate>>

Work History Gaps	Start Date	End Date	Verification Date
<<GapDescription>>	<<StartDate>>	<<EndDate>>	<<VerDate>>

Speciality & Board Certification

Type	Board Certification Date	Expiration Date	Verification Date
<<Specialty>>	<<CertDate>>	<<ExpDate>>	<<VerDate>>

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MVS Service Agreement
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<<RequestType>> of <<NameLast>>, <<NameFirst>> <<NameMI>>, <<Degree>>

Social Security Number:	<<SSN>>	**Report Date:**	<<CompletionDate>>
Date of Birth:	<<DOB>>	**Attestation Date:**	<<AttestationDate>>
		Quality Control Date:	<<AttestationDate>>

Sanctions

Data Source	Verification Date	Findings
<<DataSourceName>>	<<VerDate>>	<<Finding>>

Page 3

MVS

EXHIBIT D

HIPAA BUSINESS ASSOCIATE ADDENDUM

This Business Associate Addendum amends and is made part of the Credentials Verification Services Agreement (the "Agreement") by and between Healthcare Organization ("Covered Entity") and Medical Verification Services, LLC ("Business Associate").

Covered Entity and Business Associate mutually agree to modify the Agreement to incorporate the terms of this Addendum to comply with the requirements of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing privacy regulations at 45 CFR Parts 160-164 ("HIPAA Privacy Rule"). The parties acknowledge and agree that if any of the terms and conditions set forth in this Addendum are in conflict with or in addition to the terms and conditions set forth in the Agreement, then this Addendum will control in connection with the request, use, or disclosure of Protected Health Information ("PHI"), as that term is defined in Section 1(c) of this Addendum.

1) Definitions. For purposes of this Section, the following terms will have the indicated meanings:

   a) *Affiliated Entity*. "Affiliated Entity" will mean an entity under common control or common ownership.

   b) *HIPAA Regulations*. "HIPAA Regulations" will mean the regulations promulgated by the Secretary of Health and Human Services under the authority of Title II, Subtitle F of the Health Insurance Portability and Accountability Act (Public Law 104-191)

   c) *Protected Health Information*. "Protected Health Information" will have the meaning set forth in 45 CFR § 164.501, as amended from time to time. Generally, this term means individually identifiable health information including all information, data and materials, including demographic, medical and financial information, that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past present, or future payment for the provision of health care to an individual; and that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

2) Protected Health Information.

   a) *Permitted Uses and Disclosures*. Business Associate agrees to use or disclose PHI it creates for or receives from Covered Entity only as follows:

      i *Functions and Activities on Covered Entity's Behalf*. Business Associate is permitted to use and disclose PHI it creates for or receives from Covered Entity in order to provide services as described in the Agreement, provided that such use or disclosure would not violate the HIPAA Privacy Rule if done by Covered Entity.

      ii *Business Associate's Operations – Use of PHI*. Business Associate is permitted by this Addendum to use PHI it creates for or receives from Covered Entity if such use is essential

for Business Associate's proper management and administration, or is essential to carry out Business Associate's legal responsibilities.

iii *Business Associate's Operations – Disclosure of PHI*. Business Associate is permitted by this Addendum to disclose PHI it creates for or receives from Covered Entity if such disclosure is essential for Business Associate's proper management and administration, or is essential to carry out Business Associate's legal responsibilities, provided that such disclosure would be permitted under state and federal confidentiality laws if done by Covered Entity, and only if the following conditions are met: (1) the disclosure is required by law; or (2) Business Associate obtains reasonable assurances in writing from any person or organization to which Business Associate will disclose such PHI that the person or organization will hold such PHI as confidential, and will only use or further disclose such PHI as required by law, or for the purpose for which the Business Associate disclosed such PHI to the person or organization. The person or organization shall promptly notify the Business Associate (who shall in turn promptly notify Covered Entity) of any instance of which the person or organization becomes aware in which the confidentiality of such PHI has been breached.

iv *Minimum Necessary Standard*. In performing the functions and activities on Covered Entity's behalf as set forth above, Business Associate agrees to use, disclose or request only the minimum necessary PHI to accomplish the purpose of the use, disclosure or request.

b) *Certain Representations and Warranties*. Business Associate represents and warrants that to the extent that Business Associate is provided with any Protected Health Information, Business Associate will:

i Not use or further disclose the information other than as specifically set forth in this Business Associate Addendum;

ii Not use or further disclose the Protected Health Information in a manner that would violate the requirements of any state or federal law including the provisions of the HIPAA Regulations;

iii Use appropriate safeguards to prevent use or disclosure of the Protected Health Information other than as provided for in this Business Associate Addendum;

iv Report to Covered Entity any use or disclosure of the Protected Health Information not provided for by this Business Associate Addendum of which Business Associate may become aware;

v Ensure that any agents, including subcontractors, to whom Business Associate provides Protected Health Information received from Covered Entity or Affiliated Entities agrees to the same restrictions and conditions that apply to Business Associate with respect to such Protected Health Information;

vi Make the Protected Health Information available in accordance with the HIPAA Regulations;

vii Make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with the HIPAA Regulations;

viii Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Covered Entity available to the Secretary of Health and Human Services for purposes of determining the Covered Entity's compliance with the HIPAA Regulations;

ix Return or destroy all Protected Health Information received from the Covered Entity which Business Associate maintains in any form at the termination of this Business Associate Addendum; and

x Incorporate any amendments or corrections to the Protected Health Information which may be requested pursuant to the HIPAA Regulations.

3) Audit Rights. In order to allow Covered Entity to certify its compliance with the HIPAA Regulations, Business Associate will permit Covered Entity, at Covered Entity's expense and on five (5) days prior notice, to audit Business Associate's business systems and services, with specific emphasis on Business Associate's compliance with the provisions of this Section. Such audit, which may be conducted by Covered Entity's personnel under obligations of confidentiality or by an independent auditing firm, will not interfere unreasonably with Business Associate's business activities, and will be conducted no more than once per calendar year, unless Covered Entity has received a request from the Secretary of Health and Human Services, or unless a previous audit has disclosed a material issue indicating non-conformance to the provisions of this Business Associate Addendum. Covered Entity will use information received during an audit solely for the purposes of the Agreement and will otherwise maintain the confidentiality of such information.

4) Breach. In addition to any other rights Covered Entity may have in this Business Associate Addendum, the Agreement or by operation of law, Covered Entity may immediately terminate this Business Associate Addendum and the Agreement, if Business Associate breaches this Business Associate Addendum.

5) Third Party Rights. The terms of this Business Associate Addendum are not intended nor should they be construed to grant any rights to parties other than Business Associate and Covered Entity.

6) Applicable Law and Forum. This Business Associate Addendum will be interpreted and construed in accordance with the laws of the State of Michigan. Any dispute arising under this agreement will be resolved pursuant to the Dispute Resolution provisions of Section 7 of the Agreement.

7) Waiver. No delay or omission on the part of either party in exercising any right hereunder will operate as a waiver of such right or of any other right under this Business Associate Addendum. A waiver on any one occasion will not be construed as a bar to or waiver of any right or remedy on any further occasion. The election of either party of a particular remedy on default will not be exclusive of any other remedy, and all rights and remedies of the parties hereto will be cumulative.

8) Amendments. Any amendment to this Business Associate Addendum will not be binding on either

of the parties to this Business Associate Addendum unless such amendment is in writing and executed by the party against whom enforcement is sought.

9) Notices. Any notices required or permitted under this Business Associate Addendum will be in writing and delivered in person or sent by registered or certified mail, return receipt requested, proper postage prepaid, properly addressed to the address of the addressee set forth above or to such other more recent address of the addressee of which the sending party has received written notice.

10) Binding Effect. Entry into the Agreement constitutes entry into this Business Associate Addendum and no separate signatures or executions are required.

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MVS Service Agreement
Exhibit E - Page 1 of 1

MVS Base Agreement (Centene Corporation) v2.0.01

Initials: MVS _____ HP _____

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j. Customer Service Function

GREABHA understands that our Customer Service Function is a direct reflection of our company and impacts every aspect of our operations. We are committed to ensuring "voice and choice" and to providing respectful service to our behavioral health recipients, family members and stakeholders. Each individual in our organization – from senior management to front line representatives – is held accountable for providing high quality customer service. Moreover, customer service is at the forefront of our employee and provider training programs and is engraved within our company philosophy.

The Customer Service Function is a direct reflection of GREABHA's company culture, and our commitment to providing "voice and choice" for our consumers, family members and stakeholders

Our entire organization understands the importance of empowering our consumers by providing service options and opportunities for recovery. We work to serve consumers in an effective, understandable, and respectful manner compatible with their cultural health beliefs and practices and preferred languages.

Customer Service Access

Behavioral health recipients and family members can rapidly access services through contracted providers and can receive referrals and assistance by calling the GREABHA Customer Service Center. It is intended to be a safety net for behavioral health recipients and family members to ensure timely and appropriate access to services and service delivery problem resolution.

The GREABHA Customer Service Center will be staffed to answer calls within an average of 30 seconds and to maintain an abandonment rate of under 5%. It will be staffed Monday through Friday from 8:00 am to 5:00 pm Mountain Standard Time, and will be accessible via a toll free number, as well as local telephone numbers in each GSA served. These lines have patch capabilities to the crisis line and to 911 in each community. After-hours service and referrals will be provided by transferring the same toll free number to NurseWise, a 24/7 nurse triage call center. This arrangement provides for 24/7 access to clinical assistance for all behavioral health recipients.

The following call types will be handled by GREABHA Customer Services Representatives (CSRs). Our call tracking system provides trending reports with information on all calls received, such as the following:

- Eligibility and Benefit Information
- Referral to Provider Agencies
- Emergency and Out of Area Services
- Crisis Calls
- Formulary Information
- Administrative Requirements
- Disenrollment Statistics
- Behavioral Health Recipient Satisfaction Statistics
- Provider Information
- Claims Information Calls from Behavioral Health Recipients or Providers
- Problems with filling and re-filling prescriptions

Our Customer Service and Outreach Representatives work with the behavioral health recipients, family members and clinical liaisons to process referrals and requests for service by providing information on where and how to access behavioral health services and telephonically connecting them, "warm transfer", to the agency of their choice.

All calls from behavioral health recipients, family members and providers are logged in the system with a call type and resolution. Calls are handled in the language in which the behavioral

health recipient is most comfortable. Many of our staff will be multi-lingual, representing the predominantly spoken languages in the GSA. If a CSR who speaks the behavioral health recipient's primary language is not available at the service center, an AT&T Language Line interpreter will be teleconferenced to assist the behavioral health recipient. In addition, the Telecommunication Device for the Deaf (TDD) line is available on a 24/7 basis.

Customer Service Enhancements

Following contract award, GREABHA will establish a website that behavioral health recipients in Arizona will use to access information and contact our service center. The website will provide county specific provider and service information. The customer service function is designed to identify first time callers, as well as to assist callers already familiar with our program. First time callers will receive special attention, since this may sometimes be the only chance we have to engage the caller. We seek to understand the reason for their call, handle the issue at hand, and take the extra step to orient them to GREABHA, their rights to service and how the Arizona principles pertain to them.

Our Customer Service Representatives (CSRs) will work with our Consumer Outreach Team to stay connected with behavioral health recipients, and to assist them, their families and providers in identifying and addressing service needs.

To ensure continuity of care, we support providers by using technology that alerts them to the following situations: behavioral health recipients who are missing service plans, recipients who are in the system but have not yet been assigned clinical liaisons and those who are close to the age of majority.

Our state of the art call tracking and service facilitation systems tracks behavioral health recipient demographic and enrollment information, as well as service plans, crisis and safety plans, clinical liaison assignments and contact information for treatment teams. Providers submit this information in a variety of ways: telephone, fax, or our preferred method, which is entering the information via our web based program.

Once a behavioral health recipient is enrolled in our system, automatic alerts are set to identify any missing essential elements. Assessments are stored on our centralized database, and all information is made available for care managers, our after hours triage center and providers (following HIPAA guidelines and restrictions).

In 2003, CBH received less than 0.2 formal complaints per 1,000 members

Every GREABHA employee, in-person behavioral health recipient outreach person and telephonic Consumer Outreach Staff will be trained in the identification, acceptance and speedy resolution of complaints. GREABHA will provide the same high level of customer service for which the Centene family of companies is renowned. CBH's efforts have been overwhelmingly successful, as evidenced by the fact that in 2003 we received less than 0.2 formal complaints per 1,000 members. These numbers are based on our total membership of over 600,000.

Interface with Grievance and Appeals

All complaints, resolutions and notification of the behavioral health recipient regarding the complaint are logged by CSRs. Customer service staff are trained to know how to distinguish between a consumer concern, complaint, SMI grievance, and appeal. The Customer Service staff will make every attempt to immediately resolve issues to callers satisfaction. In addition, Customer Service staff are also trained to triage complaints to the appropriate personnel. The Customer Service Department interacts as needed to address issue resolution with the Grievance and Appeals (G&A) Coordinator, and to ensure that complaints, grievances and appeals are forwarded to the G&A Coordinator on the same day that they are received. It is the responsibility of the G&A Coordinator to respond to consumers, resolve their issues, and inform them of their rights for further appeal. All issues are logged in our Call Tracking System and tracked to ensure

timely resolution and compliance with all state notice requirements. Our G&A database creates reports that show the timeliness of resolution, and these reports are submitted monthly to the QMC for feedback and further recommendations.

Customer Service Program Activities

Following is a list of the customer service activities that GREABHA will undertake:

Type of Activity	Explanation
Behavioral Health Recipient and Family Member Communications	Behavioral health recipient and family members receive information telephonically as requested and as approved by the ADHS/DBHS. No ad hoc written information is sent without going through the appropriate approval process to ensure no misrepresentation of available services is disseminated. Information is available in English/Spanish and other languages required per ADHS/DBHS contract as well as large print and cassette to assist the visually impaired.
Behavioral Health Recipient Outreach	GREABHA Consumer Outreach Representatives (CORs) will provide outreach and education on services, system processes and consumer rights in the recipient's primary language. Staff will explain Arizona principles and assist recipients in identifying potential members of their teams, and in encouraging thoughtful processes that may include others such as peers, community members, extended family members, school staff (children), sports coaches or church acquaintances. CORs will assist recipients to connect with providers and follow up to ensure that recipients are satisfied with the service plan options offered by providers and that they feel successful with his/her behavioral health progress.
Behavioral Health Recipient Satisfaction and Behavioral Health Recipient Complaint Monitoring	Customer Service Management Department will provide information regarding recipient satisfaction with individual providers to the the QM Committee; as well as formal and informal complaints, aggregate call type information etc. in order to identify trends and potential provider outliers. If analysis of these reports reveals potential or actual problems, or non-compliance to contract specifications, GREABHA will request a corrective action plan and will undertake appropriate actions.
Provider Satisfaction and Provider Complaint Monitoring	Customer Service will also receive provider complaints. Complaints are documented in our call tracking system and forwarded to the Provider Relations/Network Management team for investigation, resolution and appropriate follow-up. Provider satisfaction surveys are also initiated and measured with recommendations on process and system improvements from the QMC.
Maintaining Confidentiality	GREABHA will be governed by a comprehensive confidentiality policy. All employees are provided with a copy of this policy when they are employed by GREABHA, and are required to sign a statement that they have received it and agree to abide by its dictates as a condition of their employment. GREABHA complies with the requirements of HIPAA and other related state and federal guidelines. All GREABHA staff is trained in HIPAA regulations and the need to protect confidential protected health information (PHI) pertaining to GREABHA behavioral health recipients at the time of employment and on a yearly basis.
CSR and Consumer Outreach Training, Audit, and Expectations	CSRs and CORs will be trained on system, policies and procedures with an emphasis on access requirements and recipient knowledge of the system. Training will include confidentiality, the Arizona principles, accreditation standards and regulations, and customer service including cultural awareness. Training tests and audits ensure that a CSR or COR is prepared to provide service to GREABHA behavioral health recipients. Ongoing silent monitoring and data integrity audits, as well as Call Center surveys ensure that each representative is providing quality service.

k. Communication with Personnel and Behavioral Health Service Providers

GREABHA's communication strategy emphasizes accurate, complete, timely and effective communication of information between GREABHA staff and behavioral health service providers. This strategy is embedded throughout all levels of our organization.

To facilitate effective communication with provider agencies, we will establish provider technical assistance teams to work hand in hand with providers. The teams will be comprised of both clinical and non-clinical operational specialists, with expertise in the Arizona principles, claims, service delivery, etc.

Accurate, timely and effective communication of information between GREABHA staff and service providers is critical to the maintenance and improvement of the service delivery system

The GREABHA provider technical assistance teams will review new communication with providers during regular, bi-monthly discussions with provider agencies, to ensure that the information is understood. Communication with technical assistance teams involving training components will include web-based training opportunities, with post tests to document completion and comprehension by individual staff members and providers. Intensive technical assistance, including coaching, mentoring, observation and training, will be delivered to staff and provider agencies to ensure that the system is accountable to the Arizona principles and the behavioral health recipients we serve.

We will overcome barriers to communication in the following ways:

- Making information readily available on the web
- Distributing notices of posted information
- Tracking recipients of this information to be sure the documents are accessed
- Reviewing information with providers to ensure comprehension and mutual understanding

Responsible Personnel

Department heads will be responsible for preparing initial drafts of communication involving policy, contracts, procedures or processes. The Compliance and Communication Officer will be responsible for reviewing and approving all public documents and for comparing them with all relevant contract requirements, cultural sensitivity, the GREABHA strategic plan and the Arizona principles. Upon approval of the final communication, the Clinical and Provider Services Administrator will be responsible for the dissemination of the communication and the tracking of receipt of the communication. The Training Administrator will be responsible for tracking provider and staff comprehension of the communication by way of signed statements of receipt and understanding of information. Communication involving contract deliverables or system performance measures will be tracked and reported by the Quality Management Administrator.

Development and Revision of Communications Documents

GREABHA department(s) seeking to distribute operational, procedural, contract or policy information will draft and submit documents to the GREABHA Communications department for review to address state regulations, the Arizona principles and appropriateness in language level as needed. The Compliance and Communication Officer will review all documents to determine if additional internal or external parties (such as the Consumer and Family Advisory Council) need to review the documents before distribution. Documents warranting review with the ADHS/DBHS will be submitted for review by the Compliance and Communication Officer. The GREABHA

Communications Department, managed by the Compliance and Communication Officer, will also review content to be sure that the communication does not conflict with the strategic objectives of the GSA, the Arizona principles or contractual agreements. The Compliance and Communication Officer will work with the respective department head to ensure that all documents are appropriately revised prior to distribution.

Distribution of Information

GREABHA understands that distribution of critical information must be orderly and carefully monitored and assessed to ensure that information is understood and effectively implemented.

In order to maintain consistency in the distribution of critical information, all public information will be distributed on the GREABHA provider website on a specified day of the week. Planning will be implemented to ensure communication is distributed according to this schedule. Sequential numbering indicating year and number will be used to assist ready reference to the information. This approach will eliminate random communication; will assist in the orderly distribution of information to provider agencies; and will assist all recipients in interpreting and implementing changes associated with the communication. Mass distribution by facsimile will not be considered an appropriate form of communication of critical information.

No communication impacting operations, procedures, contracts or policies will be distributed prior to review by the Compliance and Communication Officer. Once the content of the communication has been approved, the communication will be returned to the Clinical and Provider Services Administrator for distribution. Public documents will be distributed on the GREABHA website with email notification to all appropriate recipients. Private documents will be mailed to the intended recipients. The Clinical and Provider Services Administrator will be in charge of tracking recipients' review of critical communications to ensure that all critical communication is received, read and understood. These will be sent via an email distribution list which will track, by communication piece sent, who received it and when they read it. If a provider does not have access to email, we will help them establish an email account or implement a process to send critical information via certified mail.

GREABHA believes that in order for communication to be the most effective, it must be well-planned and well-timed. In addition, information must be presented in a format that is easily accessible and understood by the audience. Therefore, we believe that frequent and comprehensive methods of communication are essential to the success of this program. Following are some of the methods GREABHA plans to utilize in communicating with behavioral health recipients, providers and stakeholders:

- **Behavioral Health Recipient and Family Member Representation on Advisory Councils:** Behavioral health recipients and their family members will be represented on Community Advisory Councils and the Consumer Advisory Council. Communications with these groups will be overseen by the COCCA. These Councils will play an active role in system planning, policymaking, educational planning review of forms and brochures for readability, cultural sensitivity, and evaluation of services. The Advisory Councils will provide recommendation for changes in service delivery toward more flexible individualized services. Behavioral health recipients will make recommendations on the appropriate use of reinvestment funds.

- **Behavioral health recipient and Family-Led Initiatives:** Program staff will work closely with the Community Advisory Council in each county. We will establish working partnerships with local consumer and family organizations including state and local Arizona NAMI chapters; Mentally Ill Kids in Distress (MIKID), other coalitions representing children and parents; and behavioral health recipient advocacy organizations. For example, we will train parents in communication and facilitation skills to help them become active participants of their own Child and Family Teams. We will also train behavioral health recipients as peer support workers, so that they can assist other recipients in their recovery.

- **Culturally-sensitive communications materials:** GREABHA's communication materials will be sensitive to the needs and concerns of minority behavioral health recipients and behavioral health recipients with limited incomes and educational opportunities. For example, GREABHA will send out bilingual letters to behavioral health recipients, ensuring that all behavioral health recipients understand their care. Behavioral health recipient communications will be reviewed by the Cultural Expert.

I. Community Collaboration

In recognition of the importance of collaboration among behavioral health recipients, family members and community stakeholders, GREABHA has established the Department of Community and Consumer Affairs, which will be led by the Chief Officer of Community and Consumer Affairs (COCCA). The COCCA reports directly to the GREABHA CEO in order to provide maximum collaboration and access to the decision making processes within GREABHA. The COCCA is a critical member of the Executive Management Team (EMT) and is responsible for overseeing strategic planning for the organization.

Strategic planning reviews will include an assessment of accomplishments, barriers to care and problems, satisfaction survey results, service gaps, and recommendations for improvement. The Consumer and Community Affairs Department will work collaboratively to identify opportunities for improvement and to develop strategies that meet the needs of behavioral health recipients and community stakeholders. (For more details, please refer to the Community and Consumer Collaboration Flow Chart in Section F.)

This department and associated committees will be staffed with consumers and family members to maximize the influence of behavioral health recipients in the system. The responsibility of this department is to obtain initial and ongoing input from behavioral health recipients, family members and community stakeholders regarding the delivery system design, planning, and evaluation of services. (For more details, please refer to the diagram in Section F depicting the structure of the Cultural, Consumer and Community Departments.)

Community and Behavioral Health Recipient Collaboration

In order to create opportunities to obtain local community and behavioral health recipient collaboration, GREABHA will establish Community Advisory Councils in each county. Each Community Advisory Council will be comprised of behavioral health recipients and community leaders. Each council will have 12 members, six of whom must be behavioral health recipients in the community. The other six community council members will be comprised of an emergency room representative, a police department representative, an ambulance/fire representative, and three community members at large. The ethnic make up of the committees will approximate the ethnic makeup of the county.

GREABHA will assign a staff consumer representative for each council. The role of this staff member will be to conduct community assessments, satisfaction surveys, conduct community forums, meet with behavioral health recipients and report to the council regarding findings and recommendations. The COCCA is a key participant in all EMT and MLT meetings. A GREABHA Community and Consumer Affairs Department representative, the CEO and the Cultural Expert will be present at all meetings. These representatives will be responsible for communicating findings and recommendations to the GREABHA Community and Consumer Affairs Department and providing technical assistance to the councils.

The areas to be measured and the sources of information are presented in the following table:

Area	Sources of Information
Access to care	QM analysis of provider reports, Direct report of committee members; concerns and complaints
Involvement with first responders	Satisfaction surveys, Direct report of committee members; concerns and complaints
Unmet service needs	Community surveys, Direct report of committee members; concerns and complaints

Area	Sources of Information
Child/behavioral health recipient/family team concerns	Community surveys, Customer satisfaction reports from internal staff and subcontractors (such as NurseWise), concerns and complaints
Satisfaction with GREABHA and with providers	Community surveys, Direct report of committee members; concerns and complaints
Timeliness of services	QM analysis of provider reports, claims data, Direct report of committee members; concerns and complaints
Unique community needs	Community surveys, Direct report of committee members, concerns and complaints
Cultural issues	Community surveys, feedback from the Consumer Outreach Reps, QM analysis of demographic data, staff ethnicity ratio reports, Direct report of committee members; concerns and complaints
Behavioral health recipients' understanding on accessing services in the system	Feedback from the Community, input collaboration with the Consumer Outreach Reps, utilization data, call type trend reports; concerns and complaints

Family Collaboration

The Community and Consumer Affairs department will promote the inclusion of behavioral health recipients as telephonic and field Consumer Outreach Staff to increase consumer and family collaboration.

- Outreach Staff will assess behavioral health recipient satisfaction with services and will help behavioral health recipients to understand the services available to them.
- Data will be collected from each phone call and interaction to assess family satisfaction with services and ascertain any unmet needs, access to services and service barriers.
- Random calls and visits with behavioral health recipients will be conducted to monitor satisfaction with the system and identify unmet needs and barriers to care. The data from these sources will be collected and reported to the Quality Management department for dissemination and review by the CEO and the Executive Management Team.

State Agency and Stakeholder Collaboration

The Interagency Liaison Department will employ an Interagency Liaison Manager to oversee the department, as well as a child welfare expert, Arizona State Hospital Liaison, Policy Liaison, Human Rights Liaison, Health Plan Liaison, and AHCCCS Eligibility Liaison. These liaisons will be responsible for obtaining and reporting information to GREABHA and to educate stakeholders about the system. This information will be used to assess compliance with intergovernmental agreements and interagency expectations and to facilitate adjustments in the delivery system. Each liaison will work with the Interagency Liaison Manager to establish benchmarks of success for each stakeholder group and to conduct quarterly satisfaction surveys to assess progress toward the benchmarks. This data will be provided to the Quality Management Administrator for reporting to the CEO and all executive team members. GREABHA will work with each agency on the viability of co-locating staff with each agency for consistent communication and accessibility.

Previous Experience

As previously mentioned, CBH currently provides services in five states: California, Indiana, Ohio Texas and Wisconsin. In all of these states, CBH works closely with community advocates, partners, health plan members and vendors to continuously monitor the services provided and to ensure that CBH meets/exceeds consumers' needs.

In Indiana, for example, we work with a Consumer Advisory Council, which has established strong relationships with organizations such as the Indiana Minority Health Coalition, the Wheeler Unit Boys & Girls Club of Indianapolis, the American Lung Association of Indiana, and JT's Hand (a community organization developed to assist families with children in the Neonatal Intensive Care Unit). We also support MHS, a Centene-owned health plan that operates in Indiana that works with numerous community churches and other organizations that promote and reinforce healthy living through various health fairs.

Likewise, in Ohio, we work with a Member Advisory Board based in Lucas County. This Board is a locally based committee that reports to the Chief Operating Officer of the Centene-owned Buckeye Community Health Plan (BCHP). The Board's main purpose is to solicit consumer and provider collaboration into BCHP benefits and programs, in an effort to increase the quality of care and service that BCHP consumers receive. Board members represent the local Medicaid managed care population through their direct or indirect participation as a BCHP member or provider of care or service.

The Member Advisory Committee with which we work in Texas solicits consumer collaboration and uses this input to drive Quality Improvement initiatives. The committee is comprised of a minimum of ten consumers in each service area. Committee members are selected and assigned by the Director of Member Services. The responsibilities of the Member Advisory Committee include, but are not limited to, the following:

- Reviewing member satisfaction indicators, including satisfaction with Utilization Management
- Evaluating performance levels and response times of the health plan's service
- Evaluating access to needed services
- Evaluating and providing feedback on other relevant issues identified by the committee

The Texas Member Advisory Committee is comprised of representatives of the following: eligible members; parents/guardians of eligible children; SSI recipients or their representatives; and health plan Member Advocates and Care Managers. Members from each service area are invited to participate on the Member Advisory Committee. The Member Advocate or designee chairs the meetings.

All advisory committees, boards and councils across the Centene family are tightly structured to ensure collaboration with consumers, community stakeholders, providers and state agencies. The purpose is to provide recommendations based on needs that are documented and addressed through various Quality Improvement Initiatives. Centene has been very successful in implementing these forums and making substantive changes in the way we provide services, with the ultimate goal of increasing customer satisfaction through consumer involvement. The input we receive from these committees, boards and councils helps us create process improvement plans that:

- Positively impact health outcomes
- Increase consumer knowledge and empowerment
- Enhance consumer engagement

m. Community Information and Methods

GREABHA is committed to assisting recipients, stakeholders, family members and the general public in understanding the behavioral health delivery system.

The Compliance and Communications Officer is responsible for creating, implementing and overseeing all external communication. Communication to behavioral health recipients will be reviewed and approved by the Consumer Advisory Council. The Interagency Liaison is responsible for the development and dissemination of information to state agencies. Behavioral health recipients will be involved in the process of disseminating information to community stakeholders, family members and behavioral health recipients. Information will be available in all prominent languages spoken in each GSA.

GREABHA will use a variety of venues to share information with behavioral health recipients, family members, community stakeholders, peer support groups, and state agencies, including:

- Town Hall Meetings
- Behavioral health recipient newsletters
- Telephonic Consumer Outreach
- Community Consumer Outreach
- Community and Consumer Advisory Council meetings
- Individual, in person behavioral health recipient outreach
- Orientation meetings at provider's offices and in the community
- Information posted on the Web
- Existing community groups, churches, clubs, etc.
- Provider Directory
- Behavioral health recipient Handbook

Examples of the kinds of information that we will share in these venues will include:

- What are the Arizona principles and how do they facilitate successful recovery for behavioral health recipients
- Information on available services and how to access them
- What a treatment team or child and family team is and why it is so important
- Who is the clinical liaison and what is his/her role
- What is a service plan and why should it be driven by behavioral health recipient
- How to access natural supports
- How to access community and prevention services
- Information regarding recovery principles and wellness
- Information regarding efficacy of various service modalities and medication regimens
- Information regarding problem resolution
- Information regarding early warning signs, new programs and services, and links to community services
- Information on care for the Caregiver
- HIPAA Privacy Rights, consumer rights and how to change Personal Health Information (PHI)

Information will be distributed to behavioral health recipients, family members, community stakeholders, peer support groups, and state agencies via one or more of the following methods:

- Distribution by mail
- Facsimile
- GREABHA website
- Videos, in-person educational sessions
- Health fairs in the community

Printed materials will be provided in the appropriate format for the recipient, including:

- Braille
- Large print and audio and cassette tapes
- English/Spanish or other language as needed
- American sign language video if needed

n. Additional Information

This section describes the concepts that GREABHA will use to meet the needs of behavioral health recipients and the expectations of ADHS/DBHS, and the way in which we will leverage the experience, philosophy and proven success of our parent company, Centene.

Meeting the Needs of Arizona Behavioral Health Recipients

The following table illustrates how GREABHA will translate concepts into action when implementing the behavioral health system in Greater Arizona.

Concept	Actions
Local Knowledge	GREABHA is developing Community Advisory Councils that will include behavioral health recipients and families, first responders (fire, police, ambulance, etc.) and community leaders. One Community Advisory Council will be established for each county. Each council will be assigned one paid consumer outreach specialist to conduct surveys, collect information, and arrange meetings. The councils will provide regular feedback identification of relevant conditions and intervention in crisis cases. The GREABHA CEO will attend the Community Advisory Council meetings.
Consumer Driven	GREABHA provides services that are consumer-driven, strength-based, family friendly, culturally sensitive, recovery oriented and embraces natural supports.
Provider Mentoring	GREABHA will mentor providers in the recovery model of service delivery of mental illness and substance abuse, and the Arizona Vision and Principles (child and family team model) for child and adolescent services. We will ensure that all services are delivered from the perspective that persons will and do recover from these conditions, and will achieve successful independent functioning in school and the community. Ongoing training and coaching in the Arizona principles will be instrumental in institutionalizing these practices in Greater Arizona. Providers will be mentored to re-engineer their work force to increase the availability of peer support, community supports and the recruitment of consumers in the delivery system.
Cultural Competency	GREABHA will promote behavioral health recipient engagement and responsiveness to individual needs through cultural competency training of staff and providers. The 14 CLAS standards will be part of our continued focus and cultural competency will be infused throughout our organization and network. All will be held to meeting the requirements and goals for cultural competency in each GSA.
Consumer Driven System Changes	GREABHA will engage behavioral health recipients and families in the design and refinement of the behavioral health service delivery to ensure responsiveness to behavioral health recipients' individual needs. The engagement of behavioral health recipients and families shall be achieved through representation on the executive management team, employment by GREABHA of consumers and family members as consumer outreach staff, the development of a consumer advisory board that meets with the CEO and the development of the community advisory councils in each county.

Concept	Actions
Behavioral Health Best Practices	GREABHA will promote best practices in the provision of services. This will be accomplished through a web-based information center, accessible to recipients and providers, tracking service delivery through encounter data, individualized service plans, outcome data and recipient reports. Positive functional outcomes for adults in the areas of independent living, employment, least restrictive environments, reduction in antisocial behaviors, community functioning, symptom management, interpersonal relationships, development of personal strengths, and life satisfaction. Successful outcomes for children include: success in school, living with their families, avoiding delinquency, and becoming stable and productive adults.
Increased Access, Voice and Choice	GREABHA will promote increased access and choice for Greater Arizona's behavioral health recipients by using provider contracting, provider mentoring and ongoing network development efforts to create new competencies, competition, consumer "voice and choice" and research-supported treatment options within local communities, including the use of telehealth support services to assist behavioral health recipients in rural areas. New treatments that meet the cultural needs of the area will also be developed.
Integrated Data Systems	GREABHA's IT systems will integrate service, clinical, financial, and quality data indicators that measure behavioral health recipients' engagement in the process of care, effective access to a clinical liaison, a completed and up-to-date individualized service plan, effective utilization of the child and family team for children, and behavioral health recipient achievement of individualized goals for functional improvement.
Stakeholder Collaboration	GREABHA will encourage a high level of collaboration, frequent communication, and feedback from all stakeholders, community leaders, including community providers, ADHS/DBHS, behavioral health recipients, family members and other state agencies.

Leveraging the Experience of Centene

Centene, the parent company of GREABHA, has extensive experience managing the delivery of services through a managed care model. Centene and its subsidiaries have been providing comprehensive, full-risk managed care services for Medicaid, SCHIP and SSI populations since 1984, with current products serving over 530,000 behavioral health recipients in Indiana, Ohio, Texas and Wisconsin. In addition, Centene implemented Buckeye Community Health Plan (BCHP) in January, 2004 (Ohio) consisting of 25,000 Medicaid lives. Centene acquired University Health Plans, Inc. in December, 2002 with 52,000 Medicaid lives in New Jersey.

Centene's expertise lies in the ability to transition new programs with minimal disruption to both current and potential behavioral health recipients. Centene's unique model for new business implementations allows for an integrated functional team approach with coordination of efforts handled by an on-site Project Director at new locations. This "team" approach allows for the development/adoption of processes, policies, regulatory document submission, facilities, and the timely completion of all necessary tasks by each functional lead for the successful implementation of the new contract. Once the new contract is up and running smoothly, the functional leads transition their respective responsibilities to the local operational staff.

Centene's philosophy emphasizes local presence and local control. Centene's strength lies in the support that it provides to its subsidiary companies. These supports include: financial stability (with transparent financial reports available as public domain); technologically advanced Management Information Systems; state-of-the-art facility for processing encounters/claims (which boasts an impressive record for timeliness and accuracy).

Leveraging Centene's Proven Implementation Plan

Centene has found that a transition project team approach is critical to the success of an implementation of this magnitude. Centene's transition plan and the process described below will demonstrate the level of integration and communication necessary to effectively manage the project. The Centene transition plan is an over-arching document which clearly defines the transition project objective(s), identifies the Centene transition project team and key project issues, and includes the transition matrix. The key "working document" central to this process is the transition matrix. The tools used to manage implementation projects are designed to be flexible and are customized to fit the requirements and elements of the different processes.

The transition matrix addresses the following functional aspects of a major implementation:

- Organizational aspects of the project (contact lists, workgroups)
- Regulatory requirements, such as licensure and contract execution
- Financial reporting
- Transfer of data: eligibility, level 1 service status
- Consumer specific records and documentation for care management
- Stakeholder communications
- Delivery System Analysis and Needs Assessment
- Information Systems
    - Interfaces with State
    - Services configuration
    - Back-up and disaster recovery plan
    - Reporting, including encounter data
    - System readiness assessment
    - System testing
- Operational Readiness Assessment
    - Consumer and provider communications & materials
    - Network development, Credentialing and Contracts
    - Staffing and training
    - Infrastructure functions (telephones, workstations, office space)
    - Policy and procedure development and review
- Care Management Transition
- Scope of Services and Value-Added Services
- Claims cross-over process
- Claims run-out procedures
- Continuation of reporting, record retention
- Any additional elements as required by ADHS/DBHS

Establishing Project Objectives

At the initiation of the contract, GREABHA, ADHS/DBHS and other parties, as required, will participate in an initial meeting in which ADHS/DBHS identifies the desired outcome(s) for the project, the requirements for achieving the outcome(s) and the timeline under which the project will be completed. This meeting will provide the framework within which GREABHA personnel and all other parties will operate. Transition Project documentation will then be developed to accommodate the parameters set forth by ADHS/DBHS, understanding that changing circumstances can change the direction, complexity or timing of the project. During this meeting, the project teams and key contacts responsible to ADHS/DBHS for the duration of the project are identified.

A sample project plan proposal is presented in Volume 5 – Information Technology. This plan includes system conversion and testing for an implementation.