CONTRACT
Between
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT
AND
SUNFLOWER STATE HEALTH PLAN, INC.
for
Managed Care for Medicaid and CHIP Programs (KanCare)

This Contract is made and entered into by and between the Kansas Department of Health and Environment, whose address is 900 S.W. Jackson, Rm. 900N, Topeka, Kansas, 66612, hereinafter referred to as "the State" and Sunflower State Health Plan, Inc., whose address is 534 South Kansas Avenue, Suite 305, Topeka, Kansas 66603, hereinafter referred to as "Contractor."

KDHE, pursuant to Executive Reorganization Order No. 38, became the successor to the Kansas Health Policy Authority (KHPA) effective July 1, 2011. The successor can exercise any contractual authority granted to KHPA.

KDHE is authorized by K.S.A. 2007 Supp. 75-7401 et seq., to enter into a Contract to obtain managed care for the Kansas Medicaid and CHIP programs. Services included in this Contract are physical health services, behavioral health services, and long term care (LTC), including nursing facility (NF) care and home and community based services (HCBS). These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and substance use disorder (SUD) services;

The Contractor is a recognized provider of these services and desires to provide them to the State; and

a Request for Proposal (RFP), #0001028, was issued on November 8, 2011 pursuant to K.S.A. 75-37,102 for acquisition of these services; and

a Procurement Negotiating Committee (PNC) conducted negotiations and determined the best interests of the State will be served by awarding a Contract to Contractor to provide such services.

NOW, THEREFORE, for and in consideration of the mutual covenants and agreement contained herein, the State and Contractor do hereby mutually covenant and agree as follows, provided that any provisions below are intended to be in addition to and to supplement the provisions contained in the RFP, the Contractor's proposal, and any amendments and responses to those documents as specified in Section III.c.-e. below, unless the provision in this document expressly states that it is to replace a provision in one or more of the documents specified in Section III.c.-e. below:

I. NO LAPSE FOR SUCCESSOR TO KDOA AND SRS:

Pursuant to Executive Reorganization Order No. 41 (ERO 41), the Kansas Department on Aging (KDOA) will become the Kansas Department for Aging and Disability Services (KDADS), and the Kansas Department on Social and Rehabilitation Services (SRS) will become the Kansas Department for Children and Families (DCF), both effective July 1, 2012. This agreement, while executed before

this effective date, will continue in effect. The successor can exercise any contractual authority granted to KDOA. As also set forth in ERO 41, certain functions and responsibilities previously assigned to SRS will be reassigned to KDADS, with the remaining functions assigned to DCF. Any references to KDOA in the RFP or any subsequent questions or responses are hereby amended to reference KDADS. In addition, any references to SRS agency functions or responsibilities transferred to KDADS under ERO 41 are hereby amended to reference KDADS. Finally, any references to SRS agency functions or responsibilities that are not being transferred to KDADS under ERO 41 are also hereby amended to reference DCF.

II. SCOPE OF WORK:

As required in the Contract documents specified in Section 3 below, Contractor will provide the State with managed care services for the Medicaid and CHIP programs. Services included are physical health service, behavioral health services and Long Term Care (TLC), including nursing facility (NF) care, mental health nursing facility care for members age 21 and under and age 65 and older, and home and community based services (HCBS). These services will be provided statewide and include Medicaid funded inpatient and outpatient mental health and substance use disorder (SUD) services including existing 1915 c HCBS Waiver programs for children with a Serious Emotional Disturbance (SED). The Contractor agrees to furnish all the services and items in accordance with the bid specifications of RFP #0001028 and all amendments.

III. CONTRACT DOCUMENTS:

The Contract documents shall consist of the following documents. In the event of conflict of terms of language among the documents, the following order of precedence shall govern:

a. Form DA-146A;
b. Written modification to the executed Contract;
c. Written Contract signed by the parties;
d. Request for Proposal #0001028, including all attachments and exhibits, and Amendments 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12 and 13;
e. Contractor's written proposal submitted in response to the Request for Proposal as finalized, including;
   1) Original Technical, revised Technical and final Cost Proposal submitted by Contractor, dated January 31, 2012, February 22, 2012 and May 22, 2012 respectively.
   2) Contractor's written responses to State's questions/assurances.
   3) State's written responses to Contractors questions.

IV. CONTRACT PERIOD:

This Contract shall commence beginning January 1, 2013 through December 31, 2015 (the "Initial Term"), with two one (1) year renewal periods exercisable at the option of the State (each a "Renewal Term"). The State shall notify the Contractor in writing of its intent to exercise its option to renew at least six months prior to the end

of the Initial Term or the first Renewal Term. The Contractor will respond to the state within 30 calendar days of receipt of notice of State's intent.

V. CENTERS FOR MEDICARE AND MEDICAID FEDERAL REQUIREMENTS:

The following sections are added to the RFP to meet federal requirements as set forth by the Centers for Medicare and Medicaid Services (CMS):

a. 2.2.8.2.6

Any Indian who is enrolled in a non-Indian MCE and eligible to receive services from a participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider, is permitted to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services.

b. 2.2.8.3.1

CONTRACTOR(S) shall demonstrate that there are sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers.

c. 2.2.8.11.2.1

The CONTRACTOR(S) may not deny payment for treatment obtained when an enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in 42 CFR 438.114(a) of the definition of emergency medical condition.

d. Section 2.2.13.11 is amended to read:

Such value-added services may include anything permissible under applicable Federal Medicaid and CHIP regulations, including incentives offered to promote preventive services exempted in the HHS OIG Special Advisory Bulletin located at http://oig.hhs.gov/fraud/docs/alertsandbulletins/SABGiftsandInducements.pdf and may include, but will not be limited to:

e. 2.2.25.1.1.4

Timeframes for notice of action: Termination, suspension or reduction of services - MCO or PIHP gives notice by the date of the action for the following:

f. 2.2.25.1.1.4.1

an adverse determination made with regard to the preadmission screening requirements for NF admissions on or after January 1, 1989; or

g. 2.2.25.1.1.4.2

the safety or health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the nursing facility for 30 days (applies only to adverse actions for NF transfers).

h. 2.2.38.2.7

The requirements found in Section 2.2.38.2 and its subsection, shall also apply to all participating Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) provider in each CONTRACTOR'S network.

i. 2.2.40.7.1

The contractor must define service authorization in a manner that at least includes a managed care enrollee's request for the provision of a service.

j. 2.3.3.1.1.13

A recipient may request disenrollment without cause at the following times:

k. 2.3.3.1.1.13.1

Upon automatic reenrollment under 42 CFR 438.56(g), if the temporary loss of Medicaid eligibility has caused the recipient to miss the annual disenrollment opportunity.

l. 2.3.3.1.1.13.2

When the State imposes the intermediate sanction specified in 42 CFR 438.702(a)(3).

m. Section 2.3.6.8 is amended to read:

Inpatient hospitals and nursing facilities are entitled to three (3) reasonable offers at or above the FFS rates unless another payment structure is negotiated. If they do not CONTRACT with the MCO, out of network providers will receive 90% of FFS rates. This payment requirement also applies to services provided under the prudent layperson definition of emergency services.

n. 2.3.6.10

CONTRACTOR(S) shall insure that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider.

VI. PAY FOR PERFORMANCE MEASURES:

The State will work collaboratively with all three of the MCO Contractors collectively, and provide policy guidance and program direction, in a good faith effort to ensure that all Pay for Performance (PFP) measures are clearly understood; that all PFP measures are consistently defined; that the necessary data to evaluate the PFP measurements are identified and accessible (including through the establishment of selected targeted interfaces and/or supplemental data exchange efforts by the contractors); and that every concern or consideration from the three successful bidders is heard. When that process is completed, as determined by the State, the final details as to each measure will be communicated and will be binding upon each contractor.

Those measures that are built upon existing practices (such as the mental health/substance use disorder NOMS) will have some variability in terms of improvement required, none of which will be over 5% per year but some of which will be considerably under 5% each year. Those detailed sub-measure requirements will likewise be developed collaboratively between the State, the successful bidders, and with targeted input from other stakeholders. When that process is completed, as determined by the State, the final details as to each measure will be communicated and will be binding upon each contractor.

Those measures which relate specifically to services covered in the I/DD HCBS waiver (such as increased competitive employment for people using those services), as determined by the State after Contractor input, will have an additional year of benchmarking during year two of the program, and will be treated as presumptively met for year two. (This additional year for benchmarking and presumptively met status would only apply to those measures specifically identified by the State; all other measures, and portions of measures that apply also to programs other than the I/DD HCBS waiver, will remain in effect and the State will expect vendors to comply with the performance requirements.

VII. STANDARIZATION OF PROCESSES:

The Contractor agrees to standardization of work processes between the State and all KanCare providers to provide the most efficient implementation and management of the KanCare Program.

Processes to be included, but are not limited to, are as follows:

a. Provider credentialing (forms, criteria, and processing)

b. Credentialing Requirements for Pharmacists to provide Medical Therapy Management (MTM)

c. Pharmacy Website Information (Prior Authorization criteria/forms, Provider Manual, Preferred Drug List information, Pricing Lookup, etc.)

d. Authorization procedures for services

e. Claims billing processes

f. Provider network documentation

g. Provider surveys

h. Operations, quality, customer service, and grievance report formats

VIII. REIMBURSEMENT FOR CRITICAL ACCESS HOSPITALS:

The Contractor agrees the reimbursement floor for federally recognized Critical Access Hospitals (CAHs), as the state fee-for-service Diagnostic-Related Group (DRG) payment schedule for inpatient service and the fee schedule for outpatient services, as established by the State in its sole discretion from time to time, plus an adjustment using a Cost Adjustment Factor as established by the State on an annual basis. The adjustment may be a tiered or hospital-specific factor, or a similar methodology. CAHs will be reimbursed no less than 100 percent of the reimbursement floor as defined in this paragraph.

IX. CAPITATION RATES:

The capitation plan rates for the first year of the contract are based on the Contractors Low Cost Estimate (LCE) discount submission of May 22, 2012 (Attachment A). Plan discounts for 2nd and 3rd year of the base year's contract will be based on the Contractors LCE submission of April 18, 2012 (Attachment B). The rates for the first year as attached will become effective upon the date of CMS approval

The State will notify the Contractor of rate adjustments for the 2nd and 3rd years in September 2013 and September 2014, respectively. Contractors will have 30 calendar days from the date of the notification to review and comment prior to submission to CMS.

X. PHARMACY

A. Medication Therapy Management

i. Contractor agrees that beneficiaries with two (2) or more chronic disease states and whose drug therapy includes five (5) or more medications must be deemed to qualify for MTM services. Contractor may elect to provide MTM services to beneficiaries with a lower number of disease states or medications, but Contractor may not increase the above-stated minimums.

ii. Contractor agrees that MTM services should include, but not be limited to, a review of the following: drug interactions, adverse drug reactions, therapeutic duplication, appropriate drug dosing, active diagnoses and providers, patient compliance, and patient understanding of drug therapy.

iii. Contractor agrees that the listed MTM services must be reviewed both at the patient's initial MTM encounter and in subsequent Complete Drug Reviews that will occur as needed and on an annual basis.

iv. The Contractor agrees to standardization between the State and all KanCare providers of the credentialing requirements for pharmacists to provide MTM services.

v. Contractor agrees that further requirements, standards, criteria or costs related to credentialing will not be required for pharmacy providers to provide MTM services beyond the standardized credentialing requirements, to be developed in conjunction with the state and all KanCare providers as described in iv above.

vi. Contractor agrees that any willing contracted pharmacy provider who meets the MCO standardized credentialing requirements will be allowed to provide MTM services.

vii. The Contractor agrees that reimbursement for MTM services will be a separate component of reimbursement and will not be included in the participating pharmacy's dispensing fee and/or drug ingredient cost.

viii. The Contractor agrees that MTM services are to be provided on a face-to-face patient/pharmacist basis, and that these services shall be provided by a licensed Kansas pharmacist who is also MCO-credentialed.

ix. Any other MTM interventions, whether telephonic, electronic, via mail, or by any other means, will only be supplementary to a specific pharmacist/patient face-to-face MTM interaction. The Contractor further agrees the only acceptable manner of beneficiary outreach for MTM services will be via telephonic, electronic, or mail media, for notification of eligibility in the MTM program at a Kansas pharmacy.

B. Pharmacy PDL and DUR Processes

i. Kansas law permits the State to restrict access to prescription drugs through the use of a program of prior authorization or restrictive formulary only as established by duly adopted regulation. K.S.A. § 39-7,120(a). The State has done this by promulgating a list of drugs for which prior authorization (PA) will be required at K.A.R. § 129-5-1(b).

ii. Contractor understands and agrees there will be one Preferred Drug List (PDL) under KanCare. Contractor will submit criteria for prior authorization for a given drug to be reviewed by the state's Drug Utilization Review Board (DUR), per state statute. Upon approval by the DUR Board, state staff will be responsible for appearing before the Joint Committee on

Administrative Rules and Regulations for the purpose of adding drugs to K.A.R. § 129-5-1(b).

C. Pharmacy Mail Order

i. Contractor agrees that although they may offer mail order pharmacy as an option to beneficiaries, they or their Pharmacy Benefits Manager(PBM) are not allowed to require or incentivize the use of Mail Order Pharmacy, including through differential patient co pays.

D. Pharmacy Dispensing Fee

i. Contractor agrees to the reimburse pharmacy providers at or above the rate of the state-mandated pharmacy dispensing fee. As of contract date, this rate is $3.40 per claim.

E. Specialty Pharmacy

i. Contractor agrees that while specialty pharmacy options can be made available to the patient, the Contractor may not require beneficiaries to receive medications from a specialty pharmacy program.

F. Pharmacy Benefit Manager

i. Contractor agrees their contracted PBM will be directly available to State staff and oversight regarding provider concerns and issues, as well as other oversight the State deems appropriate.

G. Pharmacy Reimbursement

i. Contractor agrees that pharmacies will be reimbursed at a rate comparable to current (12/31/2012) fee-for-service reimbursement.

H. Maximum Allowable Cost List Administration

Contractor agrees that it or its PBM will:

i. On or before January 1 of each contract year, notify contracting pharmacies the basis of the methodology and sources utilized to determine the Maximum Allowable Cost (MAC) pricing of the PBM;
ii. Update MAC pricing information regularly;
iii. Make MAC pricing information available directly or by active link from a central KanCare website;
iv. Establish a process for the timely notification of the MAC pricing updates to network pharmacies;
v. Eliminate products from the MAC list or modify MAC rates in a timely fashion, consistent with pricing changes in the marketplace;
vi. Provide a reasonable administrative appeals procedure to allow a dispensing provider to contest a listed MAC rate that includes the

following:

a. The PBM must respond to a provider who has contested a MAC rate through this procedure within 30 calendar days;
b. If an update is warranted, the PBM shall make the change retroactive to the date of service and make the adjustment effective for all pharmacy providers in the network.

XI. THIRD PARTY LIABILITY SUPPLEMENTAL RECOVERY:

The State reserves the right to conduct a supplemental (come-behind) recovery program for Third Party Liability (TPL). Any TPL identified and recovered by the State more than 6 months after the date of payment of a claim will be retained by the State.

XII. SPENDDOWN: The State and the Contractor agree that the capitated rates associated with this Contract reflect all costs associated with the medically needy aged and disabled ("spenddown") populations net of shared cost. The enrollment process described below is consistent with the rate development methodology used.

Notification: The state will assign beneficiaries in the spenddown population immediately to Contractor using the regular enrollment file process.

Payment: The State will pay a capitated rate for each member of the spenddown population assigned to the Contractor's plan starting with the first month of assignment. Contractor is responsible for the provision of services to the spenddown member from the date of the assignment. Contractor is also responsible for monitoring the status of the member's spenddown, paying claims only after the spenddown has been met and keeping track of the claims not paid and applied to the member's spenddown. Contractor must identify which claims were use to meet each member's spenddown and provide that information to the State at an agreed-upon time.

XIII. RETROSPECTIVE CAPITATION PAYMENTS:

The State will make retrospective payments to Contractor for enrolled members no later than the third business day after the first Friday of the following month. For example, the State would make January 2013 capitation payments no later than Wednesday, February 6, 2013.

XIV. HEALTH HOME:

The State intends to allow as much innovation as possible with all KanCare MCO providers in the Health Home program. Should CMS mandate all the KanCare MCO's be required to conform to a single payment structure for Health Homes across all MCO's, the contractor agrees to comply with a single payment structure for Health Homes.

XV. INDIAN TRIBE, TRIBAL ORGANIZATION, OR URBAN INDIAN ORGANIZATIONS:

Indian Health Service, tribal and urban Indian organization programs will be eligible for participation in federal health programs to the same extent as any other provider. There will be no barrier to tribal members accessing any Indian Tribe, Tribal Organization, or Urban Indian Organization (I/T/U) and I/T/U providers will be reimbursed at no less than current reimbursement.

The State and the Contractor agree other protections for tribal members and I/T/U providers (including Indian Health Services and 638 clinics) will continue. These protections include, but are not limited, to the following:

a. No Medicaid premiums or cost sharing for tribal members;

b. Exemptions for Indians who have used an I/T/U or are eligible to use an I/T/U, including contract health service (CHS);

c. I/T/U and CHS provider payments may not be reduced by the amount of the cost sharing;

d. Exemption of certain Indian-specific property from consideration in determining eligibility for Medicaid, as under ARRA Section 5005(b); and

e. Exemption from Medicaid Estate Recovery Act rules, as per ARRA Section 5006(c).

And specific to managed care, the Contractor will:

f. Permit any Indian who is enrolled in a non-Indian managed care entity and eligible to receive services from a participating I/T/U provider, to choose to receive covered services from that I/T/U provider, and if that I/T/U provider participates in the network as a primary care provider, to choose that I/T/U as his or her primary care provider, as long as that provider has capacity to provide the services;

g. Provide sufficient I/T/U providers in the network to ensure timely access to services available under the contract for Indian enrollees who are eligible to receive services from such providers;

h. Agree that I/T/U providers, whether participating in the network or not, be paid for covered Medicaid or CHIP managed care services provided to Indian enrollees who are eligible to receive services from such providers either (1) at a rate negotiated between the managed care entity and the I/T/U provider, or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider; and

i. Provide that prompt payments will be made to all I/T/U providers in its network as required for payments to practitioners in individual or group practices under federal regulations at 42 CFR 447.45 and 447.46

XVI. DELAY OF FUNDING FOR HCBS SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES:

The 2012 Kansas legislature expressly restricted the use of State funding for the provision of home and community based services (HCBS) for individuals with intellectual and developmental disabilities or targeted case management for individuals with intellectual and developmental disabilities under any managed care system or under managed care oversight. Accordingly, Contractor agrees that its provision of HCBS services for individuals with intellectual and developmental disabilities will be delayed until January 1, 2014. On and after that date, Contractor agrees to be prepared to provide HCBS services to individuals with developmental disabilities as provided in Contractor's RFP responses. Contractor acknowledges and agrees that it will begin providing physical and behavioral health services for individuals with developmental disabilities on the same date as non-disabled members, specifically, January 1, 2013.

During the period of January 1 to December 31, 2013, Contractor further agrees to work with the State on the development of pilot programs for the demonstration, testing and evaluation of the delivery of services through the home and community based waiver for individuals with developmental disabilities or targeted case management for individuals with developmental disabilities.

Contractor agrees that the LCE bids referenced in Section IX above are accurate in light of the delay in provision of HCBS services to the developmentally disabled population. .

XVII. FRAUD ENFORCEMENT BY STATE ATTORNEY GENERAL:

Contractor acknowledges and agrees that the Kansas Medicaid Fraud Control Unit (MFCU), which is part of the Kansas Attorney General's office, will have the right to recover fraudulent Medicaid payments directly from participating and non-participating providers and subcontractors of Contractor, and from any other third parties in Contractor's provider network. Contractor acknowledges and agrees that it is not entitled to any portion of any recovery by the Kansas MFCU. Further, Contractor agrees to be subrogated to the State for any and all claims Contractor has or may have against pharmaceutical companies, retailers, providers, or other subcontractors, medical device manufacturers, or durable medical equipment manufacturers in the marketing and pricing of their products.

XVIII. PAYMENT:

Section 2.3.6.2 of the RFP is hereby amended to add the following sentence to the end of that Section: "Subject to the provisions of (a) this Section 2.3.6.2 above regarding performance withholds, and (b) Section 2.3.6.3 and its subsections, capitation payments made by the State to Contractor constitute full and complete payment to Contractor for all goods and services provided by Contractor to the State for the time period covered by such capitation payments."

XIX. CORRECTION OF CONTRACT YEAR REFERENCE:

Every reference in the RFP to "Contract Year 2012" is hereby changed to "Contract Year 2013."

XX. FINAL CONTRACT APPROVAL:

CMS must review and approve this Contract once it is signed by all parties. The contract will not be considered final until the State receives CMS approval.

However, the Contractor will begin development of the Contractor's MCO program prior to final CMS approval. Should CMS for any reason not approve the Contract as submitted; the State will not be held liable for any expenses incurred by the Contractor up to the date of disapproval of the Contract by CMS.

XXI. PROVIDER MANUAL UPDATES AND COMMUNICATIONS:

Contractor agrees to notify Providers of changes to the Provider Manual by written notification in the form of, but not limited to, letters, memorandum, provider newsletters and bulletins. Contract agrees to post program changes of any kind on the Contractor's website and the Contractor's provider portal.

Contractor agrees to notify Providers at least 30 days prior to the effective date of changes to the Provider Manual.

XXII. UTILIZATION MANAGEMENT:

Contractor will be transparent regarding all utilization management criteria it applies to any service, consistent with RFP section 2.2.40. This information will not be treated as proprietary and will be available broadly, including but not only on the Contractor's website, directly or by active link.

XXIII. NURSING FACILITIES FOR MENTAL HEALTH:

The State clarifies that nursing facilities for mental health is a covered service for members age 21 and under and age 65 and older.

XXIV. MODIFICATIONS:

This Contract shall only be modified by the mutual, written agreement of the parties.

XXV. OWNERSHIP

Section 4.1.1.50 of the RFP, "Ownership," is hereby amended to read as follows:

All data, forms, procedures, software, manuals, system descriptions, or set of systems rules, source code, and workflows developed by the Contractor during the term of this Contract for use under this Contract will be owned by and are the property of the State. The Contractor may not release any such materials without the written approval of the State. Software, data, processes and programs that are owned by, proprietary to, or licensed by the Contractor as of the effective date of

this Contract, or that are developed by the Contractor outside the scope of this Contract, will be owned by and are the property of the Contractor.

XXVI. FINANCIAL REPORTING:

The following Sections of the RFP are hereby amended to read as follows:

a. 2.2.28.4

The Contractor shall file with the State, a *Quarterly Financial Report.* These reports shall be on the form prescribed by the NAIC for health maintenance organizations and shall be submitted to the State on or before May 15 (covering first quarter of current year), August 15 (covering second quarter of current year), and November 15 (covering third quarter of current year). Each quarterly report shall also contain an income statement detailing the Contractor's quarterly and year-to-date revenues earned and expenses incurred as a result of the Contractor's participation in the KanCare program. The second quarterly report (submitted on August 15) shall include the Medical Loss Ratio report completed on an accrual basis that includes an actuarial certification of the claims payable (reported and unreported) and, if any, other actuarial liabilities reported. The actuarial certification shall be prepared in accordance with NAIC guidelines. The Contractor shall also submit a reconciliation of the Medical Loss Ratio report to the second quarterly NAIC report.

b. 2.3.4.4

The Contractor, the Contractor's parent company, and all non-provider subcontractors that are not affiliated with Contractor will provide the results of an annual audit performed by an independent Certified Public Accountant and to authorize the Contractor to share this information with the State. The Contractor shall authorize the independent accountant to allow representatives of the State, upon written request, to verify the audit report.

c. Parent Company Guarantee

In addition, the form Parent Company Guarantee (as provided during vendor negotiations), is hereby deleted in its entirety and replaced with the form Parent Company Guarantee attached hereto as Attachment 1.

XXVII. PRIOR PERIOD OF COVERAGE:

When developing rates for KanCare, the State included prior period of coverage.

The State and Contractor agree to monitor prior period of coverage experience; and the State will consider rate adjustments if Contractors actual prior period of coverage experience is materially different than assumed in KanCare rate development.

IN WITNESS HEREOF, the parties hereto have caused this instrument to be executed by their duly authorized official or officers this 27th day of June, 2012.

SUNFLOWER STATE HEALTH PLAN

By: _____

Printed Name: JESSE HUNTER

Title: VICE PRESIDENT

KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

By: _____

Printed Name: Robert Moser MD

Title: Secretary

I hereby certify that the competitive bid/procurement laws of the State of Kansas have been followed:

State of Kansas

By: _____ 6/27/12

Chris Howe, Director
Procurement and Contracts