

Attachment B.6.b
WellCare 10-Q for Q1 of 2011

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FORM 10-Q

WELLCARE HEALTH PLANS, INC. - WCG

Filed: May 06, 2011 (period: March 31, 2011)

Quarterly report which provides a continuing view of a company's financial position

UNITED STATES
SECURITIES AND EXCHANGE COMMISSION
Washington, D.C. 20549
FORM 10-Q

(Mark One)

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

For the quarterly period ended **March 31, 2011**
or

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

For the transition period from _____ to _____
Commission file number: **001-32209**

WELLCARE HEALTH PLANS, INC.

(Exact name of registrant as specified in its charter)

Delaware
(State or other jurisdiction of
incorporation or organization)

47-0937650
(I.R.S. Employer
Identification No.)

8725 Henderson Road, Renaissance One
Tampa, Florida
(Address of principal executive offices)

33634
(Zip Code)

(813) 290-6200
(Registrant's telephone number, including area code)

Indicate by check mark whether the registrant: (1) has filed all reports required to be filed by Section 13 or 15(d) of the Securities Exchange Act of 1934 during the preceding 12 months (or for such shorter period that the registrant was required to file such reports), and (2) has been subject to such filing requirements for the past 90 days. Yes No

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

Indicate by check mark whether the registrant is a large accelerated filer, an accelerated filer, a non-accelerated filer or a smaller reporting company. See the definitions of "large accelerated filer," "accelerated filer" and "smaller reporting company" in Rule 12b-2 of the Exchange Act

Large accelerated filer Accelerated filer Non-accelerated filer Smaller reporting company
(Do not check if a smaller reporting company)

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

As of May 4, 2011 there were 42,561,287 shares of the registrant's common stock, par value \$.01 per share, outstanding.

WELLCARE HEALTH PLANS, INC.

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Part I — FINANCIAL INFORMATION**Item 1. Financial Statements.****WELLCARE HEALTH PLANS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS
(Unaudited, in thousands, except per share data)**

	Three Months Ended March 31,	
	2011	2010
Revenues:		
Premium (see Note 1)	\$ 1,472,416	\$ 1,353,458
Investment and other income	2,326	2,495
Total revenues	<u>1,474,742</u>	<u>1,355,953</u>
Expenses:		
Medical benefits	1,245,040	1,165,972
Selling, general and administrative	169,243	163,593
Medicaid premium taxes (see Note 1)	18,864	9,744
Depreciation and amortization	6,475	5,756
Interest	77	10
Total expenses	<u>1,439,699</u>	<u>1,345,075</u>
Income before income taxes	35,043	10,878
Income tax expense	13,713	4,460
Net income	<u>\$ 21,330</u>	<u>\$ 6,418</u>
Net income per common share (see Note 1):		
Basic	\$ 0.50	\$ 0.15
Diluted	\$ 0.50	\$ 0.15

See notes to unaudited condensed consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONDENSED CONSOLIDATED BALANCE SHEETS
(In thousands, except share data)

	March 31, 2011	December 31, 2010
Assets	(Unaudited)	
Current Assets:		
Cash and cash equivalents	\$ 1,232,918	\$ 1,359,548
Investments	201,894	108,788
Premium receivables, net	190,182	127,796
Funds held for the benefit of members	—	33,182
Income taxes receivable	16,838	9,973
Prepaid expenses and other current assets, net	117,815	114,492
Deferred income tax asset	42,963	61,392
Total current assets	1,802,610	1,815,171
Property, equipment and capitalized software, net	75,980	76,825
Goodwill	111,131	111,131
Other intangible assets, net	11,045	11,428
Long-term investments	83,717	62,931
Restricted investments	105,812	107,569
Deferred income tax asset	55,188	58,340
Other assets	3,726	3,898
Total Assets	\$ 2,249,209	\$ 2,247,293
Liabilities and Stockholders' Equity		
Current Liabilities:		
Medical benefits payable	\$ 790,624	\$ 742,990
Unearned premiums	84,532	67,383
Accounts payable	7,629	8,284
Other accrued expenses and liabilities	152,348	199,033
Current portion of amounts accrued related to investigation resolution	68,799	121,406
Other payables to government partners	52,179	46,605
Funds held for the benefit of members	4,624	—
Total current liabilities	1,160,735	1,185,701
Amounts accrued related to investigation resolution	218,274	216,136
Other liabilities	12,546	13,410
Total liabilities	1,391,555	1,415,247
Commitments and contingencies (see Note 6)	—	—
Stockholders' Equity:		
Preferred stock, \$0.01 par value (20,000,000 authorized, no shares issued or outstanding)	—	—
Common stock, \$0.01 par value (100,000,000 authorized, 42,557,404 and 42,541,725 shares issued and outstanding at March 31, 2011 and December 31, 2010, respectively)	426	425
Paid-in capital	432,810	428,818
Retained earnings	426,442	405,112
Accumulated other comprehensive loss	(2,024)	(2,309)
Total stockholders' equity	857,654	832,046
Total Liabilities and Stockholders' Equity	\$ 2,249,209	\$ 2,247,293

See notes to unaudited condensed consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS
(Unaudited, in thousands)

	Three Months Ended March	
	31,	
	2011	2010
Cash from (used in) operating activities:		
Net income	\$ 21,330	\$ 6,418
Adjustments to reconcile net income to net cash used in operating activities:		
Depreciation and amortization	6,475	5,756
Equity-based compensation expense	4,849	1,142
Deferred taxes, net	21,581	16,721
Changes in operating accounts:		
Premium receivables, net	(62,386)	23,781
Prepaid expenses and other current assets, net	(3,323)	(2,985)
Medical benefits payable	47,634	(95,690)
Unearned premiums	17,149	(90,353)
Accounts payables and other accrued expenses	(43,475)	(18,466)
Other payables to government partners	5,574	4,547
Amounts accrued related to investigation resolution	(50,469)	511
Income taxes, net	(8,012)	(14,401)
Other, net	(869)	(7,525)
Net cash used in operating activities	<u>(43,942)</u>	<u>(170,544)</u>
Cash from (used in) investing activities:		
Purchases of investments	(198,305)	(117)
Proceeds from sale and maturities of investments	85,043	12,322
Purchases of restricted investments	(4,012)	(289)
Proceeds from maturities of restricted investments	5,601	368
Additions to property, equipment and capitalized software, net	(8,715)	(4,235)
Net cash (used in) provided by investing activities	<u>(120,388)</u>	<u>8,049</u>
Cash from (used in) financing activities:		
Proceeds from option exercises and other	1,034	770
Purchase of treasury stock	(744)	(3,030)
Payments on capital leases	(396)	(58)
Funds held for the benefit of members	37,806	34,019
Net cash provided by financing activities	<u>37,700</u>	<u>31,701</u>
Cash and cash equivalents:		
Decrease during period	(126,630)	(130,794)
Balance at beginning of year	1,359,548	1,158,131
Balance at end of period	<u>\$ 1,232,918</u>	<u>\$ 1,027,337</u>
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for taxes	<u>\$ 446</u>	<u>\$ 8,161</u>
Cash paid for interest	<u>\$ 74</u>	<u>\$ 7</u>
Equipment acquired through capital leases	<u>\$ —</u>	<u>\$ 8,411</u>

See notes to unaudited condensed consolidated financial statements.

WELLCARE HEALTH PLANS, INC.
NOTES TO CONDENSED CONSOLIDATED FINANCIAL STATEMENTS
(Unaudited, in thousands, except member, per share and share data)

1. ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

WellCare Health Plans, Inc., a Delaware corporation (the "Company," "we," "us," or "our"), provides managed care services exclusively to government-sponsored health care programs, serving approximately 2,383,000 members as of March 31, 2011. Through our licensed subsidiaries, as of March 31, 2011, we operate our Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Missouri, New York and Ohio, and our Medicare Advantage ("MA") coordinated care plans ("CCPs") in Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas. We also operate a stand-alone Medicare prescription drug plan ("PDP") in 49 states and the District of Columbia. We exited the Medicare private fee-for-service ("PFFS") program on December 31, 2009.

Basis of Presentation & Use of Estimates

The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2010 included in our Annual Report on Form 10-K ("2010 Form 10-K"), filed with the United States Securities and Exchange Commission (the "SEC") in February 2011. In the opinion of management, the interim financial statements reflect all normal recurring adjustments that we consider necessary for the fair presentation of our financial position, results of operations and cash flows for the interim periods presented. The interim financial statements included herein have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, certain information and footnote disclosures normally included in financial statements prepared in accordance with GAAP have been condensed or omitted. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events and accordingly, actual results may differ from those estimates. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period. Certain items in our financial statements have been reclassified from their prior year classifications to conform to our current year presentation. We have evaluated all material events subsequent to the date of these financial statements.

Significant Accounting Policies

Net Income per Share

We compute basic net income per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted net income per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding stock options, restricted shares and restricted stock units using the treasury stock method. The following table presents the calculation of net income per common share — basic and diluted:

	Three Months Ended March 31,	
	2011	2010
Numerator:		
Net income	\$ 21,330	\$ 6,418
Denominator:		
Weighted-average common shares outstanding — basic	42,621,908	42,193,662
Dilutive effect of:		
Unvested restricted stock, restricted stock units and performance stock units	280,073	360,043
Stock options	138,548	153,536
Weighted-average common shares outstanding — diluted	43,040,529	42,707,241
Net income per common share:		
Basic	\$ 0.50	\$ 0.15
Diluted	\$ 0.50	\$ 0.15

For the three months ended March 31, 2011 and 2010, certain options to purchase common stock were not included in the calculation of diluted net income per common share because their exercise prices were greater than the average market price of our common stock for the period and, therefore, the effect would be anti-dilutive. For the three months ended March 31, 2011, 142,153 restricted equity awards and 294,626 options with exercise prices ranging from \$28.27 to \$90.52 were excluded from diluted weighted-average common shares outstanding. For the three months ended March 31, 2010, approximately 119,356 restricted equity awards as well as 1,165,606 options with exercise prices ranging from \$24.17 to \$91.64 per share were excluded from diluted weighted-average common shares outstanding.

Premium Revenue Recognition

We receive premiums from state and federal agencies for the members that are assigned to, or have selected, us to provide health care services under Medicaid and Medicare. The premiums we receive for each member vary according to the specific government program and are generally determined at the beginning of the contract period. These premiums are subject to adjustment throughout the term of the contract by CMS and the states, although such adjustments are typically made at the commencement of each new contract renewal period.

Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. Our Medicare Advantage and PDP contracts with the Centers for Medicare & Medicaid Services (“CMS”) generally have terms of one year.

In most cases we receive premiums in advance of providing services, and we recognize premium revenues in the period in which we are obligated to provide services to our members. We are paid generally in the month in which we provide services. Premiums are billed monthly for coverage in the following month and are recognized as revenue in the month for which insurance coverage is provided. Premiums collected in advance of the period in which we are obligated to provide services to our members are deferred and reported as Unearned premiums in the accompanying Condensed Consolidated Balance Sheets and amounts that have not been received by the end of the period remain on the Condensed Consolidated Balance Sheets classified as Premium receivables, net.

We routinely monitor the collectability of specific accounts, the aging of receivables and historical retroactivity trends, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. We estimate, on an ongoing basis, the amount of member billings that may not be fully collectible or that will be returned based on historical collection experience, retroactive membership adjustments, anticipated or actual, compliance with requirements for certain contracts to expend a minimum percentage of premiums on eligible medical expense, and other factors. An allowance is established for the estimated amount that may not be collectible and a liability is established for premium expected to be returned. The allowance has not been significant to premium revenue.

Premium payments that we receive are based upon eligibility lists produced by the government. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, the states or CMS require us to reimburse them for premiums that we received based on an eligibility list that a state, CMS or we later discover, through our audits or otherwise, contains individuals who were not eligible for any government-sponsored program or belong to a different plan other than ours. The verification and subsequent membership changes may result in additional amounts due to us or we may owe premiums back to the government. The amounts receivable or payable identified by us through reconciliation and verification of agency eligibility lists relate to current and prior periods. The amounts receivable from government agencies for reconciling items were \$11,925 and \$270 at March 31, 2011 and December 31, 2010, respectively, and are included in Premium receivables, net, on our Condensed Consolidated Balance Sheets. The amounts due to government agencies for reconciling items were \$48,645 and \$63,289 at March 31, 2011 and December 31, 2010, respectively, and are included in Other accrued expenses and liabilities on our Condensed Consolidated Balance Sheets. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates had a minimal impact on premiums recorded during the periods presented. Our government contracts establish monthly rates per member that may be adjusted based on member demographics such as age, working status or medical history.

Risk-Adjusted Premiums

CMS employs a risk-adjustment model to determine the premium amount it pays for each member. This model apportions premiums paid to all MA plans according to the health status of each beneficiary enrolled. As a result, our CMS monthly premium payments per member may change materially, either favorably or unfavorably. The CMS risk-adjustment model pays more for Medicare members with predictably higher costs. Diagnosis data from inpatient and ambulatory treatment settings are used to calculate the risk-adjusted premiums we receive. We collect claims and encounter data and submit the necessary diagnosis data to CMS within prescribed deadlines. After reviewing the respective submissions, CMS establishes the premium payments to MA plans generally at the beginning of the calendar year, and then adjusts premium levels on two separate occasions on a retroactive basis. The first retroactive adjustment for a given fiscal year generally occurs during the third quarter of such fiscal year. This initial settlement (the "Initial CMS Settlement") represents the updating of risk scores for the current year based on the severity of claims incurred in the prior fiscal year. CMS then issues a final retroactive risk-adjusted premium settlement for that fiscal year in the following year (the "Final CMS Settlement"). We reassess the estimates of the Initial CMS Settlement and the Final CMS Settlement each reporting period and any resulting adjustments are made to MA premium revenue.

We develop our estimates for risk-adjusted premiums utilizing historical experience and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. Our models are populated with available risk score data on our members. Risk premium adjustments are based on member risk score data from the previous year. Risk score data for members who entered our plans during the current plan year, however, is not available for use in our models; therefore, we make assumptions regarding the risk scores of this subset of our member population. All such estimated amounts are periodically updated as additional diagnosis code information is reported to CMS and adjusted to actual amounts when the ultimate adjustment settlements are either received from CMS or we receive notification from CMS of such settlement amounts.

As a result of the variability of factors that determine such estimates, including plan risk scores, the actual amount of CMS retroactive payment could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of MA premium revenues related thereto, could have a material adverse effect on our results of operations, financial position and cash flows. Historically, we have not experienced significant differences between the amounts that we have recorded and the revenues that we ultimately receive. The data provided to CMS to determine the risk score is subject to audit by CMS even after the annual settlements occur. These audits may result in the refund of premiums to CMS previously received by us. While our experience to date has not resulted in a material refund, this refund could be significant in the future, which would reduce our premium revenue in the year that CMS determines repayment is required.

Medical Benefits Payable and Expense

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of incurred but not reported (“IBNR”) medical benefits. Medical benefits payable has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses, which are recorded in Selling, general, and administrative expense. Medical benefits payable on our Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement and estimates for IBNR claims. The following table provides a reconciliation of the total medical benefits payable balances as of March 31, 2011 and December 31, 2010:

	March 31, 2011	% of Total	December 31, 2010	% of Total
	(in millions)		(in millions)	
Claims adjudicated, but not yet paid	\$ 78,067	10%	\$ 50,879	7%
IBNR	712,557	90%	692,111	93%
Total medical benefits payable	\$ 790,624		\$ 742,990	

The medical benefits payable estimate has been, and continues to be, our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management’s best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members’ needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon per-member per-month (“PMPM”) claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all of which influence the resulting medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known and have the effect of increasing or decreasing the reported medical benefits expense in such periods.

Medical benefits expense for the three months ended March 31, 2011, was impacted by approximately \$51,038 of net favorable development related to prior years. For the three months ended March 31, 2010, medical benefits expense was impacted by approximately \$4,592 of net favorable development related to prior years. The net favorable prior year development in 2011 results primarily from the difference between actual medical utilization compared to original assumptions and prior year claims estimates being settled for amounts that are different than originally anticipated. The net amount of prior period developments in the 2010 was primarily attributable to the reduction of the provision for moderately adverse conditions resulting from the exit of the PFFS product on December 31, 2009. The factors impacting the changes in the determination of medical benefits payable discussed above were not discernable in advance. The impact became clearer over time as claim payments were processed and more complete claims information was obtained.

Medicaid Premium Taxes

Certain state agencies place an assessment or tax on Medicaid premiums, which is included in the premium rates established in the Medicaid contracts with each state agency and recorded as a component of revenue, as well as administrative expense, when incurred.

In October 2009, the State of Georgia stopped assessing taxes on Medicaid premiums remitted to us, which resulted in an equal reduction to Premium revenues and Medicaid premium taxes. However, effective July 1, 2010, the State of Georgia began assessing premium taxes again on Medicaid premiums. Therefore, from July 1, 2010 through March 31, 2011, we were assessed and remitted taxes on premiums in Georgia, Hawaii, Missouri, New York and Ohio. Medicaid premium taxes incurred were \$18,864 and \$9,744 for the three months ended March 31, 2011 and 2010, respectively.

Income Taxes

On a quarterly basis, our tax liability is estimated based on enacted tax rates, estimates of book-to-tax differences in income, and projections of income that will be earned in each taxing jurisdiction. Deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax basis. Deferred tax assets and liabilities are measured using tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. A valuation allowance is recognized when, based on available evidence, it is more likely than not that the deferred tax assets may not be realized. After tax returns for the applicable year are filed, the estimated tax liability is adjusted to the actual liability per the filed state and Federal tax returns. Historically, we have not experienced significant differences between our estimates of tax liability and our actual tax liability.

We sometimes face challenges from state and Federal tax authorities regarding the amount of taxes due. Positions taken on the tax returns are evaluated and benefits are recognized only if it is more likely than not that the position will be sustained on audit. Based on our evaluation of tax positions, we believe that potential tax exposures have been recorded appropriately. In addition, we are periodically audited by state and Federal taxing authorities and these audits can result in proposed assessments. We believe that our tax positions comply with applicable tax law and, as such, will vigorously defend our positions on audit. We believe that we have adequately provided for any reasonable foreseeable outcome related to these matters. Although the ultimate resolution of these audits may require additional tax payments, it is not anticipated that any additional tax payments would have a material impact to our results of operations or cash flows.

Goodwill and Intangible Assets

We review goodwill and intangible assets for impairment at least annually, or more frequently if events or changes in our business climate occur that may potentially affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting process, and complete our impairment testing during the third quarter of each year. As of our last testing date in 2010, we assessed the book value of goodwill and other intangible assets and determined that the fair value of these assets exceeds its carrying value and noted no indications that would require additional impairment testing as of March 31, 2011.

Recently Issued Accounting Standards

In December 2010, the Financial Accounting Standards Board (the "FASB") issued new guidance on business combinations to clarify that if a public entity presents comparative financial statements, the entity should disclose revenue and earnings of the combined entity as though the business combination that occurred during the current year had occurred as of the beginning of the prior annual reporting period and to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. This new guidance is effective prospectively for business combinations for which the acquisition date is on, or after, the beginning of the first annual reporting period beginning on or after December 15, 2010. Any future business combinations will be accounted for under this guidance. The adoption of this topic is not expected to have a material effect on our consolidated financial statements.

In December 2010, the FASB issued accounting guidance clarifying the requirement to test for goodwill impairment when the carrying amount of a reporting unit exceeds its fair value. Under this guidance, if the carrying amount of a reporting unit is zero or negative, an entity must assess whether any adverse qualitative factors exist that would indicate that goodwill impairment, more likely than not, exists. If it is determined that goodwill impairment would, more likely than not, be triggered, additional testing to determine whether goodwill has actually been impaired would be required and the amount of such impairment, if any, would accordingly be determined. This guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The adoption of this topic is not expected to have a material effect on our consolidated financial statements.

We have reviewed all other recently issued accounting standards in order to determine their effects, if any, on our results of operations, financial position and cash flows. Based on that review, none of these pronouncements are expected to have a significant affect on our financial statements.

2. SEGMENT REPORTING

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Accordingly, we have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited on December 31, 2009 is reported within the MA segment.

Medicaid

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of Temporary Assistance for Needy Families (“TANF”), Supplemental Security Income (“SSI”), Aged Blind and Disabled (“ABD”) and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIPs”) and Family Health Plus (“FHP”) for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits.

Medicare Advantage

Our MA segment consists of MA plans, which, following our exit from the PFFS product on December 31, 2009, is comprised of CCPs. MA is Medicare’s managed care alternative to original Medicare fee-for-service (“Original Medicare”), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

As part of our MA segment, we continue to administer our expired PFFS plans, which include processing claims payments as well as providing member and provider services, for health care services provided prior to our exit from the PFFS program on December 31, 2009. As of March 31, 2011, the remaining medical benefits payable related to the PFFS program is not material relative to the total Medical benefits payable.

Prescription Drug Plans

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries in our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

We allocate goodwill, but no other assets or liabilities, or investment and other income, or any other expenses to our reportable operating segments. A summary of financial information for our reportable operating segments as well as a reconciliation to Income before income taxes is presented in the table below.

	Three Months Ended March 31,	
	2011	2010
Premium revenue:		
Medicaid	\$ 855,843	\$ 809,033
Medicare Advantage	354,645	351,083
PDP	261,928	193,342
Total premium revenue	1,472,416	1,353,458
Medical benefits expense:		
Medicaid	703,710	701,779
Medicare Advantage	277,029	276,175
PDP	264,301	188,018
Total medical benefits expense	1,245,040	1,165,972
Gross margin:		
Medicaid	152,133	107,254
Medicare Advantage	77,616	74,908
PDP	(2,373)	5,324
Total gross margin	227,376	187,486
Investment and other income	2,326	2,495
Other expenses	(194,659)	(179,103)
Income before income taxes	\$ 35,043	\$ 10,878

3. EQUITY-BASED COMPENSATION

Equity-based compensation expense is calculated based on awards ultimately expected to vest. The compensation expense recorded related to our equity-based compensation awards, which correspondingly also increased Paid-in capital, for the three months ended March 31, 2011 and 2010 was \$4,849 and \$1,142, respectively.

Under the 2004 Equity Incentive Plan, we granted a performance share award to a former executive, of which the vesting and the amount of shares to be awarded were contingent upon achievement of an earnings per share target over three- and five-year performance periods. The earnings per share target for the first performance period was achieved. However, in accordance with the separation agreement between the former executive and us, issuance of those shares was subject to certain conditions that we have determined have not been, and are unlikely to be, met. Accordingly, the previously recorded expense of \$4,683 was reversed against equity-based compensation during the first quarter of 2010, which is included in Selling, general and administrative expense for the three months ended March 31, 2010.

A summary of our restricted stock, restricted stock unit (“RSU”) and stock option activity for the three months ended March 31, 2011 is presented in the table below.

	Restricted Stock and RSU	Weighted Average Grant-Date Fair Value	Options	Weighted Average Exercise Price
Outstanding as of January 1, 2011	718,009	\$ 28.69	1,008,757	\$ 30.02
Granted	118,131	39.68	-	-
Exercised	-	-	(46,356)	22.62
Vested	(75,386)	32.25	-	-
Forfeited and expired	(16,019)	30.51	(48,437)	56.39
Outstanding at March 31, 2011	<u>744,735</u>	30.04	<u>913,964</u>	28.99
Exercisable at March 31, 2011			<u>721,880</u>	28.86
Vested and expected to vest as of March 31, 2011			<u>855,346</u>	28.94

As of March 31, 2011, there was \$22,920 of unrecognized compensation cost related to non-vested equity-based compensation arrangements that is expected to be recognized over a weighted-average period of 1.5 years.

Performance Stock Units

The Compensation Committee awards performance stock unit awards (“PSUs”) under our long-term incentive program (“LTI Program”). PSUs are scheduled to cliff-vest three years from the grant date and are subject to adjustment in the target range of 0% to 150%, based on the achievement of certain financial and quality-based performance goals set by the Compensation Committee over the performance period and conditioned on the employee’s continued service through the vest date. The actual number of PSUs that vest will be determined by the Compensation Committee at its sole discretion. As a result of the subjective nature of the PSUs, we have determined that, for accounting purposes, a mutual understanding of the key terms and conditions does not exist; and accordingly, these awards do not have an accounting grant date. The PSUs ultimately expected to vest will be recognized as expense over the requisite service period based on the estimated progress made towards the achievement of the pre-determined performance measures, as well as subsequent changes in the market price of our common stock since the awards do not have an accounting grant date. The compensation expense related to our PSUs granted assume that targets will be met and was \$755 for the three months ended March 31, 2011. As of March 31, 2011, there was \$9,351 of unrecognized compensation cost related to non-vested PSUs that is expected to be recognized over a weighted-average period of 2.6 years.

A summary of our PSU activity for the three months ended March 31, 2011 is presented in the table below.

	PSUs	Weighted Average Grant-Date Fair Value
Outstanding as of January 1, 2011	144,801	\$ 29.58
Granted	203,309	39.75
Exercised	-	-
Vested	-	-
Forfeited and expired	(5,604)	30.97
Outstanding at March 31, 2011	<u>342,506</u>	35.59

4. FAIR VALUE MEASUREMENTS

Fair value measurements apply to all financial assets and financial liabilities that are being measured and reported on a fair value basis. Accounting standards require that fair value measurements be classified and disclosed in one of the following three categories: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Our Condensed Consolidated Balance Sheets include the following financial instruments: cash and cash equivalents, receivables, investments, accounts payable and amounts accrued related to the investigation resolution discussed in Note 6 of these Condensed Consolidated Financial Statements. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization.

Our Long-term investments include \$46,150 of municipal note investments with an auction reset feature (“auction rate securities”), at par value, as of both March 31, 2011 and December 31, 2010. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven, 14, 28 or 35 days. Auctions for these auction rate securities continued to fail during the three months ended March 31, 2011. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. However, when there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. We continue to receive interest payments on the auction rate securities we hold. Based on our analysis of anticipated cash flows, we have determined that it is more likely than not that we will be able to hold these securities until maturity or until market stability is restored. Additionally, there are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, as these securities are believed to be in an inactive market, we have estimated the fair value of these securities using a discounted cash flow model and update these estimates on a quarterly basis. Our analysis considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows and the capital adequacy and expected cash flows of the subsidiaries that hold the securities. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

Our assets measured at fair value on a recurring basis subject to the disclosure requirements of fair value accounting guidance were as follows:

Description	Fair Value Measurements at March 31, 2011:			
	March 31, 2011	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Available-for-sale securities				
Municipal variable rate bonds	\$ 89,870	\$ 89,870	\$ -	\$ -
Variable rate bond fund	50,000	50,000	-	-
Auction rate securities	42,703	-	-	42,703
Money market funds	41,720	41,720	-	-
Corporate debt and other securities	37,227	37,227	-	-
Certificates of deposit	21,128	21,128	-	-
U.S. Government securities	2,963	2,963	-	-
Total investments	\$ 285,611	\$ 242,908	\$ -	\$ 42,703
Restricted investments:				
Available-for-sale securities				
Money market funds	\$ 54,677	\$ 54,677	\$ -	\$ -
Cash and cash equivalents	27,577	27,577	-	-
U.S. Government securities	22,504	22,504	-	-
Certificates of deposit	1,054	1,054	-	-
Total restricted investments	\$ 105,812	\$ 105,812	\$ -	\$ -
Amounts accrued related to investigation resolution(1)	\$ 287,073	\$ -	\$ 287,073	\$ -

Description	Fair Value Measurements at December 31, 2010:			
	December 31, 2010	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Available-for-sale securities				
Certificates of deposit	\$ 52,309	\$ 52,309	\$ -	\$ -
Auction rate securities	42,245	-	-	42,245
Municipal variable rate bonds	29,120	29,120	-	-
Corporate debt and other securities	23,100	23,100	-	-
Variable rate bond fund	24,945	24,945	-	-
Total investments	\$ 171,719	\$ 129,474	\$ -	\$ 42,245
Restricted investments:				
Available-for-sale securities				
Money market funds	\$ 54,908	\$ 54,908	\$ -	\$ -
Cash and cash equivalents	27,581	27,581	-	-
U.S. Government securities	24,027	24,027	-	-
Certificates of deposit	1,053	1,053	-	-
Total restricted investments	\$ 107,569	\$ 107,569	\$ -	\$ -
Amounts accrued related to investigation resolution(1)	\$ 337,542	\$ -	\$ 337,542	\$ -

(1) These amounts are included in the short- and long-term portions of amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of March 31, 2011 and December 31, 2010, respectively.

The following tables present our auction rate securities measured at fair value on a recurring basis using significant unobservable inputs (i.e., Level 3 data) as of March 31, 2011 and 2010, respectively.

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)	
	2011	2010
Beginning balance at January 1	\$ 42,245	\$ 51,710
Realized gains (losses) in earnings (or changes in net assets)	-	-
Unrealized gains (losses) in other comprehensive income(a)	458	230
Purchases, sales and redemptions(b)	-	(6,300)
Transfers in and/or out of Level 3	-	-
Ending balance at March 31	\$ 42,703	\$ 45,640

(a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$458 and \$230 to Accumulated other comprehensive loss during the three months ended March 31, 2011 and 2010, respectively. The increase in unrealized gain was driven by the continued stabilization and improvement within the municipal bond market.

(b) A \$6,300 auction rate security tranche was redeemed by the issuer at par in March 2010. Accordingly, we recorded an adjustment to the fair market valuation of the issuer's auction rate securities during the first quarter of 2010.

5. INCOME TAXES

As discussed in Note 6, we made a \$52,500 payment in March 2011 that was required in connection with an agreement to resolve certain class action complaints. Settlement payments are generally deductible when paid; therefore the payment had the effect of increasing Income taxes receivable and decreasing the current portion of Deferred income tax assets as of March 31, 2011. There was no impact to the effective income tax rate since the settlement was included in the determination of taxable income in prior periods. There has been no material change in the estimated non-deductible amounts associated with amounts accrued for investigation resolution during the three month period ended March 31, 2011.

Our effective income tax rate was 39.1% for the three months ended March 31, 2011 compared to 41.0% for the same three month period in the prior year. The decrease in the effective tax rate was primarily due to the lower non-deductible executive compensation costs in 2011 and higher Income before income taxes. The effective tax rate for the three months ended March 31, 2011 and 2010 was higher when compared to the statutory rate and was primarily attributable to certain non-deductible executive compensation costs.

6. COMMITMENTS AND CONTINGENCIES

Government Investigations

Deferred Prosecution Agreement

As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the "DPA") with the United States Attorney's Office for the Middle District of Florida (the "USAO") and the Florida Attorney General's Office, resolving previously disclosed investigations by those offices.

Under the one-count criminal information (the "Information") filed with the United States District Court for the Middle District of Florida (the "Federal Court") by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Federal Court that the prosecution be deferred for the duration of the DPA. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The term of the DPA is thirty-six months, but such term may be reduced by the USAO to twenty-four months upon consideration of certain factors set forth in the DPA, including our continued remedial actions and compliance with all federal and state health care laws and regulations.

In accordance with the DPA, the USAO has filed, with the Federal Court, a statement of facts relating to this matter. As a part of the DPA, we retained an independent monitor (the "Monitor") for a period of 18 months from August 19, 2009 to February 18, 2011. The Monitor was selected by the USAO after consultation with us and was retained at our expense. In addition, we agreed to continue undertaking remedial measures to ensure full compliance with all federal and state health care laws. Among other things, the Monitor reviewed and evaluated our compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also reviewed, evaluated and, as necessary, made written recommendations concerning certain of our policies and procedures.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of \$80,000.

Civil Division of the United States Department of Justice

In October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of its pending civil inquiry, it was investigating four *qui tam* complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases was partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the *qui tam* complaints. In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided with a copy of the *qui tam* complaints, in response to our request, which otherwise remained under seal as required by 31 U.S.C. section 3730(b)(3).

As previously disclosed, we also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries (the "Leon County *qui tam* suit"). As part of our discussions to resolve pending *qui tam* and related civil investigations discussed above, we were informed that the Leon County *qui tam* suit was filed by one of the federal *qui tam* relators and contains allegations similar to those alleged in one of the recently unsealed *qui tam* complaints.

On June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the *qui tam* matters, and (ii) we announced that we reached a preliminary agreement with the Civil Division, the Civil Division of the USAO, and the Civil Division of the United States Attorney's Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010, the Federal Court lifted the seal in the three *qui tam* complaints in which the government had intervened (the "Florida Federal *qui tam* Actions"). Those complaints are now publicly available.

On April 26, 2011, we entered into certain settlement agreements, described below, which will resolve the pending inquiries of the Civil Division, the USAO and the United States Attorney's Office for the District of Connecticut (the "USAO Connecticut"). These settlement agreements are related to the Florida Federal *qui tam* Actions as well as another federal *qui tam* action that had been filed in the District of Connecticut (the "Connecticut Federal *qui tam* Action") and the Leon County *qui tam* Action. In connection with the execution of these settlement agreements, the Connecticut Federal *qui tam* Action and the Leon County *qui tam* Action were recently unsealed on April 29, 2011, and April 28, 2011, respectively.

The settlement agreements are with (a) the United States, with signatories from the Civil Division, the Office of Inspector General of the Department of Health and Human Services ("OIG-HHS") and the Civil Divisions of the USAO and the USAO Connecticut (the "Federal Settlement Agreement") and (b) the following states (collectively, the "Settling States"): Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio (collectively, the "State Settlement Agreements"). The material terms of the Federal Settlement Agreement and the State Settlement Agreements are, collectively, substantively the same as the terms of the previously disclosed preliminary settlement with the Civil Division, the USAO and the USAO Connecticut. We have agreed, among other things, to pay the Civil Division a total of \$137,500 (the "Settlement Amount"), which is to be paid in installments over a period of up to 36 months after the date of the Federal Settlement Agreement (the "Payment Period") plus interest at the rate of 3.125% per year. The settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that the Company is acquired or otherwise experiences a change in control during the Payment Period. In addition, the settlement provides for a contingent payment of an additional \$35,000 in the event that the Company is acquired or otherwise experiences a change in control within three years of the execution of the Federal Settlement Agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Federal Settlement Agreement.

In exchange for the payment of the Settlement Amount, the United States and the Settling States agree to release us from any civil or administrative monetary claim under the False Claims Act and certain other legal theories for certain conduct that was at issue in their inquiries and the *qui tam* complaints. Likewise, in consideration of the obligations in the Federal Settlement Agreement and the Corporate Integrity Agreement (as described below under *United States Department of Health and Human Services*), OIG-HHS agrees to release and refrain from instituting, directing or maintaining any administrative action seeking to exclude us from Medicare, Medicaid and other federal health care programs.

The Federal Settlement Agreement has not been executed by one of the relators. Under its terms, this failure to timely execute is deemed to be an objection to the Federal Settlement Agreement. In the case of an objection, the Federal Court is required to conduct a hearing (a "Fairness Hearing") to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. The Federal Settlement Agreement and the State Settlement Agreements will not be effective until the earlier of (a) the execution of the Federal Settlement Agreement by the objecting relator or (b) entry by the Federal Court of a final order determining that the settlement is fair, adequate and reasonable under all the circumstances.

We can make no assurances that the objecting relator will execute the Federal Settlement Agreement or that the Federal Court will approve the settlement at a Fairness Hearing and the actual outcome of these matters may differ materially from the terms of the settlement.

We have discounted the total liability of \$137,500 for the resolution of these matters and accrued this amount at its estimated fair value, which amounted to approximately \$136,259 at March 31, 2011. In addition to the Settlement Amount, another \$5,000 for estimated *qui tam* relators attorneys' fees to be paid was accrued in 2010. Approximately \$31,848 and \$104,411 has been included in the current and long-term portions, respectively, of Amounts accrued related to the investigation resolution in our Condensed Consolidated Balance Sheet as of March 31, 2011. There can be no assurance that the Federal Settlement Agreement and the State Settlement Agreements will become effective and the actual outcome of these matters may differ materially from the terms of these settlements as described above.

United States Department of Health and Human Services

On April 26, 2011, the Company entered into a Corporate Integrity Agreement (the “Corporate Integrity Agreement”) with OIG-HHS. The Corporate Integrity Agreement has a term of five years and concludes the previously disclosed matters relating to the Company under review by OIG-HHS.

The Corporate Integrity Agreement formalizes various aspects of the Company’s ethics and compliance program and contains other requirements designed to help ensure the Company’s ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, the Company’s reporting practices and bid submissions to federal health care programs.

Class Action Complaints

Putative class action complaints were filed in October 2007 and in November 2007. These putative class actions, entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, respectively, were filed in Federal Court against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of ours. The Eastwood Enterprises complaint alleged that the defendants materially misstated our reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended (“Exchange Act”). The Hutton complaint alleged that various public statements supposedly issued by the defendants were materially misleading because they failed to disclose that we were purportedly operating our business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserted claims under the Exchange Act. Both complaints sought, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued in March 2008, the Federal Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago (the “Public Pension Fund Group”) as Lead Plaintiffs. In October 2008, an amended consolidated complaint was filed in this class action asserting claims against us, Messrs. Farha and Behrens, and adding Thaddeus Bereday, our former senior vice president and general counsel, as a defendant.

In January 2009, we and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to our compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Federal Court denied the motion in September 2009 and we and the other defendants filed our answer to the amended consolidated complaint in November 2009. In April 2010, the Lead Plaintiffs filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. Discovery was stayed through March 17, 2011.

In August 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve these matters. In December 2010, the terms of the settlement were documented in a formal settlement agreement (the “Stipulation Agreement”) that was subject to approval by the Federal Court following notice to all class members. On February 9, 2011, the Federal Court entered an order preliminarily approving the settlement and scheduled the final settlement hearing for May 4, 2011.

On May 4, 2011, the Federal Court entered an order (the “Approval Order”) approving the Stipulation Agreement. As required by the Stipulation Agreement, in March 2011 the Company paid \$52,500 into an escrow account for the benefit of the class. The Stipulation Agreement also provides, among other things, that the Company will make an additional cash payment to the class of \$35,000 by July 31, 2011 (the “July 2011 Payment”). It also requires, among other things, that the Company issue to the class tradable unsecured subordinated notes having an aggregate face value of \$112,500, with a fixed coupon of 6% and a maturity date of December 31, 2016. Additionally, the Company will be required to pay to the class an additional \$25,000 if the Company experiences a change in control at a share price of \$30 or more within three years of the date of the Stipulation Agreement.

With respect to the July 2011 Payment and as required by the Stipulation Agreement, by May 9, 2011, the Company is required to deliver to the escrow agent for the class a non-negotiable promissory note in the principal amount of \$35,000 (the "Note"). The Note is due and payable in full on July 31, 2011. The unpaid principal amount of the Note will accelerate and become immediately due and payable in the event of the Company's insolvency, a general assignment for the benefit of creditors, or the commencement by or against the Company of any action seeking reorganization, liquidation, dissolution, or similar treatment of the Company's debts under any law relating to bankruptcy, relief of debtors or similar laws. The unpaid principal will also accelerate in the event the Company or any third party seeks the appointment of a receiver or other similar official for the Company or its assets which, in the case of involuntary proceedings, has not been withdrawn or dismissed within 60 days after the filing of such proceeding. If the Company fails to pay the Note in full by July 31, 2011, then interest on the unpaid balance shall accrue at the rate and pursuant to the method set forth in 28 USC §1961 until all sums due are paid. In the event the payment is accelerated as described in the previous paragraph, then such interest will begin to accrue upon such acceleration.

As a result of this settlement having been reached, our estimate for the remaining resolution amount of this matter is \$147,500. We have discounted the \$147,500 liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$145,814 at March 31, 2011. Approximately \$31,951 and \$113,863 have been included in the current and long-term portions, respectively, of Amounts accrued related to investigation resolution in our Condensed Consolidated Balance Sheet as of March 31, 2011.

Derivative Lawsuits

As previously disclosed, in connection with our government investigations, five putative stockholder derivative actions were filed between October and November 2007. Four of these actions were asserted against directors Kevin Hickey and Christian Michalik, our current directors who were directors prior to 2007, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, and former director and officer Todd Farha. These actions also named us as a nominal defendant. Two of these actions were filed in the Federal Court and two actions were filed in the Circuit Court for Hillsborough County, Florida (the "State Court"). The fifth action, filed in the Federal Court, asserts claims against directors Robert Graham, Kevin Hickey and Christian Michalik, our current directors who were directors at the time the action was filed, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, former director and officer Todd Farha, and former officers Paul Behrens and Thaddeus Bereday. A sixth derivative action was filed in January 2008 in the Federal Court and asserted claims against all of these defendants except Robert Graham. All six of these actions contended, among other things, that the defendants allegedly allowed or caused us to misrepresent our reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants' supposed breach of fiduciary duty, waste and unjust enrichment. In April 2009, upon the recommendation of the Nominating and Corporate Governance Committee of the Board, the Board formed a Special Litigation Committee, comprised of a newly-appointed independent director, to investigate the facts and circumstances underlying the claims asserted in the derivative cases and to take such action with respect to these claims as the Special Litigation Committee determines to be in our best interests. In November 2009, the Special Litigation Committee filed a report with the Federal Court determining, among other things, that we should pursue an action against three of our former officers. In December 2009, the Special Litigation Committee filed a motion to dismiss the claims against the director defendants and to realign us as a plaintiff for purposes of pursuing claims against former officers Messrs. Farha, Behrens and Bereday.

In March 2010, a Stipulation of Partial Settlement ("Stipulation I") was filed in the Federal Court. Under the terms of Stipulation I, the plaintiffs in the federal action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative stockholder derivative action also agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, we paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of \$1,688. In April 2010, the Federal Court entered an order preliminarily approving Stipulation I and directing us to provide notice to our stockholders. The Federal Court also approved Stipulation I and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in July 2010. The case is now styled *WellCare v. Farha, et al.* In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"), which is pending. In April 2011, the Federal Court stayed this action pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

In April 2010, a second Stipulation of Partial Settlement ("Stipulation II") was filed in the State Court. Under the terms of Stipulation II, the plaintiffs in the state action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we paid to plaintiffs' counsel in the state action attorneys' fees in the amount of \$563. The State Court approved Stipulation II and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in June 2010. In July 2010, Mr. Farha filed a notice of appeal in this matter, which remains pending. In April 2011, the State Court stayed this action pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties.

Risk Adjustment Data Validation Audits

CMS has performed and continues to perform Risk Adjustment Data Validation (“RADV”) audits of selected MA plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each MA member. Our Florida MA plan was selected by CMS for audit for the 2007 contract year and we anticipate that CMS will conduct additional audits of other plans and contract years on an ongoing basis. The CMS audit process selects a sample of 201 enrollees for medical record review from each contract selected. We have responded to CMS’s audit requests by retrieving and submitting all available medical records and provider attestations to substantiate CMS-sampled diagnosis codes. CMS will use this documentation to calculate a payment error rate for our Florida MA plan 2007 premiums. CMS has not indicated a schedule for processing or otherwise responding to our submissions.

CMS has indicated that payment adjustments resulting from its RADV audits will not be limited to risk scores for the specific beneficiaries for which errors are found, but will be extrapolated to the relevant plan population. In late December 2010, CMS issued a draft audit sampling and payment error calculation methodology that it proposes to use in conducting these audits. CMS invited public comment on the proposed audit methodology and announced in early February 2011 that it will revise its proposed approach based on the comments received. CMS has not given a specific timetable for issuing a final version of the audit sampling and payment error calculation methodology. Given that the RADV audit methodology is new and is subject to modification, there is substantial uncertainty as to how it will be applied to MA organizations like our Florida MA plan. At this time, we do not know whether CMS will require retroactive or subsequent payment adjustments to be made using an audit methodology that may not compare the coding of our providers to the coding of Original Medicare and other MA plan providers, or whether any of our other plans will be randomly selected or targeted for a similar audit by CMS. We are also unable to determine whether any conclusions that CMS may make, based on the audit of our plan and others, will cause us to change our revenue estimation process. Because of this lack of clarity from CMS, we are unable to estimate with any reasonable confidence a coding or payment error rate or predict the impact of extrapolating an applicable error rate to our Florida MA plan 2007 premiums and as a result, have not accrued a liability for the potential outcome. However, it is likely that a payment adjustment will occur as a result of these audits, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows, possibly in 2011 and beyond.

Other Lawsuits and Claims

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, including, without limitation, provider disputes regarding payment of claims and disputes relating to the performance of contractual obligations with state agencies, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse effect on our financial position, results of operations or cash flows.

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

Forward Looking Statements

This Quarterly Report on Form 10-Q for the quarterly period ended March 31, 2011 ("2011 Form 10-Q") may include "forward-looking statements" within the meaning of Section 21E of the Securities Act of 1934, as amended, including, in particular, estimates, projections, guidance or outlook. Generally the words "believe," "expect," "anticipate," "may," "intend," "estimate," "anticipate," "plan," "project," "should" and similar expressions identify forward-looking statements, which generally are not historical in nature. These statements may contain information about financial prospects, economic conditions and trends that involve risks and uncertainties. Please refer to Risk Factors in Part I, Item 1A of our Annual Report on Form 10-K for the year ended December 31, 2010 ("2010 Form 10-K") and in Part II, Item 1A of this 2011 Form 10-Q, for a discussion of certain risk factors which could materially affect our business, financial condition, cash flows, or results of operations. If any of those risks, or other risks not presently known to us or that we currently believe to not be significant, do materialize or develop into actual events, our business, financial condition, results of operations or prospects could be materially adversely affected. Given these risks and uncertainties, we can give no assurances that any results or events projected or contemplated by our forward-looking statements will in fact occur and we caution you not to place undue reliance on these statements. We caution you that we do not undertake any obligation to update forward-looking statements made by us.

Overview

Executive Summary

We provide managed care services exclusively to government-sponsored health care programs, serving approximately 2.4 million members nationwide in our Medicaid and Medicare business lines. We believe that our broad range of experience and exclusive government focus allows us to efficiently and effectively serve our members and providers, while managing our ongoing operations. Our strategic priorities for 2011 include improving health care quality and access for our members, ensuring a competitive cost position and delivering prudent and profitable growth. We continue to work closely with providers and government clients to further enhance health care delivery and improve the quality of, and enhance access to, government health care services for our members. Our cost management initiatives are concentrated on aligning our expense structure with our current revenue base through process improvement and other initiatives; focusing on ensuring a competitive cost position in terms of both administrative and medical expenses. We are also focused on programs that help governments provide quality care within their fiscal constraints and present us with long-term opportunities for prudent and profitable growth.

General Economic and Political Environment

New governors are in office in nearly all of our current Medicaid markets. These new administrations have been considering changes to current Medicaid programs in their respective states. These changes may include moving programs into managed care, such as the aged, blind and disabled ("ABD") populations; expanding existing programs to provide coverage to those who are currently uninsured; and reprocurement of existing managed care programs. State budget shortfalls in many states will be a significant consideration in any changes to existing Medicaid programs.

Premium Rates and Payments

The states in which we operate continue to experience fiscal challenges which have led to budget cuts and reductions in Medicaid premiums in certain states or rate increases that are below medical cost trends. In particular, we continue to experience pressure on rates in Florida and Georgia, two states from which we derive a substantial portion of our revenue.

Health Care Reform

In March 2010, the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively, the "2010 Acts") became law. The health reforms in the 2010 Acts present both challenges and opportunities for our Medicaid business. We anticipate that the reforms could significantly increase the number of citizens who are eligible to enroll in our Medicaid products. However, state budgets continue to be strained due to economic conditions and uncertain levels of federal financing for current populations. As a result, the effects of any potential future expansions are uncertain, making it difficult to determine whether the net impact of the 2010 Acts will be positive or negative for our Medicaid business.

Business and Financial Outlook

Business Trends

We received rate increases in most of our Medicaid markets during the third quarter of 2010. We received rate increases of approximately 2.5% to 3.0% in Florida effective September 1, 2010 and 1.5% to 2.0% in Georgia effective July 1, 2010. Hawaii program rate increases, which we believe have improved the stability of the program, also were effective July 1, 2010. New York program rate increases were also implemented during the third quarter of 2010 that were effective April 1, 2010.

In February, the Georgia Department of Community Health (“Georgia DCH”) notified us that it intends to amend our current Georgia Medicaid contract to extend it by one year to June 30, 2013. The amendment is also expected to include a renewal option allowing the contract term to be further extended, at the option of Georgia DCH, by one additional year to June 30, 2014.

Louisiana and Texas, states in which we have offered Medicare Advantage (“MA”) plans for several years, as well as Kentucky, have announced plans to expand Medicaid managed care programs that would be very complementary to our existing operations and infrastructure. Florida and Hawaii are also considering expansions of their Medicaid managed care programs.

As part of the 2010 Acts, MA payment benchmarks for 2011 were frozen at 2010 levels. This places increased importance on administrative cost improvements and effective medical cost initiatives.

Based on the outcome of our 2011 stand-alone prescription drug plan (“PDP”) bids, which resulted in our plans being below the benchmarks in 20 of the 34 Centers for Medicare & Medicaid Services (“CMS”) regions, up from 19 regions in 2010, we were eligible for auto-assignment of low income subsidy beneficiaries in those 20 regions for January 2011 enrollment. In addition, we maintained our auto-assigned members in eight other CMS regions where we bid within a de minimis range of the benchmark.

Some hospital contracts are directly tied to state Medicaid fee schedules, in which case reimbursement levels may be adjusted up or down, generally on a prospective basis, based on adjustments made by the state to the fee schedule. We have experienced, and may continue to experience, such adjustments. Unless such adjustments are mitigated by an increase in premiums, our profitability will be negatively impacted.

We anticipate that our withdrawal from the private fee-for-service (“PFFS”) product effective December 31, 2009 may provide approximately \$40.0 million to \$60.0 million of excess capital in the insurance companies that underwrote this line of business, which we may be able to distribute to our unregulated subsidiaries through dividends or the repayment of surplus notes. However, we currently believe we will not have the benefit of these distributions until late 2011 or possibly later, if at all. Any dividend or return of surplus capital of our applicable insurance subsidiaries, including the timing and amount of any dividend, would be subject to a variety of factors, which could materially change the aforementioned timing and amount. Those factors principally include the financial performance of other lines of business that operate in those insurance subsidiaries, approval from regulatory agencies and potential changes in regulatory capital requirements.

Strategic and Organizational Restructuring

In August 2010, we announced a strategic and organizational restructuring with the objective of ensuring administrative efficiency and a competitive cost structure. The restructuring included a workforce reduction and the elimination of a significant number of open positions resulting from streamlining and improving business processes and operations, including the centralization and consolidation of certain functions. We also allocated new resources and directed substantial investments to priority areas such as health care quality, compliance, information technology, and business development.

Assessment of opportunities to improve the efficiency and effectiveness of our administrative processes remains an important discipline for us. We continue to evaluate our operations in order to achieve our long-term target of an administrative expense ratio in the low 10% range. In addition, as part of our medical cost initiatives, we have implemented provider contracting, case and disease management and pharmacy initiatives. These medical cost initiatives contributed to the year-over-year reductions we achieved for our medical benefits ratios.

Financial Impact of Government Investigations and Litigation

For further discussion of government investigations and litigation including the associated financial impact, please refer to our *Selling, general and administrative expense* discussion under *Results of Operations* below and Part I – Note 6 – *Commitments and Contingencies*.

Basis of Presentation

Segments

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. We have three reportable operating segments within our two main business lines: Medicaid, MA and PDP. The residual financial impact from the PFFS product that we exited effective December 31, 2009 is reported within the MA segment.

Medicaid

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid plans include plans for beneficiaries of Temporary Assistance for Needy Families (“TANF”) programs, Supplemental Security Income (“SSI”) programs, Aged Blind and Disabled (“ABD”) programs and state-based programs that are not part of the Medicaid program, such as Children’s Health Insurance Programs (“CHIP”) and Family Health Plus (“FHP”) programs for qualifying families that are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

The Medicaid programs and services we offer to our members vary by state and county and are designed to serve our various constituencies effectively in the communities we serve. Although our Medicaid contracts determine to a large extent the type and scope of health care services that we arrange for our members, in certain markets we customize our benefits in ways that we believe make our products more attractive. Our Medicaid plans provide our members with access to a broad spectrum of medical benefits from many facets of primary care and preventive programs to full hospitalization and tertiary care.

In general, members are required to use our network, except in cases of emergencies, transition of care or when network providers are unavailable to meet their medical needs, and generally must receive a referral from their primary care provider (“PCP”) in order to receive health care from specialists, such as surgeons or neurologists. Members do not pay any premiums, deductibles or co-payments for most of our Medicaid plans.

MA

Medicare is a federal program that provides eligible persons age 65 and over, and some disabled persons, a variety of hospital, medical and prescription drug benefits. Our MA segment consists of MA plans which, following the exit of our PFFS product on December 31, 2009, is comprised mainly of coordinated-care plans (“CCPs”). MA is Medicare’s managed care alternative original Medicare fee-for-service (“Original Medicare”), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations (“HMOs”) and generally require members to seek health care services and select a PCP from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

We cover a wide spectrum of medical services through our MA plans, including in some cases, additional benefits not covered by Original Medicare, such as vision, dental and hearing services. Through these enhanced benefits, the out-of-pocket expenses incurred by our members are reduced, which allows our members to better manage their health care costs.

Most of our MA plans require members to pay a co-payment, which varies depending on the services and level of benefits provided. Typically, members of our MA CCPs are required to use our network of providers except in cases such as emergencies, transition of care or when specialty providers are unavailable to meet a member's medical needs. MA CCP members may see out-of-network specialists if they receive referrals from their PCPs and may pay incremental cost-sharing. In most of our markets, we also offer special needs plans to individuals who are dually eligible for Medicare and Medicaid. These plans, commonly called D-SNPs, are designed to provide specialized care and support for beneficiaries who are eligible for both Medicare and Medicaid. We believe that our D-SNPs are attractive to these beneficiaries due to the enhanced benefit offerings and clinical support programs.

PDP

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries through our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Medicare Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

Depending on medical coverage type, a beneficiary has various options for accessing drug coverage. Beneficiaries enrolled in Original Medicare can either join a stand-alone PDP or forego Part D drug coverage. Beneficiaries enrolled in MA CCPs can join a plan with Part D coverage, select a separate Part D plan, or forego Part D coverage.

Segment Financial Performance Measures

We use three measures to assess the performance of our reportable operating segments: premium revenue, medical benefits ratio ("MBR") and gross margin. MBR measures the ratio of our medical benefits expense to premiums earned, after excluding Medicaid premium taxes. Gross margin is defined as premium revenue less medical benefits expense.

Our profitability depends in large part on our ability to, among other things, effectively price our health and prescription drug plans; predict and effectively manage medical benefits expense relative to the primarily fixed premiums we receive, including reserve estimates and pharmacy costs; contract with health care providers; and attract and retain members. In addition, factors such as regulation, competition and general economic conditions affect our operations and profitability. The effect of escalating health care costs, as well as any changes in our ability to negotiate competitive rates with our providers may impose further risks to our profitability and may have a material impact on our business, financial condition and results of operations.

Premium Revenue

We receive premiums from state and federal agencies for the members that are assigned to, or have selected, us to provide health care services under Medicaid and Medicare. The primarily fixed premiums we receive for each member vary according to the specific government program. The premiums we receive under each of our government benefit plans are generally determined at the beginning of the contract period. However, these premiums are subject to adjustment throughout the term of the contract. Our Medicare premiums and certain of our Medicaid premiums are subject to subsequent modification based on the health status of each member. A portion of our premiums for certain Medicaid programs is also subject to refund if our medical costs for those programs are less than a specified minimum percentage. For further information regarding premium revenues, please refer below to *Premium Revenue Recognition* under *Critical Accounting Estimates*.

Medical Benefits Expense

Our largest expense is the cost of medical benefits that we provide, which is based primarily on our arrangements with health care providers and utilization of health care services by our members. Our arrangements with providers primarily fall into two broad categories: capitation arrangements, pursuant to which we pay the capitated providers a fixed fee per member and in some instances, additional fees for certain services, as well as risk-sharing arrangements, pursuant to which the provider assumes a portion of the risk of the cost of the health care provided. Other components of medical benefits expense are variable and require estimation and ongoing cost management.

We use a variety of techniques to manage our medical benefits expense, including payment methods to providers, referral requirements, quality and disease management programs, reinsurance and member co-payments and premiums for some of our Medicare plans. National health care costs have been increasing at a higher rate than the general inflation rate and relatively small changes in our medical benefits expense relative to premiums that we receive can create significant changes in our financial results. Changes in health care laws, regulations and practices, levels of use of health care services, competitive pressures, hospital costs, major epidemics, terrorism or bio-terrorism, new medical technologies and other external factors could reduce our ability to manage our medical benefits expense effectively.

Estimation of medical benefits payable and medical benefits expense is our most significant critical accounting estimate. For further information regarding medical benefits expense, please refer below to *Estimating Medical Benefits Expense and Medical Benefits Payable* under *Critical Accounting Estimates*.

Gross Margin and Medical Benefits Ratio

Our primary tools for measuring profitability are gross margin and MBR. Changes in gross margin and MBR from period to period result from, among other things, changes in Medicaid and Medicare funding, changes in the mix of Medicaid and Medicare membership, our ability to manage medical costs and changes in accounting estimates related to incurred but not reported (“IBNR”) claims. We use gross margin and MBRs both to monitor our management of medical benefits and medical benefits expense and to make various business decisions, including what health care plans to offer, what geographic areas to enter or exit and which health care providers to select. Although gross margin and MBRs play an important role in our business strategy, we may be willing to enter new geographical markets and/or enter into provider arrangements that might produce a less favorable gross margin and MBR if those arrangements, such as capitation or risk sharing, would likely lower our exposure to variability in medical costs or for other reasons.

Results of Operations

For the Three Months Ended March 31, 2011 Compared to the Three Months Ended March 31, 2010

Summary of Financial Information

The following table sets forth condensed consolidated statements of income data, as well as other key data used in our results of operations discussion. These historical results are not necessarily indicative of results to be expected for any future period.

Consolidated Statement of Operations Data:	For the Three Months Ended March 31,	
	2011	2010
	(In millions, except per share data)	
Revenues:		
Premium	\$ 1,472.4	\$ 1,353.5
Investment and other income	2.3	2.5
Total revenues	<u>1,474.7</u>	<u>1,356.0</u>
Expenses:		
Medical benefits	1,245.0	1,166.0
Selling, general and administrative	169.2	163.6
Medicaid premium taxes	18.9	9.7
Depreciation and amortization	6.5	5.8
Interest	0.1	0.0
Total expenses	<u>1,439.7</u>	<u>1,345.1</u>
Income before income taxes	35.0	10.9
Income tax expense	13.7	4.5
Net income	<u>\$ 21.3</u>	<u>\$ 6.4</u>
Net income per common share:		
Basic	\$ 0.50	\$ 0.15
Diluted	\$ 0.50	\$ 0.15
Consolidated MBR	85.7%	86.8%

Membership

Membership:	March 31, 2011	December 31, 2010	March 31, 2010
Medicaid	1,329,000	1,340,000	1,332,000
MA	119,000	116,000	118,000
PDP	935,000	768,000	736,000
Total Membership	<u>2,383,000</u>	<u>2,224,000</u>	<u>2,186,000</u>

As of March 31, 2011, we served approximately 2,383,000 members; an increase of 159,000 members from December 31, 2010 and 197,000 members from March 31, 2010. We experienced membership growth in both our MA and PDP segments. For our MA segment, we focused on our membership growth activities during the annual election period in 2010. Our products are designed to achieve an appropriate financial rate of return with benefit designs that are attractive to both current and prospective members. We invested in strengthening our sales processes and organization. In light of the shortened selling season and the elimination of the open enrollment period, we also invested to ensure an effective on-boarding experience for our new members. As of March 31, 2011 we added approximately 3,000 members from December 31, 2010. In our PDP segment, our plans are below the benchmark in 20 of the 34 CMS regions, which is an increase of one region from 2010. Additionally, we are within the de minimis range in an additional eight regions. As a result, we added approximately 167,000 members as of March 31, 2011 compared to December 31, 2010. These membership increases during the 2011 first quarter were partially offset by an overall decrease in Medicaid membership. We believe Medicaid membership growth opportunities exist in the states in which we currently operate, as well as states that we may decide to enter as a new market.

Summary of Consolidated Financial Results

Net income

For the three months ended March 31, 2011, our net income was \$21.3 million compared to \$6.4 million the same period in 2010. Excluding investigation-related and litigation-resolution costs of \$6.9 million and \$0.9 million, net of tax, for the three months ended March 31, 2011 and 2010, respectively, net income increased by \$20.9 million compared to the same period in the prior year. The increase resulted mainly from the impact of net favorable development of prior period medical benefits payable, which led to improved results in our Medicaid and Medicare segments, as well as, reductions in selling, general and administrative (“SG&A”) expense.

Premium revenue

Premium revenue for the three months ended March 31, 2011 increased by approximately \$118.9 million, or 8.8%, to \$1,472.4 million from \$1,353.5 million for the same period in the prior year. The increase in premium revenue is primarily attributable to the impact of rate increases in our Medicaid markets which were effective during the third quarter of 2010 and membership growth during the first quarter of 2011 in our PDP segment. Premium revenue includes \$18.9 million and \$9.7 million of Medicaid premium taxes for the three months ended March 31, 2011 and 2010, respectively.

Medical benefits expense

Total medical benefits expense for the three months ended March 31, 2011 increased \$79.0 million, or 6.8%, to \$1,245.0 million from \$1,166.0 million for the same period in 2010. The increase in medical benefits expense is due mainly to the membership growth in our PDP segment, partially offset by an increase in net favorable development of prior period medical benefits payable, which amounted to \$51.0 million for the three months ended March 31, 2011 compared to \$4.6 million for the same period in 2010.

The consolidated MBR, excluding the impact from our PFFS product, was 85.8% and 87.8% for the three months ended March 31, 2011 and 2010, respectively. The change in MBR was primarily due to the net prior period reserve development.

Selling, general and administrative expense

SG&A expense includes aggregate costs related to the resolution of the previously disclosed governmental and Company investigations and litigation, such as: legal fees, fair value accretion of settlement accruals and other related costs. Refer to Part I – Note 6 – *Commitments and Contingencies* for a further discussion of investigation-related and litigation costs. We believe it is appropriate to evaluate SG&A expense exclusive of these investigation-related and litigation costs because we do not consider them to be indicative of our long-term business operations. A reconciliation of SG&A expense, including and excluding investigation-related costs, is presented below.

	For the Three Months Ended March 31,	
	2011	2010
	(In millions)	
SG&A expense	\$ 169.2	\$ 163.6
Adjustments:		
Investigation-related and litigation resolution costs	(2.0)	(0.4)
Investigation-related administrative costs	(8.7)	(0.9)
Investigation-related and litigation costs	(10.7)	(1.3)
SG&A expense, excluding investigation-related and litigation costs	<u>\$ 158.5</u>	<u>\$ 162.3</u>

Excluding the investigation-related and litigation costs, our SG&A expense for the three months ended March 31, 2011, decreased approximately \$3.8 million, or 2.3%, to \$158.5 million from \$162.3 million for the same period in prior year. The reduction in SG&A expense was driven by the change in the Medicare marketing calendar and the elimination of the open enrollment period, which reduced our Medicare marketing expense for the three months ended March 31, 2011 compared to the same period in the prior year. Improvements in operating efficiency also contributed to this expense reduction. Our SG&A expense as a percentage of total revenue, excluding premium taxes (“SG&A ratio”), was 11.6% for the three months ended March 31, 2011 compared to 12.2% for the same period in prior year. After excluding the investigation-related and litigation costs, our SG&A ratio for the three months ended March 31, 2011 was 10.9% compared to 12.1% for the same period in the prior year. Our SG&A ratio, excluding investigation-related and litigation costs, represents solid progress toward our long-term goal of an adjusted SG&A ratio in the low 10% range, based on our current business mix. Business simplification projects, process management in our shared services functions, and continued evaluation of our organizational design continue to drive improvement in our administrative cost structure.

Medicaid premium taxes

Medicaid premium taxes incurred for the three months ended March 31, 2011 and 2010 were \$18.9 million and \$9.7 million, respectively. The increase was mainly due to the reinstatement of premium taxes by the State of Georgia in July 2010. In October 2009, the State of Georgia stopped assessing taxes on Medicaid premiums remitted to us, which resulted in an equal reduction to premium revenues and expenses. However, effective July 1, 2010, the State of Georgia began assessing premium taxes again on Medicaid premiums. Therefore, during the first quarter of 2010, we were not assessed nor did we remit any taxes on premiums in Georgia. We were assessed and remitted taxes on premiums in Hawaii, Missouri, New York and Ohio both the 2011 and 2010 periods.

We exclude Medicaid premium taxes from premium revenue when calculating our key ratios as we believe the premium tax is not indicative of our operating performance.

Income tax expense

Income tax expense for the three months ended March 31, 2011 was \$13.7 million compared to \$4.5 million for the same period in the prior year. Our effective income tax rate was 39.1% for the three months ended March 31, 2011 compared to 41.0% for the same three month period in the prior year. The decrease in the effective tax rate in the 2011 period was primarily attributable to a decrease in certain non-deductible executive compensation costs in 2011 and from improvement in our income before income taxes. The effective tax rate was higher when compared to the statutory rate for the three months ended March 31, 2011 and 2010, and was also due to certain non-deductible executive compensation costs.

Reconciling Segment Results

The following table reconciles our reportable segment results to income before income taxes, as reported under GAAP.

Reconciling Segment Results Data:	For the Three Months Ended March 31,	
	2011	2010
Gross margin:	(Dollars in millions)	
Medicaid	\$ 152.1	\$ 107.3
MA	77.7	74.9
PDP	(2.4)	5.3
Total gross margin	<u>227.4</u>	<u>187.5</u>
Investment and other income	2.3	2.5
Other expenses	(194.7)	(179.1)
Income before income taxes	<u>35.0</u>	<u>10.9</u>

Medicaid Segment Results

Medicaid Segment Results Data:	For the Three Months Ended March 31,	
	2011	2010
	(Dollars in millions)	
Premium revenue	\$ 836.9	\$ 799.4
Medicaid premium taxes	18.9	9.7
Total premiums	855.8	809.1
Medical benefits expense	703.7	701.8
Gross margin	<u>\$ 152.1</u>	<u>\$ 107.3</u>
Medicaid Membership:		
Georgia	559,000	537,000
Florida	410,000	422,000
Other states	360,000	373,000
	<u>1,329,000</u>	<u>1,332,000</u>
Medicaid MBR (excluding premium taxes)	84.1%	87.8%

Excluding Medicaid premium taxes, Medicaid premium revenue for the three months ended March 31, 2011 increased \$37.5 million when compared to the same period in the prior year. The increase in premium revenue was mainly due to rate increases that were effective in most markets during the third quarter of 2010.

Medicaid medical benefits expense for the three months ended March 31, 2011 increased \$1.9 million when compared to the same period in prior year due mainly to a change in member mix, partially offset by the impact of net favorable development of prior period medical benefits payable and the impact of medical cost initiatives that we have implemented. Our Medicaid MBR for the three months ended March 31, 2011 was 84.1% compared to 87.8% for the same period in the prior year. The decrease in MBR was primarily due to the net favorable prior period development of medical benefits payable. We expect the full year MBR for our Medicaid segment to decrease in 2011 when compared to 2010, due to the favorable development of medical benefits payable that we recognized during the first quarter of 2011 and utilization modestly below historical levels, offset in part by our expectation that the state rate environment will be challenging.

MA Segment Results

	For the Three Months Ended March 31,	
	2011	2010
MA Segment Results Data:	(Dollars in millions)	
	\$	\$
Premium revenue	354.7	351.1
Medical benefits expense	277.0	276.2
	\$	\$
Gross margin	77.7	74.9
MA Membership	119,000	118,000
MA MBR	78.1%	78.7%

MA premium revenue for the three months ended March 31, 2011 increased \$3.6 million when compared to the same period in the prior year. Membership increased by approximately 1,000 members to 119,000 as of March 31, 2011, from 118,000 as of March 31, 2010. The increase in MA premium revenue and membership was attributable to our product design, strengthening of our sales processes and heightened focus on membership growth activities during the annual election period in 2010. MA gross margin increased by \$2.8 million for the three months ended March 31, 2011, to \$77.7 million from \$74.9 million for the same period in prior year due to increased premiums. MA segment MBR decreased by 0.6% in 2011 compared to 2010 primarily due to the net favorable prior period development of medical benefits payable. We currently expect that the MA segment MBR in 2011 will increase relative to 2010 as the benefit we experienced in 2010 from the wind-down of our PFFS plans will not recur in 2011.

PDP Segment Results

	For the Three Months Ended March 31,	
	2011	2010
PDP Segment Results Data:	(Dollars in millions)	
	\$	\$
Premium revenue	261.9	193.3
Medical benefits expense	264.3	188.0
	\$	\$
Gross margin	(2.4)	5.3
PDP Membership	935,000	736,000
PDP MBR	100.9%	97.2%

During the three months ended March 31, 2011 PDP premium revenue increased \$68.6 million when compared to the same period in the prior year. The increase in premium revenue during 2011 is primarily the result of higher membership largely due to our 2011 bids. Membership increased approximately 199,000 members from March 31, 2010 to March 31, 2011. PDP MBR for the three months ended March 31, 2011 increased 3.6% over the same period in 2010 due to our bid results, member mix and higher utilization.

Liquidity and Capital Resources

Overview

Each of our existing and anticipated sources of cash is impacted by operational and financial risks that influence the overall amount of cash generated and the capital available to us. For a further discussion of risks that can affect our liquidity, see Part I – Item 1A – *Risk Factors* included in our 2010 Form 10-K.

Cash & Investment Positions

We currently believe that we will be able to meet our known monetary obligations, including the terms of the settlement agreements reached to resolve the government investigation and related litigation, and maintain sufficient liquidity to operate our business. However, one or more of our regulators could require one or more of our subsidiaries to maintain minimum levels of statutory net worth in excess of the amount required under the current applicable state laws if the regulators were to determine that such a requirement were in the interest of our members. Further, there may be other potential adverse developments that could impede our ability to meet our obligations. The table below presents our cash and investment positions as of March 31, 2011 and December 31, 2010.

	March 31, 2011	December 31, 2010
Cash and cash equivalents:	(Dollars in millions)	
Regulated	\$ 1,105.1	\$ 1,168.9
Unregulated	127.8	190.6
	<u>\$ 1,232.9</u>	<u>\$ 1,359.5</u>
Investments:		
Regulated		
Auction rate securities	\$ 40.4	\$ 40.2
Other	242.8	129.1
	<u>\$ 283.2</u>	<u>\$ 169.3</u>
Unregulated		
Auction rate securities	\$ 2.3	\$ 2.3
Other	0.1	0.1
	<u>2.4</u>	<u>2.4</u>
	<u>\$ 285.6</u>	<u>\$ 171.7</u>

Regulated cash and cash equivalents can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners. Our unregulated cash and cash equivalents decreased during the three months ended March 31, 2011 primarily as a result of \$52.5 million paid in March 2011 in connection with the preliminary resolution of certain class action complaints as well as the payment of certain investigation-related and litigation resolution costs during the first quarter of 2011. Our regulated investments increased as a result of the investment of funds to higher yielding investment alternatives.

Initiatives to Increase Our Unregulated Cash

We are pursuing alternatives to raise additional unregulated cash. Some of these initiatives include, but are not limited to, obtaining dividends from certain of our regulated subsidiaries, to the extent of the current dividend capacity for such subsidiaries based on the states' dividend restrictions, and consideration of accessing the debt or equity capital markets. However, we cannot provide any assurances that we will obtain applicable state regulatory approvals for paying additional dividends to our non-regulated subsidiaries from our regulated subsidiaries, or be successful in accessing the capital markets if we determine to do so.

Credit Facility

We entered into a credit agreement on May 12, 2010, which was subsequently amended on May 25, 2010 and March 3, 2011 (as amended, the "Credit Agreement"). The Credit Agreement provides for a \$65.0 million committed revolving credit facility that expires on November 12, 2011. Borrowings under the Credit Agreement may be used for general corporate purposes.

The Credit Agreement is guaranteed by us and our subsidiaries, other than our HMO and insurance subsidiaries. In addition, the Credit Agreement is secured by first priority liens on our personal property and the personal property of our subsidiaries, other than the personal property and equity interests of our HMO and insurance subsidiaries.

Borrowings designated by us as Alternate Base Rate borrowings bear interest at a rate per annum equal to (i) the greatest of (a) the Prime Rate (as defined in the Credit Agreement) in effect on such day; (b) the Federal Funds Effective Rate (as defined in the Credit Agreement) in effect on such day plus 1/2 of 1%; and (c) the Adjusted LIBO Rate (as defined in the Credit Agreement) for a one month interest period on such day plus 1%; plus (ii) 1.5%. Borrowings designated by us as Eurodollar borrowings bear interest at a rate per annum equal to the Adjusted LIBO Rate for the interest period in effect for such borrowing plus 2.5%.

The Credit Agreement includes negative covenants that limit certain of our activities, including restrictions on our ability to incur additional indebtedness, and financial covenants that require a minimum ratio of cash flow to total debt, a maximum ratio of total liabilities to consolidated net worth and a minimum level of statutory net worth for our HMO and insurance subsidiaries.

The Credit Agreement also contains customary representations and warranties that must be accurate in order for us to borrow under the Credit Agreement. In addition, the Credit Agreement contains customary events of default. If an event of default occurs and is continuing, we may be required to immediately repay all amounts outstanding under the Credit Agreement, and the commitments under the Credit Agreement may be terminated.

As of March 31, 2011, the credit facility has not been drawn upon and we remain in compliance with all covenants.

Auction Rate Securities

As of March 31, 2011, \$42.7 million of our long-term investments were comprised of municipal note investments with an auction reset feature (“auction rate securities”). These notes are issued by various state and local municipal entities for the purpose of financing student loans, public projects and other activities, which carry investment grade credit ratings. As of the date of this 2011 Form 10-Q, auctions for all of our auction rate securities have failed and there is no assurance that auctions on the remaining auction rate securities in our investment portfolio will succeed in the future. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. In the event that there is a failed auction the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. The securities for which auctions have failed will continue to accrue interest at the contractual rate and be auctioned every seven, 14, 28 or 35 days until the auction succeeds, the issuer calls the securities, or they mature. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. In addition, while all of our auction rate securities currently carry investment grade ratings, if the issuers are unable to successfully close future auctions and their credit ratings deteriorate, we may in the future be required to record an impairment charge on these investments.

Although auctions continue to fail, we currently believe these securities are not impaired, primarily due to our ability and present intent to hold these securities until maturity or market stability is restored and because of government guarantees or municipal bond insurance. However, it could take until the final maturity of the underlying securities to realize our investments’ recorded value. There were no sales or redemptions of such securities during the three months ended March 31, 2011.

Overview of Cash Flow Activities

For the three months ended March 31, 2011 and 2010 our cash flows are summarized as follows:

	For the Three Months Ended March 31,	
	2011	2010
	(In millions)	
Net cash used in operations	\$ (43.9)	\$ (170.5)
Net cash (used in) provided by investing activities	(120.4)	8.0
Net cash provided by financing activities	37.7	31.7

Cash used in Operations

We generally receive premiums in advance of payments of claims for health care services; however, cash flows related to our operations can fluctuate significantly in a particular period depending on the timing of receipts for premiums from our government partners or payments related to resolving government investigations and related litigation. For the three months ended March 31, 2011, cash used in operations primarily consisted of an increase in premiums receivable of \$62.4 million, a \$52.5 million payment related to the investigation resolution and \$43.5 million of payments on accounts payable and other accrued expenses, partially offset by an increase in medical benefits payable of \$47.6 million and \$17.1 million in unearned premiums.

Cash flows from operations have substantially improved when compared to the prior year since 2010 activity reflects the pay down of remaining outstanding claims associated with our exit from PFFS.

Cash (used in) provided by Investing Activities

During the three months ended March 31, 2011, cash used in investing activities primarily reflects our investment into higher yielding investment alternatives which had a net impact totaling approximately \$113.3 million and purchases of property and equipment totaling approximately \$8.7 million, partially offset by \$1.5 million of proceeds from the maturities of restricted investments net of purchases.

Cash provided by Financing Activities

Included in financing activities are funds held for the benefit of members, which increased approximately \$37.8 million as of March 31, 2011. These funds represent reinsurance and low-income cost subsidies funded by CMS in connection with the Medicare Part D program, for which we assume no risk.

Critical Accounting Estimates

In the ordinary course of business, we make a number of estimates and assumptions relating to the reporting of our results of operations and financial condition in conformity with accounting principles generally accepted in the United States (“GAAP”). We base our estimates on historical experience and on various other assumptions that we believe to be reasonable under the circumstances. Actual results could differ significantly from those estimates under different assumptions and conditions. We believe that our accounting estimates relating to premium revenue recognition, medical benefits expense and medical benefits payable, and goodwill and intangible assets, are those that are most important to the portrayal of our financial condition and results and require management’s most difficult, subjective and complex judgments, often as a result of the need to make estimates about the effect of matters that are inherently uncertain. We have not changed our methodology in deriving these critical accounting estimates from those previously disclosed in our Annual Report on Form 10-K (“2010 Form 10-K”). Our critical accounting estimates relating to premium revenue recognition, medical benefits payable and medical benefits expense, and the quantification of the sensitivity of financial results to reasonably possible changes in underlying assumptions used in such estimation, as well as assumptions relating to our impairment assessment of goodwill and intangible assets as of March 31, 2011, is discussed below.

Premium Revenue Recognition

We receive premiums from state and federal agencies for the members that are assigned to, or have selected, us to provide health care services under Medicaid and Medicare. The premiums we receive for each member vary according to the specific government program and are generally determined at the beginning of the contract period. These premiums are subject to adjustment throughout the term of the contract by CMS and the states, although such adjustments are typically made at the commencement of each new contract renewal period.

We recognize premium revenues in the period in which we are obligated to provide services to our members. Premiums are billed monthly for coverage in the following month and we are paid generally in the month in which we provide services. We estimate, on an ongoing basis, the amount of member billings that may not be fully collectible or that will be returned based on historical trends, compliance with requirements for certain contracts to expend a minimum percentage of premiums on eligible medical expense, and other factors. An allowance is established for the estimated amount that may not be collectible and a liability is established for premium expected to be returned. Historically, the allowance has not been significant relative to premium revenue.

Premium payments that we receive are based upon eligibility lists produced by the government. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, the states or CMS require us to reimburse them for premiums that we received based on an eligibility list that a state, CMS or we later discover, through our audits or otherwise, contains individuals who were not eligible for any government-sponsored program or belong to a different plan other than ours. The verification and subsequent membership changes may result in additional amounts due to us or we may owe premiums back to the government. The amounts receivable or payable identified by us through reconciliation and verification of agency eligibility lists relate to current and prior periods. The amounts receivable from government agencies for reconciling items were \$11.9 million and \$0.3 million at March 31, 2011 and December 31, 2010, respectively. The amounts due to government agencies for reconciling items were \$48.6 million and \$63.3 million at March 31, 2011 and December 31, 2010, respectively. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates had a minimal impact on premiums recorded during the periods presented. Our government contracts establish monthly rates per member that may be adjusted based on member demographics such as age, working status or medical history.

Minimum loss ratio requirement

Certain of our Medicaid contracts require us to expend a minimum percentage of premiums on eligible medical expense ("minimum loss ratio requirement"), and to the extent that we expend less than the minimum loss ratio requirement, we are required to refund all or some portion of the difference between the minimum and our actual allowable medical expense. We estimate the amounts due to the state as a return of premium each period based on the terms of our contract with the applicable state agency, and such amounts are included in our results of operations as adjustments to premium revenues.

Risk corridor

The amount of premium relating to PDP coverage is subject to adjustment, positive or negative, based upon the application of risk corridors that compare our prescription drug costs estimated in our bids to CMS to our actual prescription drug costs. We estimate the amounts due to or from CMS for risk protection under the risk corridor provisions of our contract with CMS each period based on pharmacy claims experience to date as if the annual contract were to terminate at the end of the reporting period, and such amounts are included in our results of operations as adjustments to premium revenues.

Risk-Adjusted Premiums

CMS employs a risk-adjustment model to determine the premium amount it pays for each member. This model apportions premiums paid to all MA plans according to the health status of each beneficiary enrolled. As a result, our CMS monthly premium payments per member may change materially, either favorably or unfavorably. The CMS risk-adjustment model pays more for Medicare members with predictably higher costs. Diagnosis data from inpatient and ambulatory treatment settings are used to calculate the risk-adjusted premiums we receive. We collect claims and encounter data and submit the necessary diagnosis data to CMS within prescribed deadlines. After reviewing the respective submissions, CMS establishes the premium payments to MA plans generally at the beginning of the calendar year, and then adjusts premium levels on two separate occasions on a retroactive basis. The first retroactive adjustment for a given fiscal year generally occurs during the third quarter of such fiscal year. This initial settlement (the "Initial CMS Settlement") represents the updating of risk scores for the current year based on the severity of claims incurred in the prior fiscal year. CMS then issues a final retroactive risk-adjusted premium settlement for that fiscal year in the following year (the "Final CMS Settlement"). We reassess the estimates of the Initial CMS Settlement and the Final CMS Settlement each reporting period and any resulting adjustments are made to MA premium revenue.

We develop our estimates for risk-adjusted premiums utilizing historical experience and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. Our models are populated with available risk score data on our members. Risk premium adjustments are based on member risk score data from the previous year. Risk score data for members who entered our plans during the current plan year, however, is not available for use in our models; therefore, we make assumptions regarding the risk scores of this subset of our member population. All such estimated amounts are periodically updated as additional diagnosis code information is reported to CMS and adjusted to actual amounts when the ultimate adjustment settlements are either received from CMS or we receive notification from CMS of such settlement amounts.

As a result of the variability of factors that determine such estimates, including plan risk scores, the actual amount of CMS retroactive payment could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of MA premium revenues related thereto, could have a material adverse effect on our results of operations, financial position and cash flows. Historically, we have not experienced significant differences between the amounts that we have recorded and the revenues that we ultimately receive. The data provided to CMS to determine the risk score is subject to audit by CMS even after the annual settlements occur. These audits may result in the refund of premiums to CMS previously received by us. While our experience to date has not resulted in a material refund, this refund could be significant in the future, which would reduce our premium revenue in the year that CMS determines repayment is required.

CMS has performed and continues to perform Risk Adjustment Data Validation ("RADV") audits of selected MA plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each MA member. Our Florida MA plan was selected by CMS for audit for the 2007 contract year and we anticipate that CMS will conduct additional audits of other plans and contract years on an ongoing basis. The CMS audit process selects a sample of 201 enrollees for medical record review from each contract selected. We have responded to CMS's audit requests by retrieving and submitting all available medical records and provider attestations to substantiate CMS-sampled diagnosis codes. CMS will use this documentation to calculate a payment error rate for our Florida MA plan 2007 premiums. CMS has not indicated a schedule for processing or otherwise responding to our submissions.

CMS has indicated that payment adjustments resulting from its RADV audits will not be limited to risk scores for the specific beneficiaries for which errors are found, but will be extrapolated to the relevant plan population. In December 2010, CMS issued a draft audit sampling and payment error calculation methodology that it proposes to use in conducting these audits. CMS invited public comment on the proposed audit methodology and announced in early February 2011 that it will revise its proposed approach based on the comments received. CMS has not given a specific timetable for issuing a final version of the audit sampling and payment error calculation methodology. Given that the RADV audit methodology is new and is subject to modification, there is substantial uncertainty as to how it will be applied to MA organizations like our Florida MA plan. At this time, we do not know whether CMS will require retroactive or subsequent payment adjustments to be made using an audit methodology that may not compare the coding of our providers to the coding of Original Medicare and other MA plan providers, or whether any of our other plans will be randomly selected or targeted for a similar audit by CMS. We are also unable to determine whether any conclusions that CMS may make, based on the audit of our plan and others, will cause us to change our revenue estimation process. Because of this lack of clarity from CMS, we are unable to estimate with any reasonable confidence a coding or payment error rate or predict the impact of extrapolating an applicable error rate to our Florida MA plan 2007 premiums. However, it is likely that a payment adjustment will occur as a result of these audits, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows, possibly in 2011 and beyond.

Estimating Medical Benefits Payable and Medical Benefits Expense

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of IBNR medical benefits. Medical benefits payable has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses, which are recorded in Selling, general, and administrative expense. Medical benefits payable on our Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement and estimates for IBNR. The following table provides a reconciliation of the total medical benefits payable balances as of March 31, 2011 and December 31, 2010:

	March 31, 2011	% of Total	December 31, 2010	% of Total
	(in millions)		(in millions)	
Claims adjudicated, but not yet paid	\$ 78.0	10%	\$ 50.9	7%
IBNR	712.6	90%	692.1	93%
Total medical benefits payable	\$ 790.6		\$ 743.0	

The medical benefits payable estimate has been, and continues to be, our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management's best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

The factors and assumptions described above that are used to develop our estimate of medical benefits expense and medical benefits payable inherently are subject to greater variability when there is more limited experience or information available to us. The ultimate claims payment amounts, patterns and trends for new products and geographic areas cannot be precisely predicted at their onset, since we, the providers and the members do not have experience in these products or geographic areas. Standard accepted actuarial methodologies, discussed above, would allow for this inherent variability. This can result in larger differences between the originally estimated medical benefits payable and the actual claims amounts paid. Conversely, during periods where our products and geographies are more stable and mature, we have more reliable claims payment patterns and trend experience. With more reliable data, we should be able to more closely estimate the ultimate claims payment amounts; therefore, we may experience smaller differences between our original estimate of medical benefits payable and the actual claim amounts paid.

In developing our estimates, we apply different estimation methods depending on the month for which incurred claims are being estimated. For the more recent months, which constitute the majority of the amount of the medical benefits payable, we estimate claims incurred by applying observed trend factors to the fixed fee per-member per-month ("PMPM") costs for prior months, which costs have been estimated using completion factors, in order to estimate the PMPM costs for the most recent months. We validate our estimates of the most recent PMPM costs by comparing the most recent months' utilization levels to the utilization levels in prior months and actuarial techniques that incorporate a historical analysis of claim payments, including trends in cost of care provided and timeliness of submission and processing of claims.

Many aspects of the managed care business are not predictable. These aspects include the incidences of illness or disease state (such as congestive heart failure cases, cases of upper respiratory illness, the length and severity of the flu season, diabetes, the number of full-term versus premature births and the number of neonatal intensive care babies). Therefore, we must continually monitor our historical experience in determining our trend assumptions to reflect the ever-changing mix, needs and size of our membership. Among the factors considered by management are changes in the level of benefits provided to members, seasonal variations in utilization, identified industry trends and changes in provider reimbursement arrangements, including changes in the percentage of reimbursements made on a capitation as opposed to a fee-for-service basis. These considerations are reflected in the trends in our medical benefits expense. Other external factors such as government-mandated benefits or other regulatory changes, catastrophes and epidemics may impact medical cost trends. Other internal factors such as system conversions and claims processing interruptions may impact our ability to accurately predict estimates of historical completion factors or medical cost trends. Medical cost trends potentially are more volatile than other segments of the economy. Management uses considerable judgment in determining medical benefits expense trends and other actuarial model inputs. We believe that the amount of medical benefits payable as of March 31, 2011 is adequate to cover our ultimate liability for unpaid claims as of that date; however, actual payments may differ from established estimates. If the completion factors we used in estimating our IBNR for the three months ended March 31, 2011 were decreased by 1%, our net income would decrease by approximately \$20.2 million. If the completion factors were increased by 1%, our net income would increase by approximately \$19.6 million.

We record reserves for estimated referral claims related to health care providers under contract with us who are financially troubled or insolvent and who may not be able to honor their obligations for the costs of medical services provided by other providers. In these instances, we may be required to honor these obligations for legal or business reasons. Based on our current assessment of providers under contract with us, such losses have not been and are not expected to be significant.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members' needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon PMPM claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all influencing the resulting medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known, and have the effect of increasing or decreasing the reported medical benefits expense and resulting MBR in such periods.

In establishing our estimate of reserves for IBNR at each reporting period, we use standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors, which vary by business segment, to determine an estimate of the base reserve. Actuarial standards of practice require that a margin for uncertainty be considered in determining the estimate for unpaid claim liabilities. If a margin is included, the claim liabilities should be adequate under moderately adverse conditions. Therefore, we make an additional estimate in the process of establishing the IBNR, which also uses standard actuarial techniques, to account for adverse conditions that may cause actual claims to be higher than estimated compared to the base reserve, for which the model is not intended to account. We refer to this additional liability as the provision for moderately adverse conditions. The provision for moderately adverse conditions is a component of our overall determination of the adequacy of our IBNR reserve. The provision for moderately adverse conditions is intended to capture the potential adverse development from factors such as our entry into new geographical markets, our provision of services to new populations such as the aged, blind and disabled, the variations in utilization of benefits and increasing medical cost, changes in provider reimbursement arrangements, variations in claims processing speed and patterns, claims payment, the severity of claims, and outbreaks of disease such as the flu. Because of the complexity of our business, the number of states in which we operate, and the need to account for different health care benefit packages among those states, we make an overall assessment of IBNR after considering the base actuarial model reserves and the provision for moderately adverse conditions. We consistently apply our IBNR estimation methodology from period to period. We review our overall estimates of IBNR on a monthly basis. As additional information becomes known to us, we adjust our assumptions accordingly to change our estimate of IBNR. Therefore, if moderately adverse conditions do not occur, evidenced by more complete claims information in the following period, then our prior period estimates will be revised downward, resulting in favorable development. However, any favorable prior period reserve development would affect (increase) current period net income only to the extent that the current period provision for moderately adverse conditions is less than the benefit recognized from the prior period favorable development. If moderately adverse conditions occur and are more than we estimated, then our prior period estimates will be revised upward, resulting in unfavorable development, which would decrease current period net income.

Medical benefits expense for the three months ended March 31, 2011, was impacted by approximately \$51.0 million of net favorable development related to prior years. For the three months ended March 31, 2010, medical benefits expense was impacted by approximately \$4.6 million of net favorable development related to prior years. The net favorable prior year development in 2011 results primarily from the difference between actual medical utilization compared to original assumptions and prior year claims estimates being settled for amounts that are different than originally anticipated. The net amount of prior period developments in the 2010 was primarily attributable to the reduction of the provision for moderately adverse conditions resulting from the exit of the PFFS product on December 31, 2009. The factors impacting the changes in the determination of medical benefits payable discussed above were not discernable in advance. The impact became clearer over time as claim payments were processed and more complete claims information was obtained.

Goodwill and Intangible Assets

We use a two-step process to review goodwill for impairment. The first step is a screen for potential impairment, and the second step measures the amount of impairment, if any. We review goodwill and intangible assets for potential impairment at least annually, or more frequently if events or changes in circumstances occur that may affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We evaluate the potential impairment of goodwill and intangible assets using both the income and market approach. In doing so, we must

make assumptions and estimates, such as the discount factor and peer benchmarking, in estimating fair values. While we believe these assumptions and estimates are appropriate, other assumptions and estimates could be applied and might produce significantly different results. An impairment loss is recognized for goodwill and intangible assets if the carrying value of such assets exceeds its fair value. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting process. As of our last impairment test as of June 30, 2010, we assessed the book value of goodwill and other intangible assets and determined that the fair value of these assets exceeds its carrying value and noted no indications that would require additional impairment testing as of March 31, 2011.

We also evaluate the intangible assets used in our PFFS business, which primarily consisted of state licenses for the insurance companies that underwrote that line of business. As we continue to use these company licenses for other lines of business and the licenses have a market value, we determined that these assets were not impaired.

Item 3. Quantitative and Qualitative Disclosures about Market Risk.

As of March 31, 2011, we had cash and cash equivalents of \$1,232.9 million, investments classified as current assets of \$201.9 million, long-term investments of \$83.7 million and restricted investments on deposit for licensure of \$105.8 million. The short-term investments classified as current assets consist of highly liquid securities with maturities between three and twelve months and longer term bonds with floating interest rates that are considered available for sale. Restricted assets consist of cash and cash equivalents and U.S. Treasury instruments deposited or pledged to state agencies in accordance with state rules and regulations. These restricted assets are classified as long-term regardless of the contractual maturity date due to the nature of the states' requirements. The investments classified as long term are subject to interest rate risk and will decrease in value if market rates increase. Because of their contractual maturity dates, however, we would not expect the value of these investments to decline significantly as a result of a sudden change in market interest rates. Assuming a hypothetical and immediate 1% increase in market interest rates at March 31, 2011, the fair value of our fixed income investments would decrease by approximately \$1.5 million. Similarly, a 1% decrease in market interest rates at March 31, 2011 would increase the fair value of our investments by approximately \$2.0 million.

Item 4. Controls and Procedures.

Evaluation of Disclosure Controls and Procedures

Our management carried out an evaluation required by Rule 13a-15 under the Exchange Act, under the leadership and with the participation of our President and Chief Executive Officer ("CEO") and Chief Financial Officer ("CFO"), of the effectiveness of our disclosure controls and procedures as defined in Rule 13a-15 under the Exchange Act ("Disclosure Controls"). Based on the evaluation, our CEO and CFO concluded that our Disclosure Controls were effective as of the end of the period covered by this Quarterly Report.

Changes in Internal Control over Financial Reporting

There has not been any change in our internal control over financial reporting (as defined in Rule 13a-15(f) of the Exchange Act) identified in connection with the evaluation required by Rule 13a-15(d) under the Exchange Act during the quarter ended March 31, 2011 that has materially affected, or is reasonably likely to materially affect, our internal control over financial reporting.

Part II – OTHER INFORMATION

Item 1. Legal Proceedings.

Government Investigations

Civil Division of the United States Department of Justice

On April 26, 2011, the Company entered into certain settlement agreements, described below, which will resolve the pending inquiries of the Civil Division of the United States Department of Justice (the “Civil Division”), the USAO and the United States Attorney’s Office for the District of Connecticut (the “USAO Connecticut”). These settlement agreements are related to four federal *qui tam* complaints filed by relators against WellCare under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733 as well as one state *qui tam* action filed in Leon County, Florida (the “Leon County Action”), which is similar to one of the federal *qui tam* complaints. In connection with the execution of these settlement agreements, one of the federal *qui tam* actions, which had been filed in the District of Connecticut, was recently unsealed on April 29, 2011. The other three federal *qui tam* actions, which are pending in the Middle District of Florida, had been unsealed in June 2010. Additionally, the Leon County Action was unsealed on April 28, 2011.

The settlement agreements are with (a) the United States, with signatories from the Civil Division, the Office of Inspector General of the Department of Health and Human Services (“OIG-HHS”) and the Civil Divisions of the USAO and the USAO Connecticut (the “Federal Settlement Agreement”) and (b) the following states (collectively, the “Settling States”): Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio (collectively, the “State Settlement Agreements”). The material terms of the Federal Settlement Agreement and the State Settlement Agreements are, collectively, substantively the same as the terms of the previously disclosed preliminary settlement with the Civil Division, the USAO and the USAO Connecticut. We have agreed, among other things, to pay the Civil Division a total of \$137.5 million (the “Settlement Amount”), which is to be paid in installments over a period of up to 36 months after the date of the Federal Settlement Agreement (the “Payment Period”) plus interest at the rate of 3.125% per year. The settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that the Company is acquired or otherwise experiences a change in control during the Payment Period. In addition, the settlement provides for a contingent payment of an additional \$35 million in the event that the Company is acquired or otherwise experiences a change in control within three years of the execution of the Federal Settlement Agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Federal Settlement Agreement.

In exchange for the payment of the Settlement Amount, the United States and the Settling States agree to release us from any civil or administrative monetary claim under the False Claims Act and certain other legal theories for certain conduct that was at issue in their inquiries and the *qui tam* complaints. Likewise, in consideration of the obligations in the Federal Settlement Agreement and the Corporate Integrity Agreement (as described below under *United States Department of Health and Human Services*), OIG-HHS agrees to release and refrain from instituting, directing or maintaining any administrative action seeking to exclude us from Medicare, Medicaid and other federal health care programs.

The Federal Settlement Agreement has not been executed by one of the relators. Under its terms, this failure to timely execute is deemed to be an objection to the Federal Settlement Agreement. In the case of an objection, the Federal Court is required to conduct a hearing (a “Fairness Hearing”) to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. The Federal Settlement Agreement and the State Settlement Agreements will not be effective until the earlier of (a) the execution of the Federal Settlement Agreement by the objecting relator or (b) entry by the Federal Court of a final order determining that the settlement is fair, adequate and reasonable under all the circumstances.

We can make no assurances that the objecting relator will execute the Federal Settlement Agreement or that the Federal Court will approve the settlement at a Fairness Hearing and the actual outcome of these matters may differ materially from the terms of the settlement.

United States Department of Health and Human Services

On April 26, 2011, the Company entered into a Corporate Integrity Agreement (the “Corporate Integrity Agreement”) with OIG-HHS. The Corporate Integrity Agreement has a term of five years and concludes the previously disclosed matters relating to the Company under review by OIG-HHS.

The Corporate Integrity Agreement formalizes various aspects of the Company's ethics and compliance program and contains other requirements designed to help ensure the Company's ongoing compliance with Federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, the Company's reporting practices and bid submissions to federal health care programs.

Class Action Complaints

On May 4, 2011, the Federal Court entered an order (the "Approval Order") approving the Stipulation and Agreement of Settlement (the "Stipulation Agreement") entered into on December 17, 2010 by the Company and a group of five public pension funds appointed by the Federal Court to act as lead plaintiffs in the consolidated securities class action *Eastwood Enterprises, L.L.C. v. Farha, et al.*, Case No. 8:07-cv-1940-VMC-EAJ. The Federal Court had preliminarily approved the Stipulation Agreement on February 9, 2011. Subsequently, notice was sent to all class members, and other legally required procedural steps were taken, in advance of the final approval hearing, which was held May 4, 2011.

In March 2011 the Company paid \$52.5 million into an escrow account for the benefit of the class pursuant to the Stipulation Agreement. As previously disclosed, the Stipulation Agreement also provides, among other things, that the Company will make an additional cash payment to the class of \$35.0 million by July 31, 2011 (the "July 2011 Payment"). It also requires, among other things, that the Company issue to the class tradable unsecured subordinated notes having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. Additionally, the Company will be required to pay to the class an additional \$25.0 million if the Company experiences a change in control at a share price of \$30 or more within three years of the date of the Stipulation Agreement.

With respect to the July 2011 Payment and as required by the Stipulation Agreement, by May 9, 2011, the Company is required to deliver to the escrow agent for the class a non-negotiable promissory note in the principal amount of \$35 million (the "Note"). The Note is due and payable in full on July 31, 2011. The unpaid principal amount of the Note will accelerate and become immediately due and payable in the event of the Company's insolvency, a general assignment for the benefit of creditors, or the commencement by or against the Company of any action seeking reorganization, liquidation, dissolution, or similar treatment of the Company's debts under any law relating to bankruptcy, relief of debtors or similar laws. The unpaid principal will also accelerate in the event the Company or any third party seeks the appointment of a receiver or other similar official for the Company or its assets which, in the case of involuntary proceedings, has not been withdrawn or dismissed within 60 days after the filing of such proceeding. If the Company fails to pay the Note in full by July 31, 2011, then interest on the unpaid balance shall accrue at the rate and pursuant to the method set forth in 28 USC §1961 until all sums due are paid. In the event the payment is accelerated as described in the previous paragraph, then such interest will begin to accrue upon such acceleration.

Derivative Lawsuits

As previously disclosed, putative derivative actions were filed in connection with our government investigations naming the Company as a nominal defendant. As previously disclosed, the Federal Court approved a Stipulation of Partial Settlement ("Stipulation I") and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action. The case is now styled *WellCare v. Farha, et al.* In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"). As previously disclosed, the Circuit Court for Hillsborough County, Florida (the "State Court") approved a second Stipulation of Partial Settlement ("Stipulation II") and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action. In July 2010, Mr. Farha filed a notice of appeal in this matter. In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties. In April 2011, both the Federal Court and the State Court stayed these actions pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

Item 1A. Risk Factors.

Set forth below are material updates to the risk factors disclosed in Part I – Item 1A – *Risk Factors* included in our 2010 Form 10-K.

Failure to comply with the terms of our government contracts could negatively impact our profitability and subject us to fines, penalties and liquidated damages or the termination of our contract.

We contract with various governmental agencies to provide managed health care services. These contracts contain certain provisions regarding data submission, provider network maintenance, quality measures, continuity of care, call center performance and other requirements specific to program regulations. If we fail to comply with these requirements, we may be subject to fines, penalties and liquidated damages that could impact our profitability. If we fail to comply repeatedly over an extended time period, the applicable contract may be subject to termination. We anticipate that we may not meet the performance requirements of our contracts to provide services under the New York Medicaid Managed Care / Family Health Plus programs for the third consecutive year. If the state determines that we have failed to meet the contractual requirements, these contracts will be subject to termination, or other remedies, at the discretion of the state. We are unable to predict what actions that state may take, if any, when assessing our contractual performance.

Additionally, we could be required to file a corrective plan of action with the state and we could be subject to fines, penalties and liquidated damages and additional corrective action measures if we do not comply with the corrective plan of action. Our failure to comply could also affect future membership enrollment levels and our ability to compete for new business. These limitations could negatively impact our revenues and operating results.

Under the terms of our contracts with state governmental agencies, we are subject to various reviews, audits and investigations to verify our compliance with the contracts and applicable laws and regulations. Any adverse review, audit or investigation could result in any of the following: refunds to state government agencies of premiums we have been paid pursuant to our contracts; imposition of fines, penalties and other sanctions; loss of our right to participate in various markets; or loss of one or more of our licenses. Any such action could negatively impact our revenues and operating results.

Item 2. Unregistered Sales of Equity Securities and Use of Proceeds.*Recent Sales of Unregistered Securities*

We did not sell any securities in the three months ended March 31, 2011 that were not registered under the Securities Act of 1933, as amended.

Issuer Purchases of Equity Securities

We do not have a stock repurchase program. However, during the quarter ended March 31, 2011, certain of our employees were deemed to have surrendered shares of our common stock to satisfy their tax withholding obligations associated with the vesting of shares of restricted common stock. The following table summarizes these repurchases:

Period	Total Number of Shares Purchased(1)	Average Price Paid Per Share(1)	Total Number of Shares Purchased as Part of Publicly Announced Plans or Programs	Maximum Number of Shares that May Yet Be Purchased Under the Plans or Programs
January 1, 2011 through January 31, 2011	862	\$31.51 (2)	N/A	N/A
February 1, 2011 through February 28, 2011	303	\$35.22 (3)	N/A	N/A
March 1, 2011 through March 31, 2011	5,592	\$37.00 (4)	N/A	N/A
Total during quarter ended March 31, 2011	6,757	\$36.61 (5)	N/A	N/A

(1) The number of shares purchased represent the number of shares of our common stock deemed surrendered by our employees to satisfy their withholding tax obligations due to the vesting of shares of restricted common stock. For the purposes of this table, we determined the average price paid per share based on the closing price of our common stock as of the date of the determination of the withholding tax amounts (i.e., the date that the shares of restricted stock vested). We do not currently have a stock repurchase program. We did not pay any cash consideration to repurchase these shares.

(2) The weighted average price paid per share during the period was \$31.84.

(3) The weighted average price paid per share during the period was \$35.41.

- (4) The weighted average price paid per share during the period was \$37.42.
- (5) The weighted average price paid per share during the period was \$36.64.

Item 5. Other Information.

Class Action Complaints

On May 4, 2011, the United States District Court for the Middle District of Florida (the “Federal Court”) entered an order (the “Approval Order”) approving the Stipulation and Agreement of Settlement (the “Stipulation Agreement”) entered into on December 17, 2010 by the Company and a group of five public pension funds appointed by the Federal Court to act as lead plaintiffs in the consolidated securities class action *Eastwood Enterprises, L.L.C. v. Farha, et al.*, Case No. 8:07-cv-1940-VMC-EAJ. The Federal Court had preliminarily approved the Stipulation Agreement on February 9, 2011. Subsequently, notice was sent to all class members, and other legally required procedural steps were taken, in advance of the final approval hearing, which was held May 4, 2011.

In March 2011 the Company paid \$52.5 million into an escrow account for the benefit of the class pursuant to the Stipulation Agreement. As previously disclosed, the Stipulation Agreement also provides, among other things, that the Company will make an additional cash payment to the class of \$35.0 million by July 31, 2011 (the “July 2011 Payment”). It also requires, among other things, that the Company issue to the class tradable unsecured subordinated notes having an aggregate face value of \$112.5 million, with a fixed coupon of 6% and a maturity date of December 31, 2016. Additionally, the Company will be required to pay to the class an additional \$25.0 million if the Company experiences a change in control at a share price of \$30 or more within three years of the date of the Stipulation Agreement.

A copy of the Stipulation Agreement was attached as Exhibit 10.44 to the Company’s Annual Report on Form 10-K for the year ended December 31, 2010.

With respect to the July 2011 Payment and as required by the Stipulation Agreement, by May 9, 2011, the Company is required to deliver to the escrow agent for the class a non-negotiable promissory note in the principal amount of \$35 million (the “Note”). The Note is due and payable in full on July 31, 2011. The unpaid principal amount of the Note will accelerate and become immediately due and payable in the event of the Company’s insolvency, a general assignment for the benefit of creditors, or the commencement by or against the Company of any action seeking reorganization, liquidation, dissolution, or similar treatment of the Company’s debts under any law relating to bankruptcy, relief of debtors or similar laws. The unpaid principal will also accelerate in the event the Company or any third party seeks the appointment of a receiver or other similar official for the Company or its assets which, in the case of involuntary proceedings, has not been withdrawn or dismissed within 60 days after the filing of such proceeding.

If the Company fails to pay the Note in full by July 31, 2011, then interest on the unpaid balance shall accrue at the rate and pursuant to the method set forth in 28 USC §1961 until all sums due are paid. In the event the payment is accelerated as described in the previous paragraph, then such interest will begin to accrue upon such acceleration.

Item 6. Exhibits.

Exhibits are incorporated herein by reference or are filed with this report as set forth in the Exhibit Index on page 42 hereof.

SIGNATURES

Pursuant to the requirements of the Securities and Exchange Act of 1934, the registrant has duly caused this report to be signed on its behalf by the undersigned thereunto duly authorized in Tampa, Florida on May 6, 2011.

WELLCARE HEALTH PLANS, INC.

By: /s/ Thomas L. Tran
Thomas L. Tran
Senior Vice President and Chief Financial Officer (Principal Financial Officer)

By: /s/ Maurice S. Hebert
Maurice S. Hebert
Chief Accounting Officer (Principal Accounting Officer)

Exhibit Index

Exhibit Number	Description	INCORPORATED BY REFERENCE		
		Form	Filing Date with SEC	Exhibit Number
2.1	Agreement and Plan of Merger, dated as of February 12, 2004, between WellCare Holdings, LLC and WellCare Group, Inc.	S-1/A	June 8, 2004	2.1
3.1	Amended and Restated Certificate of Incorporation of the Registrant	10-Q	August 13, 2004	3.1
3.1.1	Amendment to Amended and Restated Certificate of Incorporation	10-Q	November 4, 2009	3.1.1
3.2	Third Amended and Restated Bylaws of the Registrant	8-K	November 2, 2010	3.2
4.1	Specimen common stock certificate	10-Q	November 4, 2010	4.1
10.1	Contract to Provide Comprehensive Medical Services among HealthEase of Florida, Inc., WellCare of Florida, Inc., and the Florida Healthy Kids Corporation.	8-K	January 3, 2011	10.1
10.2	Medicare Advantage Health Plan Agreement between WellCare of Georgia, Inc., and the Georgia Department of Community Health.	8-K	March 2, 2011	10.1
10.3	Amendment No. 2, dated March 3, 2011 to the \$65,000,000 Credit Agreement, dated May 12, 2010, among the Registrant, The WellCare Management Group, Inc., the Lenders party thereto and JPMorgan Chase Bank, N.A., as administrative agent, and J.P. Morgan Securities Inc., as sole bookrunner and sole lead arranger	8-K	March 9, 2011	10.1
10.4	Form of Performance Stock Unit Agreement under the Registrant's 2004 Equity Incentive Plan (adopted March 24, 2011)*	8-K	March 28, 2011	10.1
10.5	Form of Performance Stock Unit Agreement under the Registrant's 2004 Equity Incentive Plan (with deferral feature) (adopted March 24, 2011)*	8-K	March 28, 2011	10.2
10.6	Form of Award Agreement under the Registrant's Long Term Incentive Cash Bonus Award Agreement (adopted March 24, 2011)*	8-K	March 28, 2011	10.3
10.7	Form of Amendment (adopted March 24, 2011) to Performance Stock Unit Agreements (adopted March 31, 2010 and December 17, 2010) under the Registrant's 2004 Equity Incentive Plan*	8-K	March 28, 2011	10.4
10.8	Form of Amendment (adopted March 24, 2011) to Award Agreements (adopted March 31, 2010 and December 17, 2010) under the Registrant's Long Term Incentive Cash Bonus Award Agreement*	8-K	March 28, 2011	10.5
10.9	Amendment No. 5 to Contract No. FA904 by and between the State of Florida, Agency for Health Care Administration and WellCare of Florida, Inc. d/b/a Staywell Health Plan of Florida (Medicaid Non-Reform 2009-2012) †			
10.10	Amendment No. 5 to Contract No. FA905 by and between the State of Florida, Agency for Healthcare Administration and HealthEase of Florida, Inc. (Medicaid Non-Reform 2009-2012) †			

31.1	Certification of President and Chief Executive Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †
31.2	Certification of Chief Financial Officer pursuant to Section 302 of Sarbanes-Oxley Act of 2002 †
32.1	Certification of President and Chief Executive Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †
32.2	Certification of Chief Financial Officer pursuant to Section 906 of Sarbanes-Oxley Act of 2002 †
101.INS	XBRL Instance Document ††
101.SCH	XBRL Taxonomy Extension Schema Document ††
101.CAL	XBRL Taxonomy Calculation Linkbase Document ††
101.LAB	XBRL Taxonomy Labels Linkbase Document ††
101.PRE	XBRL Taxonomy Presentation Linkbase Document ††

* Denotes a management contract or compensatory plan, contract or arrangement
† Filed herewith
†† Furnished herewith and not filed for purposes of Section 11 and Section 12 of the Securities Act of 1933 and Section 18 of the Securities Exchange Act of 1934.

Wellcare of Florida, Inc.
d/b/a Staywell Health Plan of Florida

Medicaid HMO Non-Reform Contract

**AHCA CONTRACT NO. FA904
AMENDMENT NO. 5**

THIS CONTRACT, entered into between the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**" and **WELLCARE OF FLORIDA, INC. D/B/A STAYWELL HEALTH PLAN OF FLORIDA**, hereinafter referred to as the "**Vendor**," or "**Health Plan**," is hereby amended as follows:

1. Standard Contract, Section III., Item E., Name, Mailing and Street Address of Payee, sub-items 1. and 2., are hereby deleted and replaced as follows:

1. The name (Vendor name as shown on Page 1 of this Contract) and mailing address of the official payee to whom the payment shall be made:

WellCare of Florida, Inc. d/b/a
Staywell Health Plan of Florida
P.O. Box 31379
Tampa, FL 33634

2. The name of the contact person and street address where financial and administrative records are maintained:

Thomas Tran
WellCare of Florida, Inc. d/b/a
Staywell Health Plan of Florida
8735 Henderson Road
Tampa, FL 33634

2. Attachment II, Core Contract Provisions, Section I, Definitions and Acronyms, Item A., Definitions, the following definitions are hereby included or amended to now read as follows:

Avatar — In relation to Section XI, Information Management Systems, Item K., Social Networking: A small graphic or pseudonym used on a website that identifies the person logging in.

Blog (Web Blog) — In relation to Section XI, Information Management Systems, Item K., Social Networking: A type of website, usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order.

Broadcast — In relation to Section XI, Information Management Systems, Item K., Social Networking: Video, audio, text, or email messages transmitted through an internet, cellular or wireless network for display on any device.

Direct Submitter (FFS PSNs Only) — A Medicaid fee-for-service provider that has been authorized by the fee-for-service Health Plan to submit electronic claims directly to the Agency's Medicaid fiscal agent for payment without requiring such claims to be submitted by the provider to the Health Plan for individual authorization and subsequent submission by that FFS Health Plan to the Medicaid fiscal agent. The FFS Health Plan must submit direct submitter authorization requests, in writing, to its Health Systems Development contract manager in order for such providers to be processed by the Medicaid fiscal agent for direct submitter inclusion. The payment reconciliation process specified in Attachment II, Section XIII, Method of Payment, includes claims submitted by direct submitters.

AHCA Contract No. FA904, Amendment No. 5, Page 1 of 45

Excluded Parties List System (EPLS) — The Excluded Parties List System (EPLS) is a federal database containing information regarding entities debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits.

Friends/Followers — In relation to Section XI, Information Management Systems, Item K., Social Networking: Persons that choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

Interactions — In relation to Section XI, Information Management Systems, Item K., Social Networking: Conversational exchange of messages.

Overpayment — Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Protected Health Information (PHI) — For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Health Plan from, or on behalf of the Agency.

Social Networking Applications — In relation to Section XI, Information Management Systems, Item K., Social Networking: Web-based services (excluding the Health Plan's State-mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation and instant messaging services.

Static Content — In relation to Section XI, Information Management Systems, Item K., Social Networking: Copy written by the Health Plan or taken from an outside authoritative source for web posting, for any period of time, shall be defined as Static Content and considered member materials under Attachment II, Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, of this Contract. Static content does not include individualized emails or status messages.

Tags/Tagging — In relation to Section XI, Information Management Systems, Item K., Social Networking: Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.

Username — In relation to Section XI, Information Management Systems, Item K., Social Networking: An identifying pseudonym associating the author to messages or content generated.

3. Attachment II, Core Contract Provisions, Section II, General Overview, Item D., General Responsibilities of the Health Plan, sub-item 4.a. is hereby amended to now read as follows:
 - a. The Health Plan shall provide written materials for Agency review as follows unless specified elsewhere in the Contract:
 - (1) Third party administrator subcontracts for FFS PSNs to BMHC at least ninety (90) calendar days before the effective date of the subcontract or change;
 - (2) Managed Behavioral Health Organization subcontracts to BMHC at least forty-five (45) calendar days before the effective date of the subcontract or change; and
 - (3) Other written materials to BMHC at least forty-five (45) calendar days before the effective date of the material or change.
4. Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, Item C., Disenrollment, sub-item 4., Involuntary Disenrollment Requests, is hereby amended to include sub-item a.(3) as follows:
 - (3) Falsification of prescriptions by an enrollee. In such cases the Health Plan shall report the event to MPI.
5. Attachment II, Core Contract Provisions, Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, sub-item 6.a.(12) is hereby amended to change the telephone number to (850) 412-4502.
6. Attachment II, Core Contract Provisions, Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, sub-item 6.a.(23) is hereby amended to now read as follows:
 - (23) Procedures for reporting fraud, abuse and overpayment that includes the following specific language:
 - (a) To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx;
 - (b) If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of \$500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

7. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, sub-item 2.e. is hereby amended to now read as follows:
 - e. The Health Plan shall cover fluoride treatment by a physician or a dentist for children/adolescents even if the Health Plan does not provide dental coverage. Fluoride varnish application in a physician's office is limited to children up to three and one half (3 ½) years (42 months) of age.
8. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, sub-item 8., Out of Plan Use of Non-Emergency Services, the third sentence is hereby amended to now read as follows:

Written follow-up documentation of the approval must be provided to the out-of-network provider within one (1) business day after the approval.
9. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, sub-item 16.j. is hereby amended to now read as follows:
 - j. Capitated Health Plans shall submit behavioral health pharmacy encounter data if behavioral health is a Health Plan covered service, to the BMHC secure file transfer protocol site in a format supplied by the Agency on an on-going quarterly schedule, as specified in Attachment II, Section XII, Reporting Requirements and the Health Plan Report Guide.
10. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, is hereby amended to include sub-item 16.I. as follows:
 - I. Capitated health plans may have a pharmacy lock-in program that conforms to the requirements in the Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, provided it is submitted in writing to BMHC and approved by the Agency in advance of implementation.
11. Attachment II, Core Contract Provisions, Section VII, Provider Network, Item B., Network Standards, sub-item 3.c. is hereby amended to include the following:

The Health Plan shall not deny claims for services delivered by these providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred and sixty-five (365) calendar days, and shall be reimbursed by the Health Plan at the rate negotiated between the Health Plan and the public provider or the applicable Medicaid fee-for-service rate. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD cost-based rate as specified by the County Health Department Clinic Services Coverage and Limitations Handbook for applicable rates.
12. Attachment II, Core Contract Provisions, Section VII, Provider Network, Item H., Credentialing and Recredentialing, sub-item 2.c.(2) is hereby amended to now read as follows:
 - (2) The Health Plan shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;

13. Attachment II, Core Contract Provisions, Section VII, Provider Network, Item H., Credentialing and Recredentialing, is hereby amended to now include sub-item 8. as follows:
8. The Health Plan shall submit disclosures and notifications to the federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in Section X, E.,11., Fraud and Abuse Prevention, of this Contract.
14. Attachment II, Core Contract Provisions, Section VIII, Quality Management, Item A., Quality Improvement, sub-item 3.a.(7) is hereby deleted in its entirety and replaced with the following:
- (7) PIP Documentation
- (a) PIP Proposal
- (i) Within ninety (90) calendar days after initial Contract execution, the Health Plan shall submit to the BMHC, in writing, a proposal for each planned PIP.
- (ii) Each PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. The EQRO PIP validation form may be obtained from the following website: www.myfloridaeqro.com/. Instructions for using the form to submit PIP proposals and updates may be obtained from the BMHC.
- (iii) Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal.
- (iv) In the event the Health Plan elects to modify a portion of the PIP proposal after initial Agency approval, a written request to do so must be submitted to the BMHC.
- (b) Annual PIP Submission
- (i) The Health Plan shall submit on-going PIPs annually by August 1st to the BMHC for review and approval.
- (ii) The Health Plan shall update the EQRO PIP validation form in its annual submission to reflect the Health Plan's progress. The Health Plan is not required to transfer on-going PIPs to a new, updated EQRO form.
- (iii) The Health Plan shall submit the BMHC-approved EQRO PIP validation form to the EQRO upon its request for validation. The Health Plan shall not make changes to the BMHC-approved PIP being submitted to the EQRO unless expressly permitted by the BMHC in writing.
15. Attachment II, Core Contract Provisions, Section VIII, Quality Management, Item A., Quality Improvement, sub-item 4.a., Cultural Competency Plan, the third sentence is hereby amended to now read as follows:
- The CCP shall be updated annually and submitted to BMHC by June 1st for approval for implementation by September 1st of each Contract year.

16. Attachment II, Core Contract Provisions, Section IX, Grievance System, Item A., General Requirements, sub-item 8. is hereby amended to now read as follows:
 8. The Health Plan shall keep a log of complaints that do not become grievances, including date, complainant and enrollee name(s), nature of complaint, description of resolution and final disposition. The Health Plan shall submit this report upon request of the Agency.
17. Attachment II, Core Contract Provisions, Section IX, Grievance System, Item E., Resolution and Notification, sub-item 7.c.(4) is hereby amended to change the telephone number to (850) 412-4502.
18. Attachment II, Core Contract Provisions, Section X, Administration and Management, Item B., Staffing, is hereby amended to include sub-item 2.m. as follows:
 - m. Social Networking Administrator: If the Health Plan elects to use social networking, the Health Plan shall have a Social Networking Administrator, who may hold another position, but is ultimately responsible for policy development, implementation and oversight of all social networking activities.
19. Attachment II, Core Contract Provisions, Section X, Administration and Management, Item E., Fraud and Abuse Prevention, is hereby deleted and replaced in its entirety as follows:

E. Fraud and Abuse Prevention

1. The Health Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 74; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and 59A-12.0073, 59G and 69D-2, FAC.
2. The Health Plan's compliance officer as described in Attachment II, Section X, Administration and Management, Item B., Staffing, sub-item 2.j., shall have unrestricted access to the Health Plan's governing body for compliance reporting, including fraud and abuse and overpayment.
3. The Health Plan shall have adequate staffing and resources to enable the compliance officer to investigate unusual incidents and develop and implement corrective action plans relating to fraud and abuse and overpayment.
 - a. The Health Plan shall establish and maintain a fraud investigative unit to investigate possible acts of fraud, abuse or overpayment, or may subcontract such functions.
 - b. If a Health Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Health Plan shall file the following with the Bureau of Medicaid Program Integrity (MPI) for approval at least sixty (60) calendar days before subcontract execution:
 - (1) The names, addresses, telephone numbers, e-mail addresses, and fax numbers of the principals of the entity with which the Health Plan wishes to subcontract;

- (2) A description of the qualifications of the principals of the entity with which the Health Plan wishes to subcontract; and
- (3) The proposed subcontract.
 - c. The Health Plan shall submit to MPI such executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty (30) calendar days after execution.
 - d. The Health plan shall notify MPI and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) calendar days after execution of such agreements.
 - e. The Health Plan shall notify MPI and provide a copy of any corrective action plans required by the Department of Financial Services (DFS) and/or federal governmental entities, excluding AHCA, within thirty (30) calendar days after execution of such plans.
4. The Health Plan's written fraud and abuse prevention program shall have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, correct and report known or suspected fraud and abuse activities.
5. The Health Plan shall submit its compliance plan, anti-fraud plan, and its fraud and abuse policies and procedures, or any changes to these items, to MPI for written approval at least forty-five (45) calendar days before those plans and procedures are implemented.
 - a. At a minimum the compliance plan shall include:
 - (1) Written policies, procedures and standards of conduct that articulate the Health Plan's commitment to comply with all applicable federal and state standards;
 - (2) The designation of a compliance officer and a compliance committee accountable to senior management;
 - (3) Effective training and education of the compliance officer and the Health Plan's employees
 - (4) Effective lines of communication between the compliance officer and the Health Plan's employees;
 - (5) Enforcement of standards through well-publicized disciplinary guidelines;
 - (6) Provision for internal monitoring and auditing; and
 - (7) Provisions for prompt response to detected offenses and for development of corrective action initiatives.

- b. At a minimum, the Health Plan shall submit its anti-fraud plan to MPI annually on July 1st. The anti-fraud plan shall comply with s. 409.91212, F.S., and, at a minimum, shall include:
- (1) A written description or chart outlining the organizational arrangement of the Health Plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, or fraud;
 - (2) A description of the Health Plan's procedures for detecting and investigating possible acts of fraud, abuse, and overpayment;
 - (3) A description of the Health Plan's procedures for the mandatory reporting of possible overpayment, abuse, or fraud to MPI;
 - (4) A description of the Health Plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, and overpayment;
 - (a) At a minimum, training shall be conducted within thirty (30) calendar days of new hire and annually thereafter;
 - (b) The Health Plan shall have a methodology to verify training occurs as required; and
 - (c) The Health Plan shall also include deficit reduction act requirements in the training curriculum.
 - (5) The name, address, telephone number, e-mail address, and fax number of the individual responsible for carrying out the anti-fraud plan; and
 - (6) A summary of the results of the investigations of fraud, abuse, or overpayment which were conducted during the previous year by the Health Plan's fraud investigative unit.
- c. At a minimum, the Health Plan's compliance plan, anti-fraud plan, and fraud and abuse policies and procedures shall comply with s. 409.91212, F.S., and with the following:
- (1) Ensure that all officers, directors, managers and employees know and understand the provisions;
 - (2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Health Plan assure that non-participating providers are compliant with this Contract, but the Health Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected;
 - (3) Describe the Health Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols;

- (4) Incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including, but not limited to:
 - (a) Claims edits;
 - (b) Post-processing review of claims;
 - (c) Provider profiling, credentialing, and recredentialing, including a review process for claims and encounters that shall include providers and non-participating providers:
 - (i) Who demonstrate a pattern of submitting falsified encounter data or service reports;
 - (ii) Who demonstrate a pattern of overstated reports or up-coded levels of service;
 - (iii) Who alter, falsify or destroy clinical record documentation;
 - (iv) Who make false statements relating to credentials;
 - (v) Who misrepresent medical information to justify enrollee referrals;
 - (vi) Who fail to render medically necessary covered services they are obligated to provide according to their provider contracts;
 - (vii) Who charge enrollees for covered services; and
 - (viii) Who bill for services not rendered;
 - (d) Prior authorization;
 - (e) Utilization management;
 - (f) Subcontract and provider contract provisions;
 - (g) Provisions from the provider and the enrollee handbooks; and
 - (h) Standards for a code of conduct;
- (5) Contain provisions pursuant to this section for the confidential reporting of Health Plan violations to MPI and other agencies as required by law;
- (6) Include provisions for the investigation and follow-up of any reports;
- (7) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse;
- (8) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, Health Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under state and/or federal law be reported to MPI within fifteen (15) calendar days of detection. Additionally, any final resolution reached by the Health Plan shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter;

- (9) Ensure that the Health Plan and all providers and subcontractors, upon request and as required by state and/or federal law, shall:
 - (a) Make available to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS any and all administrative, financial and medical records and data relating to the delivery of items or services for which Medicaid monies are expended; and
 - (b) Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS to any place of business and all medical records and data, as required by state and/or federal law. Access shall be provided during normal business hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have after-hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances;
- (10) Ensure that the Health Plan shall cooperate fully in any investigation by federal and state oversight agencies and any subsequent legal action that may result from such an investigation;
- (11) Ensure that the Health Plan does not retaliate against any individual who reports violations of the Health Plan's fraud and abuse policies and procedures or suspected fraud and abuse;
- (12) Not knowingly have affiliations with individuals debarred or excluded by federal agencies under ss. 1128 and 1128A of the Social Security Act and 42 CFR 438.610;
- (13) Check monthly the federal List of Excluded Individuals and Entities (LEIE), or its equivalent, and the federal Excluded Parties List System (EPLS) to identify excluded parties during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Health Plan shall not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act;
- (14) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:
 - (a) The False Claim Act;

- (b) The penalties for submitting false claims and statements;
 - (c) Whistleblower protections;
 - (d) The law's role in preventing and detecting fraud, waste and abuse;
 - (e) Each person's responsibility relating to detection and prevention; and
 - (f) The toll-free state telephone numbers for reporting fraud and abuse.
6. The Health Plan shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI
7. In accordance with s. 6032 of the federal Deficit Reduction Act of 2005, the Health Plan shall make available written fraud and abuse policies to all employees. If the Health Plan has an employee handbook, the Health Plan shall include specific information about s. 6032, the Health Plan's policies, and the rights of employees to be protected as whistleblowers.
8. The Health Plan shall comply with all reporting requirements as set forth below; and in s. 409.91212, F.S.; Attachment II, Section XII, Reporting Requirements; and the Health Plan Report Guide.
- a. The Health Plan shall report on a quarterly basis a comprehensive fraud and abuse prevention activity report regarding its investigative, preventive, and detective activity efforts.
 - b. The Health Plan shall, by September 1st of each year, report to MPI its experience in implementing an anti-fraud plan, and, on conducting or subcontracting for investigations of possible fraudulent or abusive acts during the prior state fiscal year. The report must include, at a minimum:
 - (1) The dollar amount of health plan losses and recoveries attributable to overpayment, abuse and fraud; and
 - (2) The number of health plan referrals to MPI.
9. The Health Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect and overpayment issues.
10. Notwithstanding any other provisions related to the imposition of sanctions or fines in this Contract, including any attachments, exhibits, addendums or amendments hereto, if the Health Plan fails to comply with the requirements of s. 409.91212, F.S., the Agency shall impose those administrative fines set forth in s. 409.91212(5) and (6), F.S.
11. The Health Plan shall notify DHHS OIG and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s.1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.

- a. In accordance with 42 CFR 455.106, the Health Plan shall disclose to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:
 - (1) Has ownership or control interest in the Health Plan, or is an agent or managing employee of the Health Plan; and
 - (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
- b. In addition to the disclosure required under 42 CFR 455.106, the Health Plan shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, to additionally disclose any person who:
 - (1) Has ownership or control interest in a Health Plan network provider, or subcontractor, or is an agent or managing employee of a Health Plan network provider or subcontractor; and
 - (2) Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs;
 - (3) Has been denied initial entry into the Health Plan's network for program integrity-related reasons; or
 - (4) Is a provider against whom the Health Plan has taken any action to limit the ability of the provider to participate in the Health Plan's provider network, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or Health Plan provider network to avoid a formal sanction.
- c. The Health Plan shall submit the written notification referenced above to DHHS OIG via email to: floridaexclusions@oig.hhs.gov and copy MPI via email to: mpifo@ahca.myflorida.com. Document information examples include but are not limited to court records such as indictments, plea agreements, judgments, and conviction/sentencing documents.
- d. In lieu of an email notification, a hard copy notification is acceptable to DHHS OIG at:

Attention: Florida Exclusions
Office of the Inspector General
Office of Investigations
7175 Security Boulevard, Suite 210
Baltimore, MD 21244

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With a copy to MPI at:

Attention: Florida Exclusions
Office of the Inspector General
Medicaid Program Integrity
2727 Mahan Drive, M.S. #6
Tallahassee, FL 32308-5403

20. Attachment II, Core Contract Provisions, Section XI, Information Management and Systems, is hereby amended to include Item K., Social Networking as follows:

K. Social Networking

This section provides requirements for policy development, permitted uses of applications and acceptable content for social networking. If the Health Plan chooses to use social networking applications/tools in its Medicaid line of business, these contract requirements apply to it and all communications by the Health Plan or its subcontractors with enrollees, providers and website requirements, when conducted through social networking applications.

1. General Requirements

- a. The Health Plan shall establish a social networking administrator, who can hold another position, but is ultimately responsible for the Health Plan's policy development, implementation and oversight of all social networking activities.
- b. The Health Plan shall develop and maintain written social networking policies and procedures and a social networking monitoring plan in accordance with this Contract. The policies and procedures shall include a statement of purpose/general information stating how the Health Plan uses social networking; for example, customer service, community outreach or notifications to enrollees and/or providers. The social networking monitoring plan shall be developed in accordance with sub-item 5., Monitoring, of this section.
 - (1) The Health Plan shall submit these policies, procedures and monitoring plan, including the intended uses and all initial social networking site static, distributed or broadcast content to BMHC for approval sixty (60) calendar days prior to the launch of any new social networking application.
- (a) Changes in social networking usage and/or content must be submitted to BMHC for approval sixty (60) calendar days prior to the effective date of the change.
- (b) The Health Plan shall evaluate and annually submit these policies, procedures and monitoring plan, including social networking site content to BMHC each September 1st. However, if the policies, procedures or monitoring plan have been approved by BMHC within six (6) months prior to the annual evaluation/submission above, and are unchanged from the previous Contract year, the Health Plan shall submit an attestation to BMHC that the prior year's social networking policies, procedures and monitoring plan are still in place.

- (2) The policies and procedures must include the requirement that, when using social networking applications, the protection of PHI and all HIPAA Privacy Rule-related information must be maintained and monitored. The Health Plan shall ensure that social networking records are maintained in accordance with this Contract, for the purposes of monitoring of this requirement.
 - (3) The social networking policies and procedures shall identify management resources, internal teams, external management resources (subcontractors) and human resources needed or used to monitor usage, analyze information trends and prepare responses for the public or private individuals/organizations.
 - (4) The social networking policies and procedures shall specify record retention requirements in accordance with this Contract, and include those records kept of each update and who is responsible for the update as it occurs, updates, communications or messages posted, with identifying handle or representative code in order to specify which Health Plan employee has issued the communication.
- c. The Health Plan shall develop and maintain a social networking matrix that identifies staff and subcontractors participating in social networking activities on behalf of the Health Plan. The Health Plan shall provide the Agency with unrestricted access to this matrix upon request. This matrix shall be updated within one (1) business day of any change and include the following information for each person:
- (1) The social networking application name; for example, MySpace, Twitter, facebook, Nixle.com, etc.;
 - (2) First and last name of the individual;
 - (3) Username (if applicable);
 - (4) Email address;
 - (5) Password; and
 - (6) Description of the social networking role, responsibility usage and control.
- d. The Health Plan shall provide to its employees instruction and training on this Contract and the Health Plan's social networking policies and procedures before using social networking applications on behalf of the Health Plan.
- e. The Health Plan is vicariously liable for any social networking violations of its employees, agents, vendors or subcontractors.
- (1) In addition to any other sanctions available in Attachment II, Section XIV, Sanctions, any violations of this section shall subject the Health Plan to administrative action by the Agency as determined by the Agency. The Health Plan may dispute any such administrative action pursuant to Attachment II, Section XVI, Terms and Conditions, Item I., Disputes.

- (2) The Health Plan shall report to BMHC any Health Plan staff who violates any requirements of the social networking policies and procedures or of this Contract within fifteen (15) calendar days of knowledge of such violation.
- f. The Health Plan shall comply with copyright and intellectual property law and shall reference or cite sources appropriately on all social networking sites.
- g. In addition to all other review and monitoring aspects of this Contract, the Agency reserves the right to monitor or review the Health Plan's monitoring of all social networking activity without notice.
- h. The Health Plan shall ensure its social networking applications and sites comply with the community outreach and marketing requirements specified in Attachment II, Section IV, Enrollee Services, Community Outreach and Marketing, Item B., Community Outreach and Marketing, of this Contract.

2. Social Networking Applications

- a. The following social networking applications or media communications are permitted by the Agency upon its written approval:
 - (1) Micro-blogging/Presence applications: Twitter, Plurk, Tumblr, Jaiku, fmylife;
 - (2) Social networking: Bebo, Facebook, LinkedIn, MySpace, Orkut, Skyrock, Hi5, Ning, Elgg;
 - (3) Social Network aggregation: NutshellMail, FriendFeed; and
 - (4) Events: Upcoming, Eventful, Meetup.com.
- b. Unless listed in a. above, the following Health Plan social networking sites or media are prohibited. Examples of prohibited social networking sites or media include but are not limited to:
 - (1) Collaboration
 - (a) Wikis: Wikipedia, PBwiki, wetpaint;
 - (b) Social bookmarking (or social tagging): Delicious, StumbleUpon, Google Reader, CiteULike;
 - (c) Social news: Digg, Mixx, Reddit, NowPublic; and
 - (d) Opinion sites: epinions, Yelp.
 - (2) Multimedia
 - (a) Photo sharing: Flickr, Zoomr, Photobucket, SmugMug, Picasa;
 - (b) Video sharing: YouTube, Vimeo, sevenload;
 - (c) Livecasting: Ustream.tv, Justin.tv, Stickam; and

- (d) Audio and Music sharing: imeem, The Hype Machine, Last.fm, ccMixer.
- (3) Reviews and Opinions
 - (a) Product Reviews: epinions.com, MouthShut.com; and
 - (b) Community Q&A: Yahoo! Answers, WikiAnswers, Askville, Google Answers.
- (4) Entertainment
 - (a) Media and Entertainment Platforms: Cisco Eos;
 - (b) Virtual worlds: Second Life, The Sims Online, Forterra; and
 - (c) Game sharing: Miniclip, Kongregate.
- (5) Other
 - (a) Information aggregators: Netvibes, Twine (website);
 - (b) Platform providers: Huzu; and
 - (c) Blogs: Blogger, LiveJournal, Open Diary, TypePad, WordPress, Vox, Expression Engine.
- c. In any invitation, link or information about third party social networking applications or sites presented by the Health Plan that requires a user to have a membership, the Health Plan shall clearly advise users of the following:
 - (1) That participation will require the user to become a member of the third party host;
 - (2) Disclaim the Health Plan's responsibility for the third party membership; and
 - (3) That the third party controls the membership, privacy, and data exchanged, and may use information for its own marketing purposes (or sell it.)

3. User Requirements

- a. The Health Plan's presence on such social networking sites shall include an avatar and/or a username that clearly indicates the Health Plan that is being represented and cannot use any Agency logo or State of Florida seal. When registering for social networking applications, the Health Plan shall use its email address. If the application requires a username, the following syntax shall be used: http://twitter.com/<Healthplan_identifier><username>
- b. The Health Plan shall personalize its interactions to include an identifying handle or representative code in order to specify which Health Plan employee has issued the communication. The Health Plan shall keep social networking records in accordance with social networking record retention requirements specified in Attachment II, Core Contract Provisions, Section XI, Information Management Systems, Item K., Social Networking, sub-item 1.b.(4).

- c. All Social Networking connections must be initiated by the external user and not the Health Plan.
- d. The Health Plan's social networking interactions with the public must either be general broadcast messages of information availability or responses to inquiry that contain only referral to authoritative resources such as the Health Plan or appropriate state or federal agency websites (including emergency public health advisories). The Health Plan shall not reference, cite, or publish information, views or ideas of any third party without the third party's written consent and only as permitted by the Agency for the purpose of conducting business in accordance with this Contract.
- e. The Health Plan may distribute updates, messages and reminders only to registered friends/followers who have chosen to receive these types of communication whether actively or passively (through a subscription initiated by the external user). Any subscription must be initiated by an opt-in from a user. Any communication resulting from such a subscription shall include a link/method to opt-out of the subscription.
- f. The Health Plan shall not conduct business relating to this Contract that involves the communication of personal identifying, confidential or sensitive information on a Health Plan social network application.
- g. The Health Plan shall place photographs on pages that are hosted on the site and not linked from outside web pages. The Health Plan shall not post information, photos, links/URLs or other items online that would reflect negatively on any individual(s), its enrollees, the Agency or the state.
- h. The Health Plan shall not place/embed video on its social networking sites.
- i. The Health Plan shall not tag photographic or video content and must remove all tags placed by others upon discovery.
- j. The Health Plan shall not allow advertising, whether targeted or general, on its social networking sites.
- k. The Health Plan shall not use affiliate/referral links or banners on its social networking sites. This includes links to other non-Medicaid lines of business in which the Health Plan or a parent company is engaged. The Health Plan shall ensure the following:
 - (1) Any site that automatically generates such linkage, recommendation, or endorsement on side bars or pop-ups must contain a message prominently displayed in the area under the Health Plan's control that such items, resources, and companies are NOT endorsed by the Health Plan or the Agency; and
 - (2) Any external links on any websites controlled by the Health Plan must be clearly identified as external links and must pop up a warning dialog when clicked on informing the user that they are leaving the Health Plan site.

4. Functionalities

a. The following functionalities are permitted:

- (1) Search – Finding information through keyword search;
- (2) Links – Guides to other related information; and
- (3) Signals – The use of syndication technology such as RSS to notify users of content changes.

b. The following functionalities are prohibited:

- (1) Authoring – The ability to create and update content leads to the collaborative work of many rather than just a few web authors. In wikis, users may extend, undo and redo each other's work. In blogs, posts and the comments of individuals build up over time;
- (2) Tags – Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories;
- (3) Extensions – Software that makes the Web and application platform as well as a document server; and
- (4) Forums – Sites hosted by a company that allow users to create topics (threads) and post comments, questions, etc., that are available for public conversation among all members in the forum.

5. Monitoring

The Health Plan shall include the following social networking areas in its monitoring:

- a. Social networking matrix of users as specified in Section K.1.c. of this section;
- b. Social networking content updates and posting;
- c. Social networking records retention; and
- d. Social networking permitted and prohibited activities and functionalities.

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21. Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, Item A., Health Plan Reporting Requirements, Table 1-A, Revised Summary of Reporting Requirements, is hereby deleted in its entirety and replaced with Table 1-B, Revised Summary of Reporting Requirements, as follows. All references in the Contract to Table 1-A shall hereinafter refer to Table 1-B.

TABLE 1-B
REVISED SUMMARY OF REPORTING REQUIREMENTS

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section II and Exhibit 2	Benefit Maximum Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC	Monthly , fifteen (15) calendar days after the end of the reporting month in which claims reach \$450,000 in enrollee costs	HSD Contract Manager once \$450,000 is reached, and to BMHC that initial month and monthly thereafter through the end of the Contract year
Section III and Exhibit 3	Newborn Enrollment Report	NR FFS PSN; Ref FFS PSN; CCC	Weekly , on Wednesday	Medicaid Area Office
Section III and Exhibit 3	Involuntary Disenrollment Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly , first Thursday of month	Choice Counseling Vendor
Section IV	Medicaid Redetermination Notice Summary Report	All Plans that participate per Attachment I	Quarterly , forty-five (45) calendar days after end of reporting quarter	BMHC
Section IV	Community Outreach Health Fairs/Public Events Notification	All Plans	Monthly, no later than 20 th calendar day of month before event month; amendments two (2) weeks before event	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section IV	Community Outreach Representative Report	All Plans	Two (2) weeks before activity Quarterly , forty-five (45) calendar days after end of reporting quarter	BMHC
Section V and Exhibit 4	Enhanced Benefits Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly , ten (10) calendar days after end of reporting month	BMHC
Section V, Exhibit 5	Customized Benefit Notifications Report	Ref HMO; Ref Cap PSN	Monthly , fifteen (15) calendar days after end of reporting month	BMHC
Section V	CHCUP (CMS-416) & FL 60% Screening (Child Health Check Up report)	All Plans	Annually , unaudited by January 15 th for prior federal fiscal year; Annually , audited report by October 1 st	BMHC
Section V	Inpatient Discharge Report	NR Ref HMO; NR Cap PSN; Ref HMO; Ref Cap PSN; HIV/AIDS	Quarterly , thirty (30) calendar days after end of reporting quarter	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section V	Hernandez Settlement Ombudsman Log	NR HMO; NR FFS PSN*; NR Cap PSN; Ref HMO; Ref FFS PSN*; Ref Cap PSN; CCC*; HIV/AIDS * If the FFS Health Plan has authorization requirements for prescribed dru services	Quarterly, fifteen (15) calendar days after end of reporting quarter	BMHC
Section V	Hernandez Settlement Agreement Survey	NR HMO; NR FFS PSN*; NR Cap PSN; Ref HMO; Ref FFS PSN*; Ref Cap PSN; CCC*; HIV/AIDS * If the FFS Health Plan has authorization requirements for prescribed drug services	Annually, on August 1 st	BMHC
Section V and Exhibit 6	Behavioral Health – Pharmacy Encounter Data Report	NR HMO; Ref HMO; Ref Cap PSN; HIV/AIDS	Quarterly, forty-five (45) calendar days after end of Reporting quarter	BMHC
Section V	Pharmacy Navigator Report	Ref HMO; Ref Cap PSN; HIV/AIDS	Annually, by December 1 st	Choice Counseling Vendor

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section VI, Exhibit 6	Behavioral Health Annual 80/20 Expenditure Report	NR HMO	Annually, by April 1 st ; Supplemental file due February 1 st of the following year for plans that reported IBNR	BMHC
Section VI, Exhibit 6	Behavioral Health Critical Incident Report - Individual	NR HMO; Ref-HMO; Ref. FFS PSN; Ref Cap. PSN; CCC; HIV/AIDS	Immediately, no later than twenty-four (24) hours after occurrence or knowledge of incident	BMHC
Section VI, Exhibit 6	Behavioral Health Critical Incident Report - Summary	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly, by the 15 th	BMHC
Section VI, Exhibit 6	Behavioral Health - Required Staff/Providers Report	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Quarterly, forty-five (45) calendar days after end of reporting quarter for Health Plans operating less than one (1) year; Annually, by August 15 th , for all other Health Plans	BMHC
Section VI, Exhibit 6	Behavioral Health - FARS/CFARS	NR HMO Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Semi-Annually, August 15 th and February 15 th	BMHC
Section VI, Exhibit 6	Behavioral Health - Enrollee Satisfaction Survey Summary	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Annually by March 1 st	BMHC behavioral health analyst

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section VI, Exhibit 6	Behavioral Health - Stakeholders' Satisfaction Survey Summary	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Annually, by March 1 st	BMHC
Section VI, Exhibit 6	Behavioral Health - Encounter Data Report	NR HMO; Ref HMO; Ref Cap PSN; HIV/AIDS	Quarterly, forty-five (45) calendar days after end of reporting quarter	BMHC
Section VII	Provider Network File	All Plans	Monthly, first Thursday of month (optional weekly submissions each Thursday for remainder of month)	AHCA Choice Counseling Vendor and Medicaid fiscal agent for Reform; For non-Reform, to Medicaid fiscal agent and BMHC
Section VII	Provider Termination and New Provider Notification Report	All Plans	Summary of new and terminated providers due monthly, by the fifteenth (15 th) calendar day of the month following the reporting month	BMHC
Section VII	PCP Wait Times Report	All Plans	Annually, by February 1 st	BMHC
Section VIII	Cultural Competency Plan (and Annual Evaluation)	All Plans	Annually, June 1 st	BMHC
Section VIII and Exhibit 5	Performance Measures	All Plans	Annually, on July 1 st	BMQM
Section IX	Complaints, Grievance, and Appeals Report	All Plans	Quarterly, fifteen (15) calendar days after end of quarter	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section X	MPI – Quarterly Fraud & Abuse Activity Report	All Plans	Quarterly, fifteen (15) calendar days after the end of reporting quarter	MPI
Section X	MPI – Annual Fraud & Abuse Activity Report	All Plans	Annually by September 1 st .	MPI
Section X	MPI - Suspected/Confirmed Fraud & Abuse Reporting	All Plans	Within fifteen (15) calendar days of detection	MPI
Section X	Claims Aging Report & Supplemental Filing Report	All Plans	Quarterly, forty-five (45) calendar days after end of reporting quarter; Capitated Plans, optional supplemental filing – one-hundred and five (105) calendar days after end of reporting quarter	BMHC
Section XIII, Exhibit 13	Medicaid Reform Supplemental HIV/AIDS Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly, by second Thursday of month	BMHC
Section XIII, Exhibit 13	Catastrophic Component Threshold Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC per Attachment I	Monthly, fifteen (15) calendar days after end of reporting month	BMHC
Section XV, Exhibit 15	Insolvency Protection Multiple Signatures Agreement Form	NR HMO; NR Cap PSN; Ref HMO; Ref Cap PSN; HIV/AIDS	Annually, by April 1 st ; Thirty (30) calendar days after any change	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section XV	Audited Annual and Unaudited Quarterly Financial Reports	All Plans except CCC	Audited - Annually by April 1 st for calendar year; Unaudited – Quarterly, forty-five (45) calendar days after end of reporting quarter	BMHC

NR HMO = Non-Reform health maintenance organization, includes Health Plans covering Frail/Elderly Program services as specified in Attachment I

Ref HMO = Reform health maintenance organization

Ref Cap PSN = Reform capitated provider service network

Ref FFS PSN = Reform Fee-for-Service Provider Service Network

NR Cap PSN = Non-Reform Capitated Provider Service Network

NR FFS PSN = Non-Reform Fee-for-Service Provider Service Network

CCC = Specialty plan for children with chronic conditions

HIV/AIDS = Specialty plan for recipients living with HIV/AIDS

22. Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, Item A., Health Plan Reporting Requirements, Table 2-B, Revised Summary of Submission Requirements, is hereby deleted in its entirety and replaced with Table 2-C, Revised Summary of Submission Requirements, as follows. All references in the Contract to Table 2-B shall hereinafter refer to Table 2-C.

TABLE 2-C

REVISED SUMMARY OF SUBMISSION REQUIREMENTS

Contract Section	Submission	Plan Type	Frequency	Submit To
Attachment I, Section B., Item 3.a.	Increase in enrollment levels	Capitated Health Plans; FFS PSNs; CCC	Before increases occur	BMHC and HSD
Attachment I, Section D., Item 3.b.	Changes to optional or expanded services	FFS PSNs; CCC	Annually, by June 15 th	HSD
Attachment I, Section D., Item 3.c.	Changes to optional or expanded services	Capitated Health Plans	Annually, by June 15 th	HSD

i. Subsequent references are to Attachment II and its Exhibits

Contract Section	Submission	Plan Type	Frequency	Submit To
Section II, Item D.4.	Policies, procedures, model provider agreements & amendments, subcontracts, All materials related to Contract for distribution to enrollees, providers, public	All	Before beginning use; whenever changes occur	BMHC
Section II, Item D.4.a.	Written materials	All	Forty-five (45) calendar days before effective date	BMHC
Section II, Item D.4.b	Written notice of change to enrollees	All	Thirty (30) calendar days before effective date	Enrollees affected
Section II, Item D.6.	Enrollee materials, PDL, provider & enrollee handbooks	All	Available on Health Plan's website without log-in	Plan website
Section III, Item B.3.c.(1)	Enrollee pregnancy	All	Upon confirmation	DCF & MPI
Section III, Item B.3.c.(3)	Unborn activation notice	All	Presentation for delivery	DCF & MPI
Section III, Item B.3.d.	Birth information if no unborn activation	All	Upon delivery	DCF
Section III, Item C.4.b.	Involuntary disenrollment request	All	Forty-five (45) calendar days before effective date	BMHC
Section III, Item C.4.e.	Notice that Health Plan is requesting disenrollment in next Contract month	All	Before effective date	Enrollees affected

Contract Section	Submission	Plan Type	Frequency	Submit To
Section IV, Item A.1.e.	Notice of reinstatement	All	By 1 st calendar day of month after learning of reinstatement or within five (5) calendar days from receipt of enrollment file, whichever is later	Enrollee affected
Section IV, Item A.2.a. and Item A.6.a.(17); Section VIII, Item A.4.	How to get Health Plan information in alternative formats	All	Include in cultural competency plan and enrollee handbook, and upon request	Enrollees & potential enrollees
Section IV, Item A.2.c.	Right to get information about Health Plan	All	Annually	Enrollees
Section IV, Item A.7.c.	Provider directory online file	All	Update monthly & submit attestation	BMHC
Section IV, Item A.9.a.	Enrollee assessments	All	Within thirty (30) calendar days of enrollment notify about pregnancy screening	Enrollees
Section IV, Item A.9.c.	Enrollees more than 2 months behind in periodicity screening	All	Contact twice, if needed	Enrollees who meet criteria
Section IV, Item A.11.f.	Toll-free help line performance standards	All	Get approval before beginning operation	BMHC
Section IV, Item A.12. and Item A.,6.a.(17); Section VIII, Item A.4.	How to access translation services	All	Include in cultural competence plan and enrollee handbook	Enrollees
Section IV, Item A.14.a.	Incentive program	All	Get approval before offering	BMHC
Section IV, Item A.14.g.	Pre-natal care programs	All	Before implementation	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Section IV, Item A.17.c.	Notice of change in participation in redetermination notices	All	Annually, by June 1 st , if change in plan participation	BMHC
Section IV, Item A.17.c.(1)	Redetermination policies & procedures	All	When Health Plan agrees to participate	BMHC
Section IV, Item A.17.c.(1)(a)	Notice in writing to discontinue Medicaid redetermination date data use	All	Thirty (30) calendar days before stopping	BMHC
Section IV, Item B.3.c.	Member services phone script responding to community outreach calls and outreach materials	All	Before use	BMHC
Section IV, Item B.4.c.	In case of force majeure, notice of participation in health fair or other public event	All	By day of event	BMHC
Section IV, Item B.6.f.	Report of staff or community outreach rep. violations	All	Within fifteen (15) calendar days of knowledge	BMHC
Section V, Item C.1.	Written details of expanded services	All	Before implementation	HSD
Section V, Item F.	Decision to not offer a service on moral/religious grounds	All	One-hundred and twenty (120) calendar days before implementation Thirty (30) calendar days before implementation	BMHC Enrollees

Contract Section	Submission	Plan Type	Frequency	Submit To
Section V, Item H.10.b.2.	UNOS form & disenrollment request for specified transplants	All	When enrollee listed	BMHC
Section V, Item H.14.e.	Attestation that the Health Plan has advised providers to enroll in VFC program	All	Annually, by October 1 st	BMHC
Section V, Item H.16.a.(4)	PDL update	All	Annually, by October 1 st . Thirty (30) calendar days written notice of change.	BMHC and Bureau of Medicaid Pharmacy Services
Section VII, Item A.2.	Capacity to provide covered services	All	Before taking enrollment	BMHC
Section VII, Item C.1.	Request for initial or expansion review	All	When requesting initial enrollment or expansion into a county.	BMHC and HSD
Section VII, Item C.2.	Compliance with access requirements following significant changes in service area or new populations	All	Before expansion	BMHC and HSD
Section VII, Item C.3.	Significant network changes	All	Within seven (7) business days	BMHC
Section VII, Item C.5.	When PCP leaves network	All	Within fifteen (15) calendar days of knowledge. A copy of the enrollee notice for terminated providers is due no more than fifteen (15) calendar days after receipt of the PCP termination notice.	BMHC & affected enrollees

Contract Section	Submission	Plan Type	Frequency	Submit To
Section VII, Item D.2.jj.	Waiver of provider agreement indemnifying clause	All	Approval before use	BMHC
Section VII, Item E.3.	Notice of terminated providers due to imminent danger/impairment	All	Immediate	BMHC and Provider
Section VII, Item E.4.	Termination or suspension of providers; for “for cause” terminations, include reasons for termination	All	Sixty (60) calendar days before termination effective date	BMHC, affected enrollees, & provider
Section VII, Item H.8.	Notice of individuals with conditions giving rise to permissive or mandatory exclusions	All	Within ten (10) business days of learning of the health care-related criminal conviction; or Denial of credentialing for program integrity related reasons, or other required disclosure.	DHHS OIG With a copy to MPI
Section VIII, Item A.1.b.	Written Quality Improvement Plan	All	Within thirty (30) calendar days of initial Contract execution; Thereafter, Annually by April 1 st .	BMHC
Section VIII, Item A.3.a.(7)(a)	Proposal for each planned PIP	All	Ninety (90) calendar days after Contract execution.	BMHC
Section VIII, Item A.3.a.(7)(b)	Annual PIP proposal for each planned PIP	All	Thereafter, Annually by August 1	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Section VIII, Item A.3.c.(1)	Performance measure data and auditor certification	All	Annually by July 1 st	BMQM
Section VIII, Item A.3.c.(4)	Performance measure action plan	All	Within thirty (30) calendar days of determination of unacceptable performance	BMQM
Section VIII, Item A.3.e.(7)	Written strategies for medical record review	All	Before use	BMHC
Section VIII, Item B.1.a.(4)(a)	Service authorization protocols & any changes	All	Before use	BMHC
Section VIII, Item B.4.	Changes to UM component	All	Thirty (30) calendar days before effective date	BMHC
Section IX, Item A.8.	Complaint log	All	Upon request	BMHC
Section X, Item B.2.	Changes in staffing	All	Five (5) business days of any change	BMHC & HSD
Section X, Item B.2.b.	Full-Time Administrator	All	Before designating duties of any other position	BMHC
Section X, Item D.3.a.	Reform and non-Reform historical encounter data for all typical and atypical services	All	According to Agency-approved schedules and no later than 10/31/09	MEDS team & Agency Fiscal Agent
Section X, Item D.3.b.	Encounter data for all typical and atypical services	All	Within sixty (60) calendar days following end of month in which Health Plan paid claims for services, and as specified in MEDS Companion Guide	MEDS Team & Agency Fiscal Agent
Section X, Item E.3.b.	Subcontract for investigation of Fraud and Abuse	All	At least sixty (60) calendar days before anticipated subcontract execution date	MPI

Contract Section	Submission	Plan Type	Frequency	Submit To
Section X, Item E.3.c.	Executed Subcontract for investigation of Fraud and Abuse	All	Within thirty (30) calendar days after subcontract execution	MPI
Section X, Item E.3.d.	Corporate Integrity Agreements and/or Corporate Compliance Agreements	All	Within thirty (30) calendar days after execution	MPI
Section X, Item E.3.e.	Corrective Action Plans required by the Florida Department of Financial Services (DFS) and/or Federal governmental entities	All	Within thirty (30) calendar days after execution	MPI
Section X, Item E.5.	Compliance plan, anti-fraud plan, and related fraud and abuse policies & procedures	All	Within forty-five (45) calendar days after Agency contract execution; Upon initial implementation or revision; or As requested by MPI	MPI
Section X, Item E.5.b.	Anti-fraud plan annual submission	All	Annually on July 1 st , upon revision, or as requested by MPI.	MPI

Contract Section	Submission	Plan Type	Frequency	Submit To
Section X, Item E.11.	Notice of individuals with conditions giving rise to permissive or mandatory exclusions	All	Within ten (10) business days of learning of the health care-related criminal conviction; or Denial of credentialing for program integrity related reasons, or other required disclosure.	DHHS OIG With a copy to MPI
Section XI, Item D.4.a.	Any problem that threatens system performance	All	Within one (1) hour	Applicable Agency staff
Section XI, Item D.8.a.	Business Continuity-Disaster Recovery Plan	All	Before beginning operation. Ten (10) business days before change. Certification if plan is unchanged by April 30th, annually thereafter.	BMHC
Section XI, Item E.1.	System changes	All	Ninety (90) calendar days before change	HSD

Contract Section	Submission	Plan Type	Frequency	Submit To
Section XI, Item K.1.b.	Social Networking policies, procedures and monitoring plan	All	Sixty (60) calendar days before beginning any new social networking application; Sixty (60) calendar days before change in policy, procedure or monitoring plan; Attestation if policies, procedures and monitoring plan are unchanged by September 1 of each Contract year.	BMHC
Section XI, Item K.1.b.	Social networking content and intended use	All	Sixty (60) calendar days before launch of any new social networking application or policy, procedure or monitoring plan; Sixty (60) calendar days before effective date of change in usage and/or content.	BMHC
Section XIV, Item A.1.(a)	Corrective action plan	All	Within ten (10) business days of notice of violation or non-compliance with Contract	Agency Bureau sending violation notice
Section XIV, Item A.1.(b)	Performance measure action plan	All	Within thirty (30) calendar days of notice of failure to meet a performance standard	BMQM
Section XV, Item C.	Proof of working capital	All	Before enrollment	BMHC
Section XV, Item G.2.	Physician incentive plan	All	Written description before use	BMHC
Section XV, Item H.	Third party coverage identified	All	As soon as known	Medicaid Third Party Liability Vendor

Contract Section	Submission	Plan Type	Frequency	Submit To
Section XV, Item I.	Proof of fidelity bond coverage	All	Within sixty (60) calendar days of Contract execution & before delivering health care	HSD Contract manager
Section XVI, Item C.1.	Request for assignment or transfer of contract in approved merger/acquisition	All	Ninety (90) days before effective date	HSD
Section XVI, Item M.	Use of "Medicaid" or "AHCA"	All	Before use	BMHC
Section XVI, Item O.	All subcontracts for Agency approval	All	Before effective date	BMHC
Section XVI, Item O.1.f.	Subcontract monitoring schedule	All	Annually, by December 1 st	BMHC
Section XVI, Item V.1.	Ownership & management disclosure forms	All	With initial application; and then annually by September 1 st	HSD – for initial application; BMHC & HSD for annual
Section XVI, Item V.1.	Changes in ownership & control	All	Within five (5) calendar days of knowledge & sixty (60) days before effective date	BMHC & HSD
Section XVI, Item V.4.a.	Fingerprints for principals	All	Before Contract execution.	HSD
Section XVI, Item V.4.c.	Fingerprints of newly hired principals	All except CCC	Within thirty (30) calendar days of hire date	HSD
Section XVI, Item V.5.	Information about offenses listed in 435.04	All	Within five (5) business days of knowledge	HSD
Section XVI, Item V.6.	Corrective action plan related to principals committing offenses under 435.04	All	As prescribed by the Agency	HSD

Contract Section	Submission	Plan Type	Frequency	Submit To
Section XVI, Item Y.	General insurance policy declaration pages	All except CCC	Annually upon renewal	BMHC
Section XVI, Item Z.	Workers' compensation insurance declaration page	All except CCC	Annually upon renewal	BMHC
Section XVI, Item BB.	Emergency Management Plan	All	Before beginning operation and by May 31st annually thereafter	BMHC
Exhibit 2, Section II, Item D.4.c.	Policies & procedures for screening for clinical eligibility & any changes to them	CCC	Before implementation	BMHC
Exhibit 3, Section III, Item C.5.	Disenrollment notice	CCC	Get template approved before use At least two (2) months before anticipated effective date of involuntary disenrollment	BMHC Enrollee
Exhibit 5, Section V, Item A.6.	Letters about exhaustion of benefits under customized benefit package	Reform capitated Health Plans	Before use	BMHC
Exhibit 5, Section V, Item H.20.g.	Transportation subcontract	NR HMO offering transportation; Reform Health Plans	Before execution	BMHC
Exhibit 5, Section V, Item H.20.h.	Transportation policies & procedures	NR HMO offering transportation; Reform Health Plans	Before use	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Exhibit 5, Section V, Item H.20.i.	Transportation adverse incidents	NR HMO offering transportation; Reform Health Plans	Within two (2) business days of the occurrence	BMHC
Exhibit 5, Section V, Item H.20.i.	Transportation suspected fraud	NR HMO offering transportation; Reform Health Plans	Immediately upon identification	MPI
Exhibit 5, Section V, Item H.20.p.	Transportation performance measures	NR HMO offering transportation; Reform Health Plans	Annually report by July 1st	BMQM
Exhibit 5, Section V, Item H.20.q. & r.	Attestation that Health Plan complies with transportation policies & procedures & drivers pass background checks & meet qualifications	NR HMO offering transportation; Reform Health Plans	Annually by January 1st	BMHC
Exhibit 6, Item A.3.	Review & approval of behavioral health services staff & subcontractors for licensure compliance	Reform Health Plans & NR HMOs	Before providing services	BMHC
Exhibit 6, Item B.9.	Model agreement with community mental health centers	Reform Health Plans & NR HMOs	Before agreement is executed	BMHC
Exhibit 6, Item C.3.e.	Denied appeals from providers for emergency services claims	Plans covering behavioral health	Within ten (10) calendar days after Health Plan's final denial	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Exhibit 6, Item C.5.a.(3)	Medical necessity criteria for community mental health services	Plans covering behavioral health	Before use and before changes implemented	BMHC
Exhibit 6, Item L.2.	MBHO staff psychiatrist and model contracts for each specialty type	Plans covering behavioral health	Before execution	BMHC
Exhibit 6, Item M.	Optional services	Plans covering behavioral health	Before offering	BMHC
Exhibit 6, Item R.3.a.	Schedule for administrative and program monitoring and clinical record review	Plans covering behavioral health	Annually by July 1 st	BMHC
Exhibit 8, Section VIII, Item B.5.	Substitute disease management initiatives	CCC	Within sixty (60) calendar days of Contract execution	BMHC
Exhibit 8, Section VIII, Item A.3.f.	Provider satisfaction survey plan & questions	All Reform Health Plans	By end of 8 th month of Contract for approval	BMHC
Exhibit 8, Section VIII, Item A.3.f.	Provider satisfaction survey results	All Reform Health Plans	Four (4) months after the beginning of the 2 nd year of Contract	BMHC
Exhibit 8, Section VIII, Item B.5.b.	Policies and procedures and program descriptions for each disease management program	All Reform Health Plans	Annually, by April 1 st	BMHC
Exhibit 8, Section VIII, Item B.1.e. (5)	Caseload maximums for case managers	HIV/AIDS specialty plan	Before providing services	BMHC
Exhibit 10, Section X, Item C.5.a.	Discrepancies in ERV	FFS Health Plans; CCC	Within ten (10) business days of discovery	HSD analyst

Contract Section	Submission	Plan Type	Frequency	Submit To
Exhibit 15, Section XV, Item A.1.a.	Conversion application to capitated Health Plan	FFS PSNs; CCC	By September 1, 2012	HSD
Exhibit 15, Section XV, Item I.	Proof of coverage for any non-government subcontractor	CCC	Within sixty (60) calendar days of execution and before delivery of care	BMHC
Exhibit 16, Section XVI, Item V.4.c.	Fingerprints of newly hired principals	CCC	Within thirty (30) calendar days of hire date	Letter to HSD contract manager with list of hires and FDLE screening results

NR HMO = Non-Reform health maintenance organization, includes Health Plans covering Frail/Elderly Program services as specified in Attachment I

Ref HMO = Reform health maintenance organization

Ref Cap PSN = Reform capitated provider service network

Ref FFS PSN = Reform Fee-for-Service Provider Service Network

NR Cap PSN = Non-Reform Capitated Provider Service Network

NR FFS PSN = Non-Reform Fee-for-Service Provider Service Network

CCC = Specialty plan for children with chronic conditions

HIV/AIDS = Specialty plan for recipients living with HIV/AIDS

23. Attachment II, Core Contract Provisions, Section XIV, Sanctions, Item A., General Provisions, sub-item 1.(b) is hereby amended to now read as follows:
- (b) If the Agency determines that the Health Plan has not met its performance standards, the Health Plan shall submit to the Bureau of Medicaid Quality Management (BMQM) a performance measure action plan (PMAP) within thirty (30) calendar days of receiving notice from the Agency.
24. Attachment II, Core Contract Provisions, Section XIV, Sanctions, Item E., Civil Monetary Penalties, is hereby amended to include sub-item 5. as follows:
5. Notwithstanding the provisions of this Section, the Health Plan is subject to the fines set forth in s. 409.91212, F. S. See Attachment II, Section X, Administration and Management, Item E., Fraud and Abuse Prevention, of this Contract.
25. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item C., Assignment, is hereby amended to include sub-item 5. as follows:
5. The entity requesting the assignment or transfer and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, particularly those requiring care coordination/case management.

26. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item O., Subcontracts, sub-item 1.c. is hereby amended to now read as follows:
- c. The Agency encourages use of minority business enterprise subcontractors. See Attachment II, Section VII, Provider Network, Item D., Provider Contract Requirements, for provisions and requirements specific to provider contracts. See Attachment II, Section XVI, Terms and Conditions, Item W., Minority Recruitment and Retention Plan, for other minority recruitment and retention plan requirements.
27. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item V., Ownership and Management Disclosure, sub-items 4., 5. and 6. are hereby deleted in their entirety and replaced as follows:
- 4. By September 1st of each Contract Year, the Health Plan shall conduct an annual background check with the Florida Department of Law Enforcement on all persons with five percent (5%) or more ownership interest in the Health Plan, or who have executive management responsibility for the Health Plan, or have the ability to exercise effective control of the Health Plan (see ss. 409.912 and 435.04, F.S.).
 - a. The Health Plan shall submit, prior to execution of this Contract, complete sets of fingerprints of principals of the Health Plan to HSD for the purpose of conducting a criminal history record check (see s. 409.907, F.S.).
 - b. Principals of the Health Plan shall be as defined in s. 409.907, F.S.
 - c. The Health Plan shall submit to the Agency Contract Manager complete sets of fingerprints of newly hired principals (officers, directors, agents, and managing employees) within thirty (30) calendar days of the hire date.
 - 5. The Health Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Health Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in s. 435.04, F.S. The Health Plan shall submit information to HSD for such persons who have a record of illegal conduct according to the background check. The Health Plan shall keep a record of all background checks to be available for Agency review upon request.
 - 6. The Agency shall not contract with a Health Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Health Plan, who has committed any of the above listed offenses (see ss. 409.912 and 435.04, F.S.). In order to avoid termination, the Health Plan shall submit a corrective action plan, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Health Plan.
28. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item W., Minority Recruitment and Retention Plan, the header row is hereby amended to now read as follows:

W. Minority Recruitment and Retention Plan

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29. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, is hereby amended to include Items DD through FF, as follows:

DD. Authority to Act

Any person executing this Contract or any documents, instruments or assurances, created, presented or reasonably necessary or appropriate to carry out the full intent and purpose of this Contract, in a representative capacity, hereby warrants to the Agency that it has implied, express or delegated authority to enter into, execute, attest or certify this Contract or aforementioned documents on behalf of such party which it represents. The Health Plan shall not raise the fact that a person executing a document, instrument or assurance as set forth herein lacks authority to bind the Health Plan for which it is representing as a defense to the enforcement of this Contract or other document executed in connection with this Contract.

EE. Proof of Execution by Electronic Copy or Facsimile.

For purposes of executing this Contract or any documents, instruments and assurances created, presented or reasonably necessary or appropriate to carry out the full intent and purpose of this Contract, a document signed or electronically signed and transmitted by facsimile, e-mail or other form of electronic transmission is to be treated as an original document. The signature or electronic signature of any party thereon, for purposes hereof, is to be considered as an original signature, and the document transmitted is to be considered to have the same binding effect as an original signature on an original document. At the request of the Agency, any document transmitted by facsimile, telecopy, e-mail or other form of electronic transmission is to be executed in original form by the Health Plan. The Health Plan shall not raise the fact that any signature was transmitted through the use of a facsimile, e-mail or other form of electronic transmission as a defense to the enforcement of this Contract or other document executed in connection with this Contract.

FF. Remedies Cumulative

Except as otherwise expressly provided herein, all rights, powers and privileges conferred hereunder upon the Health Plan are cumulative and not restrictive of those given by law. No remedy herein conferred is exclusive of any other available remedy; but each and every such remedy is cumulative and is in addition to every other remedy given by Contract or now or hereafter existing at law, in equity or by statute.

30. Attachment II, Core Contract Provisions, Exhibit 5, Covered Services, Item 2., Non-Reform Health Plans covering dental as an optional service and Reform Health Plans, Section V, Covered Services, Item H., Coverage Provisions, sub-item 3., Dental Services, is hereby deleted in its entirety and replaced with the following:

Dental services are defined in the Medicaid Dental Services Coverage and Limitations Handbook.

- a. For enrollees under age 21, the Health Plan shall cover diagnostic services, preventive treatment, CHCUP dental screening (including a direct referral to a dentist for enrollees beginning at three (3) years of age or earlier as indicated); restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, complete and partial dentures, complete and partial denture relines and repairs, and adjunctive and emergency services. Fluoride varnish application in a physician's office under CHCUP is limited to children up to three and one half (3 ½) years (42 months) of age. The Health Plan shall ensure the following for active orthodontia:

- (1) The Health Plan shall ensure continuity of care for active orthodontia until completion of care, regardless of provider network affiliation;
 - (2) The Health Plan shall ensure reimbursement to providers for active orthodontia until completion of care, regardless of provider network affiliation;
 - (3) The Health Plan shall ensure maintenance of written case management continuity of care protocol(s) that include the following minimum functions:
 - (a) Appropriate referral of and scheduling assistance for enrollees needing specialty dental care.
 - (b) Documentation of referral services in enrollees' dental records, including results.
 - (c) Monitoring enrollees with on-going dental conditions and coordination of services for high users such that the following functions are addressed as appropriate: acting as a liaison between the member and providers, ensuring the member is receiving routine dental care, ensuring that the member has adequate support at home, and assisting enrollees who are unable to access necessary care due to their medical or emotional conditions or who do not have adequate community resources to comply with their care.
 - (4) Documentation in dental records of member emergency encounters with appropriate indicated follow-up.
 - b. Adult services include adult full and partial denture services and medically necessary emergency dental procedures to alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary x-rays, extractions, and incision and drainage of abscess.
31. Attachment II, Core Contract Provisions, Exhibit 6, HMOs & Reform Health Plans, Behavioral Health Care, Item 1., Reform Health Plans and Non-Reform HMOs, sub-item A., General Provisions, sub-item 5., is hereby amended to now read as follows:
5. The Health Plan shall provide the following services as described in the Mental Health Targeted Case Management Coverage & Limitations Handbook and the Community Behavioral Health Services Coverage & Limitations Handbook (the Handbooks). The Health Plan shall not alter the amount, duration and scope of such services from that specified in the Handbooks. The Health Plan shall not establish service limitations that are lower than, or inconsistent with, the Handbooks.
 - a. Inpatient hospital services for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
 - b. Outpatient hospital services for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);

- c. Psychiatric physician services (for psychiatric specialty codes 42, 43, 44 and ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
 - d. Community mental health services (ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9); and for these procedure codes H0031; H0031HO; H0031HN; H0031TS; H0032; H0032TS; H0046; H2000; H2000HO; H2000HP; H2010HO; H2010HE; H2010HQ; H2012; H2017; H2019; H2019HM; H2019HN; H2019HO; H2019HQ; H2019HR; T1015; T1015HE; or T1023HE;
 - e. Community substance abuse services when the appropriate ICD-9 CM diagnosis code (290 through 290.43, 293 through 298.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9) has been documented: H0001, H0001HN; H0001HO, H0001TS, H0047, H2010HF, H2012HF, T1007, T1007TS, T1015HF or T1023HF;
 - f. Mental Health Targeted Case Management (Children: T1017HA; Adults: T1017); and
 - g. Mental Health Intensive Targeted Case Management (Adults: T1017HK).
32. Attachment II, Core Contract Provisions, Exhibit 6, HMOs & Reform Health Plans, Behavioral Health Care, Item 1., Reform Health Plans and Non-Reform HMOs, sub-item C., Service Requirements, sub-item 3., Emergency Services – Behavioral Health Services is hereby deleted in its entirety and replaced with the following:

3. Emergency Services – Behavioral Health Services

The Health Plans shall provide emergency behavioral health services pursuant, but not limited, to s. 394.463, F.S.; s. 641.513, F.S.; and Title 42 CFR Chapter IV.

a. Crisis Intervention Mental Health Services and Post-Stabilization Care Services

- (1) Crisis intervention services include intervention activities of less than twenty-four (24) hour duration (within a twenty-four (24) hour period) designed to stabilize an enrollee in a psychiatric emergency.
 - (2) Post-stabilization care services include any of the mandatory services that a treating physician views as medically necessary, that are provided after an enrollee is stabilized from an emergency mental health condition in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee's condition.
- b. Emergency service providers shall make a reasonable attempt to notify the Health Plan within twenty-four (24) hours of the enrollee's presenting for emergency behavioral health services. In cases in which the enrollee has no identification, or is unable to orally identify himself/herself when presenting for behavioral health services, the provider shall notify the Health Plan within twenty-four (24) hours of learning the enrollee's identity.

- c. The emergency service provider shall notify the Health Plan as soon as possible prior to discharge of the enrollee from the emergency care area or notify the Health Plan within twenty-four (24) hours or on the next business day after the enrollee's inpatient admission.
 - d. The Health Plan shall process all out-of-plan emergency behavioral health service claims within the time frames specified for emergency claims payment in Attachment II, Section V, Covered Services, Item H., Coverage Provisions, sub-item 7., Emergency Services.
 - e. The Health Plan shall submit to BMHC within ten (10) calendar days after the Health Plan's final appeal determination for review and final determination all denied appeals from behavioral health care providers and out-of-plan, non-participating behavioral health care providers for denied emergency behavioral health service claims.
 - f. The Health Plan shall not deny emergency services for enrollees presenting at receiving facilities for involuntary examination under the Baker Act.
 - (1) The receiving facility will make every effort to notify the Health Plan within twenty-four (24) hours of receiving the enrollee.
 - (2) The Health Plan shall begin coordinating the enrollee's care upon notification by the receiving facility.
 - (3) A stabilized condition is determined when the physician treating the enrollee decides when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the Health Plan (42 CFR 438.114(d)(3)).
 - g. Fee-for-service Health Plans shall follow provisions of subparagraph f. above for receiving facilities that are not CSUs.
33. Attachment II, Core Contract Provisions, Exhibit 6, HMOs and Reform Health Plans, Behavioral Health Care, Item 1., Reform Health Plans and Non-Reform HMOs, sub-item D., Transition Plan, sub-item 2., the second sentence is hereby amended to now read as follows:

For enrollees who have received behavioral health services for at least six (6) months from a behavioral health care provider, whether the provider is in the Health Plan's network or not, the Health Plan shall continue to authorize all valid claims until the Health Plan has:

Unless otherwise stated, this amendment is effective upon execution.

All provisions not in conflict with this amendment are still in effect and are to be performed at the level specified in the Contract.

This amendment, and all its attachments, are hereby made part of the Contract.

This amendment cannot be executed unless all previous amendments to this Contract have been fully executed.

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IN WITNESS WHEREOF, the Parties hereto have caused this forty-five (45) page amendment (including all attachments) to be executed by their officials thereunto duly authorized.

**WELLCARE OF FLORIDA, INC. D/B/A
STAYWELL HEALTH PLAN OF FLORIDA**

**STATE OF FLORIDA, AGENCY FOR
HEALTH CARE ADMINISTRATION**

BY: /s/ Christina Cooper

BY: /s/ Elizabeth Dudek

NAME: Christina Cooper

NAME: Elizabeth Dudek

TITLE: President FL & HI Division

TITLE: Secretary

DATE: 3/27/11

DATE: 3/31/11

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Healthcare of Florida, Inc.

Medicaid HMO Non-Reform Contract

**AHCA CONTRACT NO. FA905
AMENDMENT NO. 5**

THIS CONTRACT, entered into between the **STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION**, hereinafter referred to as the "**Agency**" and **HEALTHEASE OF FLORIDA, INC.**, hereinafter referred to as the "**Vendor**," or "**Health Plan**," is hereby amended as follows:

1. Standard Contract, Section III., Item E., Name, Mailing and Street Address of Payee, sub-items 1. and 2., are hereby deleted and replaced as follows:

1. The name (Vendor name as shown on Page 1 of this Contract) and mailing address of the official payee to whom the payment shall be made:

Healthcare of Florida, Inc.
P.O. Box 31379
Tampa, FL 33634

2. The name of the contact person and street address where financial and administrative records are maintained:

Thomas Tran
Healthcare of Florida, Inc.
8735 Henderson Road
Tampa, FL 33634

2. Attachment II, Core Contract Provisions, Section I, Definitions and Acronyms, Item A., Definitions, the following definitions are hereby included or amended to now read as follows:

Avatar — In relation to Section XI, Information Management Systems, Item K., Social Networking: A small graphic or pseudonym used on a website that identifies the person logging in.

Blog (Web Blog) — In relation to Section XI, Information Management Systems, Item K., Social Networking: A type of website, usually maintained by an individual with regular entries of commentary, descriptions of events, or other material such as graphics or video. Entries are commonly displayed in reverse-chronological order.

Broadcast — In relation to Section XI, Information Management Systems, Item K., Social Networking: Video, audio, text, or email messages transmitted through an internet, cellular or wireless network for display on any device.

Direct Submitter (FFS PSNs Only) — A Medicaid fee-for-service provider that has been authorized by the fee-for-service Health Plan to submit electronic claims directly to the Agency's Medicaid fiscal agent for payment without requiring such claims to be submitted by the provider to the Health Plan for individual authorization and subsequent submission by that FFS Health Plan to the Medicaid fiscal agent. The FFS Health Plan must submit direct submitter authorization requests, in writing, to its Health Systems Development contract manager in order for such providers to be processed by the Medicaid fiscal agent for direct submitter inclusion. The payment reconciliation process specified in Attachment II, Section XIII, Method of Payment, includes claims submitted by direct submitters.

Excluded Parties List System (EPLS) — The Excluded Parties List System (EPLS) is a federal database containing information regarding entities debarred, suspended, proposed for debarment, excluded or disqualified under the nonprocurement common rule, or otherwise declared ineligible from receiving federal contracts, certain subcontracts, and certain federal assistance and benefits.

Friends/Followers — In relation to Section XI, Information Management Systems, Item K., Social Networking: Persons that choose to interact through online social networks by creating accounts or pages and proactively connecting with others.

Interactions — In relation to Section XI, Information Management Systems, Item K., Social Networking: Conversational exchange of messages.

Overpayment — Overpayment defined in accordance with s. 409.913, F.S., includes any amount that is not authorized to be paid by the Medicaid program whether paid as a result of inaccurate or improper cost reporting, improper claiming, unacceptable practices, fraud, abuse, or mistake.

Protected Health Information (PHI) — For purposes of this Attachment, protected health information shall have the same meaning and effect as defined in 45 CFR 160 and 164, limited to the information created, received, maintained or transmitted by the Health Plan from, or on behalf of the Agency.

Social Networking Applications — In relation to Section XI, Information Management Systems, Item K., Social Networking: Web-based services (excluding the Health Plan's State-mandated website content, member portal, and provider portal) that provide a variety of ways for users to interact, such as email, comment posting, image sharing, invitation and instant messaging services.

Static Content — In relation to Section XI, Information Management Systems, Item K., Social Networking: Copy written by the Health Plan or taken from an outside authoritative source for web posting, for any period of time, shall be defined as Static Content and considered member materials under Attachment II, Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, of this Contract. Static content does not include individualized emails or status messages.

Tags/Tagging — In relation to Section XI, Information Management Systems, Item K., Social Networking: Placing personal identification information within a picture or video. Tags generally are presented as hovering links to additional information about the individual identified.

Username — In relation to Section XI, Information Management Systems, Item K., Social Networking: An identifying pseudonym associating the author to messages or content generated.

3. Attachment II, Core Contract Provisions, Section II, General Overview, Item D., General Responsibilities of the Health Plan, sub-item 4.a. is hereby amended to now read as follows:
 - a. The Health Plan shall provide written materials for Agency review as follows unless specified elsewhere in the Contract:
 - (1) Third party administrator subcontracts for FFS PSNs to BMHC at least ninety (90) calendar days before the effective date of the subcontract or change;
 - (2) Managed Behavioral Health Organization subcontracts to BMHC at least forty-five (45) calendar days before the effective date of the subcontract or change; and
 - (3) Other written materials to BMHC at least forty-five (45) calendar days before the effective date of the material or change.
4. Attachment II, Core Contract Provisions, Section III, Eligibility and Enrollment, Item C., Disenrollment, sub-item 4., Involuntary Disenrollment Requests, is hereby amended to include sub-item a.(3) as follows:
 - (3) Falsification of prescriptions by an enrollee. In such cases the Health Plan shall report the event to MPI.
5. Attachment II, Core Contract Provisions, Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, sub-item 6.a.(12) is hereby amended to change the telephone number to (850) 412-4502.
6. Attachment II, Core Contract Provisions, Section IV, Enrollee Services, Community Outreach and Marketing, Item A., Enrollee Services, sub-item 6.a.(23) is hereby amended to now read as follows:
 - (23) Procedures for reporting fraud, abuse and overpayment that includes the following specific language:
 - (a) To report suspected fraud and/or abuse in Florida Medicaid, call the Consumer Complaint Hotline toll-free at 1-888-419-3456 or complete a Medicaid Fraud and Abuse Complaint Form, which is available online at: https://apps.ahca.myflorida.com/InspectorGeneral/fraud_complaintform.aspx;
 - (b) If you report suspected fraud and your report results in a fine, penalty, or forfeiture of property from a doctor or other health care provider, you may be eligible for a reward through the Attorney General's Fraud Rewards Program (toll-free 1-866-966-7226 or 850-414-3990). The reward may be up to twenty-five percent (25%) of the amount recovered, or a maximum of \$500,000 per case (Florida Statutes Chapter 409.9203). You can talk to the Attorney General's Office about keeping your identity confidential and protected.

7. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, sub-item 2.e. is hereby amended to now read as follows:
 - e. The Health Plan shall cover fluoride treatment by a physician or a dentist for children/adolescents even if the Health Plan does not provide dental coverage. Fluoride varnish application in a physician's office is limited to children up to three and one half (3 ½) years (42 months) of age.
8. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, sub-item 8., Out of Plan Use of Non-Emergency Services, the third sentence is hereby amended to now read as follows:

Written follow-up documentation of the approval must be provided to the out-of-network provider within one (1) business day after the approval.
9. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, sub-item 16.j. is hereby amended to now read as follows:
 - j. Capitated Health Plans shall submit behavioral health pharmacy encounter data if behavioral health is a Health Plan covered service, to the BMHC secure file transfer protocol site in a format supplied by the Agency on an on-going quarterly schedule, as specified in Attachment II, Section XII, Reporting Requirements and the Health Plan Report Guide.
10. Attachment II, Core Contract Provisions, Section V, Covered Services, Item H., Coverage Provisions, is hereby amended to include sub-item 16.I. as follows:
 - I. Capitated health plans may have a pharmacy lock-in program that conforms to the requirements in the Medicaid Prescribed Drug Services Coverage, Limitations and Reimbursement Handbook, provided it is submitted in writing to BMHC and approved by the Agency in advance of implementation.
11. Attachment II, Core Contract Provisions, Section VII, Provider Network, Item B., Network Standards, sub-item 3.c. is hereby amended to include the following:

The Health Plan shall not deny claims for services delivered by these providers solely based on the period between the date of service and the date of clean claim submission, unless that period exceeds three-hundred and sixty-five (365) calendar days, and shall be reimbursed by the Health Plan at the rate negotiated between the Health Plan and the public provider or the applicable Medicaid fee-for-service rate. The Medicaid FFS rate is the standard Medicaid fee schedule rate or the CHD cost-based rate as specified by the County Health Department Clinic Services Coverage and Limitations Handbook for applicable rates.
12. Attachment II, Core Contract Provisions, Section VII, Provider Network, Item H., Credentialing and Recredentialing, sub-item 2.c.(2) is hereby amended to now read as follows:
 - (2) The Health Plan shall not contract with any provider who has a record of illegal conduct; i.e., found guilty of, regardless of adjudication, or who entered a plea of nolo contendere or guilty to any of the offenses listed in s. 435.04, F.S.;

13. Attachment II, Core Contract Provisions, Section VII, Provider Network, Item H., Credentialing and Recredentialing, is hereby amended to now include sub-item 8. as follows:
8. The Health Plan shall submit disclosures and notifications to the federal Department of Health and Human Services (DHHS) Office of the Inspector General (OIG) and to MPI in accordance with s. 1128, s. 1156, and s. 1892, of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1, as described in Section X, E.,11., Fraud and Abuse Prevention, of this Contract.
14. Attachment II, Core Contract Provisions, Section VIII, Quality Management, Item A., Quality Improvement, sub-item 3.a.(7) is hereby deleted in its entirety and replaced with the following:
- (7) PIP Documentation
- (a) PIP Proposal
- (i) Within ninety (90) calendar days after initial Contract execution, the Health Plan shall submit to the BMHC, in writing, a proposal for each planned PIP.
- (ii) Each PIP proposal shall be submitted using the most recent version of the EQRO PIP validation form. The EQRO PIP validation form may be obtained from the following website: www.myfloridaeqro.com/. Instructions for using the form to submit PIP proposals and updates may be obtained from the BMHC.
- (iii) Activities 1 through 6 of the EQRO PIP validation form must be addressed in the PIP proposal.
- (iv) In the event the Health Plan elects to modify a portion of the PIP proposal after initial Agency approval, a written request to do so must be submitted to the BMHC.
- (b) Annual PIP Submission
- (i) The Health Plan shall submit on-going PIPs annually by August 1st to the BMHC for review and approval.
- (ii) The Health Plan shall update the EQRO PIP validation form in its annual submission to reflect the Health Plan's progress. The Health Plan is not required to transfer on-going PIPs to a new, updated EQRO form.
- (iii) The Health Plan shall submit the BMHC-approved EQRO PIP validation form to the EQRO upon its request for validation. The Health Plan shall not make changes to the BMHC-approved PIP being submitted to the EQRO unless expressly permitted by the BMHC in writing.
15. Attachment II, Core Contract Provisions, Section VIII, Quality Management, Item A., Quality Improvement, sub-item 4.a., Cultural Competency Plan, the third sentence is hereby amended to now read as follows:

The CCP shall be updated annually and submitted to BMHC by June 1st for approval for implementation by September 1st of each Contract year.

16. Attachment II, Core Contract Provisions, Section IX, Grievance System, Item A., General Requirements, sub-item 8. is hereby amended to now read as follows:
 8. The Health Plan shall keep a log of complaints that do not become grievances, including date, complainant and enrollee name(s), nature of complaint, description of resolution and final disposition. The Health Plan shall submit this report upon request of the Agency.
17. Attachment II, Core Contract Provisions, Section IX, Grievance System, Item E., Resolution and Notification, sub-item 7.c.(4) is hereby amended to change the telephone number to (850) 412-4502.
18. Attachment II, Core Contract Provisions, Section X, Administration and Management, Item B., Staffing, is hereby amended to include sub-item 2.m. as follows:
 - m. Social Networking Administrator: If the Health Plan elects to use social networking, the Health Plan shall have a Social Networking Administrator, who may hold another position, but is ultimately responsible for policy development, implementation and oversight of all social networking activities.
19. Attachment II, Core Contract Provisions, Section X, Administration and Management, Item E., Fraud and Abuse Prevention, is hereby deleted and replaced in its entirety as follows:

E. Fraud and Abuse Prevention

1. The Health Plan shall establish functions and activities governing program integrity in order to reduce the incidence of fraud and abuse and shall comply with all state and federal program integrity requirements, including but not limited to the applicable provisions of the Social Security Act, ss. 1128, 1902, 1903, and 1932; 42 CFR 431, 433, 434, 435, 438, 441, 447, 455; 45 CFR Part 74; Chapters 409, 414, 458, 459, 460, 461, 626, 641 and 932, F.S., and 59A-12.0073, 59G and 69D-2, FAC.
2. The Health Plan's compliance officer as described in Attachment II, Section X, Administration and Management, Item B., Staffing, sub-item 2.j., shall have unrestricted access to the Health Plan's governing body for compliance reporting, including fraud and abuse and overpayment.
3. The Health Plan shall have adequate staffing and resources to enable the compliance officer to investigate unusual incidents and develop and implement corrective action plans relating to fraud and abuse and overpayment.
 - a. The Health Plan shall establish and maintain a fraud investigative unit to investigate possible acts of fraud, abuse or overpayment, or may subcontract such functions.
 - b. If a Health Plan subcontracts for the investigation of fraudulent claims and other types of program abuse by enrollees or service providers, the Health Plan shall file the following with the Bureau of Medicaid Program Integrity (MPI) for approval at least sixty (60) calendar days before subcontract execution:
 - (1) The names, addresses, telephone numbers, e-mail addresses, and fax numbers of the principals of the entity with which the Health Plan wishes to subcontract;

- (2) A description of the qualifications of the principals of the entity with which the Health Plan wishes to subcontract; and
- (3) The proposed subcontract.
 - c. The Health Plan shall submit to MPI such executed subcontracts, attachments, exhibits, addendums or amendments thereto, within thirty (30) calendar days after execution.
 - d. The Health plan shall notify MPI and provide a copy of any corporate integrity or corporate compliance agreements within thirty (30) calendar days after execution of such agreements.
 - e. The Health Plan shall notify MPI and provide a copy of any corrective action plans required by the Department of Financial Services (DFS) and/or federal governmental entities, excluding AHCA, within thirty (30) calendar days after execution of such plans.
4. The Health Plan's written fraud and abuse prevention program shall have internal controls and policies and procedures in place that are designed to prevent, reduce, detect, correct and report known or suspected fraud and abuse activities.
5. The Health Plan shall submit its compliance plan, anti-fraud plan, and its fraud and abuse policies and procedures, or any changes to these items, to MPI for written approval at least forty-five (45) calendar days before those plans and procedures are implemented.
 - a. At a minimum the compliance plan shall include:
 - (1) Written policies, procedures and standards of conduct that articulate the Health Plan's commitment to comply with all applicable federal and state standards;
- (2) The designation of a compliance officer and a compliance committee accountable to senior management;
 - (3) Effective training and education of the compliance officer and the Health Plan's employees
- (4) Effective lines of communication between the compliance officer and the Health Plan's employees;
- (5) Enforcement of standards through well-publicized disciplinary guidelines;
- (6) Provision for internal monitoring and auditing; and
- (7) Provisions for prompt response to detected offenses and for development of corrective action initiatives.

- b. At a minimum, the Health Plan shall submit its anti-fraud plan to MPI annually on July 1st. The anti-fraud plan shall comply with s. 409.91212, F.S., and, at a minimum, shall include:
- (1) A written description or chart outlining the organizational arrangement of the Health Plan's personnel who are responsible for the investigation and reporting of possible overpayment, abuse, or fraud;
 - (2) A description of the Health Plan's procedures for detecting and investigating possible acts of fraud, abuse, and overpayment;
 - (3) A description of the Health Plan's procedures for the mandatory reporting of possible overpayment, abuse, or fraud to MPI;
 - (4) A description of the Health Plan's program and procedures for educating and training personnel on how to detect and prevent fraud, abuse, and overpayment;
 - (a) At a minimum, training shall be conducted within thirty (30) calendar days of new hire and annually thereafter;
 - (b) The Health Plan shall have a methodology to verify training occurs as required; and
 - (c) The Health Plan shall also include deficit reduction act requirements in the training curriculum.
 - (5) The name, address, telephone number, e-mail address, and fax number of the individual responsible for carrying out the anti-fraud plan; and
 - (6) A summary of the results of the investigations of fraud, abuse, or overpayment which were conducted during the previous year by the Health Plan's fraud investigative unit.
- c. At a minimum, the Health Plan's compliance plan, anti-fraud plan, and fraud and abuse policies and procedures shall comply with s. 409.91212, F.S., and with the following:
- (1) Ensure that all officers, directors, managers and employees know and understand the provisions;
 - (2) Include procedures designed to prevent and detect potential or suspected fraud and abuse in the administration and delivery of services under this Contract. Nothing in this Contract shall require that the Health Plan assure that non-participating providers are compliant with this Contract, but the Health Plan is responsible for reporting suspected fraud and abuse by non-participating providers when detected;
 - (3) Describe the Health Plan's organizational arrangement of anti-fraud personnel, their roles and responsibilities, including a description of the internal investigational methodology and reporting protocols;

- (4) Incorporate a description of the specific controls in place for prevention and detection of potential or suspected fraud and abuse, including, but not limited to:
 - (a) Claims edits;
 - (b) Post-processing review of claims;
 - (c) Provider profiling, credentialing, and recredentialing, including a review process for claims and encounters that shall include providers and non-participating providers:
 - (i) Who demonstrate a pattern of submitting falsified encounter data or service reports;
 - (ii) Who demonstrate a pattern of overstated reports or up-coded levels of service;
 - (iii) Who alter, falsify or destroy clinical record documentation;
 - (iv) Who make false statements relating to credentials;
 - (v) Who misrepresent medical information to justify enrollee referrals;
 - (vi) Who fail to render medically necessary covered services they are obligated to provide according to their provider contracts;
 - (vii) Who charge enrollees for covered services; and
 - (viii) Who bill for services not rendered;
 - (d) Prior authorization;
 - (e) Utilization management;
 - (f) Subcontract and provider contract provisions;
 - (g) Provisions from the provider and the enrollee handbooks; and
 - (h) Standards for a code of conduct;
- (5) Contain provisions pursuant to this section for the confidential reporting of Health Plan violations to MPI and other agencies as required by law;
- (6) Include provisions for the investigation and follow-up of any reports;
- (7) Ensure that the identities are protected for individuals reporting in good faith alleged acts of fraud and abuse;
- (8) Require all suspected or confirmed instances of internal and external fraud and abuse relating to the provision of, and payment for, Medicaid services including, but not limited to, Health Plan employees/management, providers, subcontractors, vendors, delegated entities, or enrollees under state and/or federal law be reported to MPI within fifteen (15) calendar days of detection. Additionally, any final resolution reached by the Health Plan shall include a written statement that provides notice to the provider or enrollee that the resolution in no way binds the State of Florida nor precludes the State of Florida from taking further action for the circumstances that brought rise to the matter;

- (9) Ensure that the Health Plan and all providers and subcontractors, upon request and as required by state and/or federal law, shall:
- (a) Make available to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS any and all administrative, financial and medical records and data relating to the delivery of items or services for which Medicaid monies are expended; and
 - (b) Allow access to all authorized federal and state oversight agencies and their agents, including but not limited to the Agency, the Florida Attorney General, and DFS to any place of business and all medical records and data, as required by state and/or federal law. Access shall be provided during normal business hours, except under special circumstances when the Agency, the Florida Attorney General, and DFS shall have after-hours admission. The Agency and the Florida Attorney General shall determine the need for special circumstances;
- (10) Ensure that the Health Plan shall cooperate fully in any investigation by federal and state oversight agencies and any subsequent legal action that may result from such an investigation;
- (11) Ensure that the Health Plan does not retaliate against any individual who reports violations of the Health Plan's fraud and abuse policies and procedures or suspected fraud and abuse;
- (12) Not knowingly have affiliations with individuals debarred or excluded by federal agencies under ss. 1128 and 1128A of the Social Security Act and 42 CFR 438.610;
- (13) Check monthly the federal List of Excluded Individuals and Entities (LEIE), or its equivalent, and the federal Excluded Parties List System (EPLS) to identify excluded parties during the process of engaging the services of new employees, subcontractors and providers and during renewal of agreements and recredentialing. The Health Plan shall not engage the services of an entity that is in nonpayment status or is excluded from participation in federal health care programs under ss. 1128 and 1128A of the Social Security Act;
- (14) Provide details and educate employees, subcontractors and providers about the following as required by s. 6032 of the federal Deficit Reduction Act of 2005:
- (a) The False Claim Act;

- (b) The penalties for submitting false claims and statements;
 - (c) Whistleblower protections;
 - (d) The law's role in preventing and detecting fraud, waste and abuse;
 - (e) Each person's responsibility relating to detection and prevention; and
 - (f) The toll-free state telephone numbers for reporting fraud and abuse.
6. The Health Plan shall query its potential non-provider subcontractors before contracting to determine whether the subcontractor has any existing or pending contract(s) with the Agency and, if any, notify MPI
7. In accordance with s. 6032 of the federal Deficit Reduction Act of 2005, the Health Plan shall make available written fraud and abuse policies to all employees. If the Health Plan has an employee handbook, the Health Plan shall include specific information about s. 6032, the Health Plan's policies, and the rights of employees to be protected as whistleblowers.
8. The Health Plan shall comply with all reporting requirements as set forth below; and in s. 409.91212, F.S.; Attachment II, Section XII, Reporting Requirements; and the Health Plan Report Guide.
- a. The Health Plan shall report on a quarterly basis a comprehensive fraud and abuse prevention activity report regarding its investigative, preventive, and detective activity efforts.
 - b. The Health Plan shall, by September 1st of each year, report to MPI its experience in implementing an anti-fraud plan, and, on conducting or subcontracting for investigations of possible fraudulent or abusive acts during the prior state fiscal year. The report must include, at a minimum:
 - (1) The dollar amount of health plan losses and recoveries attributable to overpayment, abuse and fraud; and
 - (2) The number of health plan referrals to MPI.
9. The Health Plan shall meet with the Agency periodically, at the Agency's request, to discuss fraud, abuse, neglect and overpayment issues.
10. Notwithstanding any other provisions related to the imposition of sanctions or fines in this Contract, including any attachments, exhibits, addendums or amendments hereto, if the Health Plan fails to comply with the requirements of s. 409.91212, F.S., the Agency shall impose those administrative fines set forth in s. 409.91212(5) and (6), F.S.
11. The Health Plan shall notify DHHS OIG and MPI within ten (10) business days of discovery of individuals who have met the conditions giving rise to mandatory or permissive exclusions per s. 1128, s. 1156, and s.1892 of the Social Security Act, 42 CFR 455.106, 42 CFR 1002.3, and 42 CFR 1001.1.

- a. In accordance with 42 CFR 455.106, the Health Plan shall disclose to DHHS OIG, with a copy to MPI within ten (10) business days after discovery, the identity of any person who:
 - (1) Has ownership or control interest in the Health Plan, or is an agent or managing employee of the Health Plan; and
 - (2) Has been convicted of a criminal offense related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs.
- b. In addition to the disclosure required under 42 CFR 455.106, the Health Plan shall also disclose to DHHS OIG with a copy to MPI within ten (10) business days after discovery, the identity of any person described in 42 CFR 1002.3 and 42 CFR 1001.1001(a)(1), and to the extent not already disclosed, to additionally disclose any person who:
 - (1) Has ownership or control interest in a Health Plan network provider, or subcontractor, or is an agent or managing employee of a Health Plan network provider or subcontractor; and
 - (2) Has been convicted of a crime as identified in s. 1128 of the Social Security Act and/or conviction of a crime related to that person's involvement in any program under Medicare, Medicaid, or the Title XX services program since the inception of those programs;
 - (3) Has been denied initial entry into the Health Plan's network for program integrity-related reasons; or
 - (4) Is a provider against whom the Health Plan has taken any action to limit the ability of the provider to participate in the Health Plan's provider network, regardless of what such an action is called. This includes, but is not limited to, suspension actions, settlement agreements and situations where an individual or entity voluntarily withdraws from the program or Health Plan provider network to avoid a formal sanction.
- c. The Health Plan shall submit the written notification referenced above to DHHS OIG via email to: floridaexclusions@oig.hhs.gov and copy MPI via email to: mpifo@ahca.myflorida.com. Document information examples include but are not limited to court records such as indictments, plea agreements, judgments, and conviction/sentencing documents.
- d. In lieu of an email notification, a hard copy notification is acceptable to DHHS OIG at:

Attention: Florida Exclusions
Office of the Inspector General
Office of Investigations
7175 Security Boulevard, Suite 210
Baltimore, MD 21244

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With a copy to MPI at:

Attention: Florida Exclusions
Office of the Inspector General
Medicaid Program Integrity
2727 Mahan Drive, M.S. #6
Tallahassee, FL 32308-5403

20. Attachment II, Core Contract Provisions, Section XI, Information Management and Systems, is hereby amended to include Item K., Social Networking as follows:

K. Social Networking

This section provides requirements for policy development, permitted uses of applications and acceptable content for social networking. If the Health Plan chooses to use social networking applications/tools in its Medicaid line of business, these contract requirements apply to it and all communications by the Health Plan or its subcontractors with enrollees, providers and website requirements, when conducted through social networking applications.

1. General Requirements

- a. The Health Plan shall establish a social networking administrator, who can hold another position, but is ultimately responsible for the Health Plan's policy development, implementation and oversight of all social networking activities.
 - b. The Health Plan shall develop and maintain written social networking policies and procedures and a social networking monitoring plan in accordance with this Contract. The policies and procedures shall include a statement of purpose/general information stating how the Health Plan uses social networking; for example, customer service, community outreach or notifications to enrollees and/or providers. The social networking monitoring plan shall be developed in accordance with sub-item 5., Monitoring, of this section.
 - (1) The Health Plan shall submit these policies, procedures and monitoring plan, including the intended uses and all initial social networking site static, distributed or broadcast content to BMHC for approval sixty (60) calendar days prior to the launch of any new social networking application.
- (a) Changes in social networking usage and/or content must be submitted to BMHC for approval sixty (60) calendar days prior to the effective date of the change.
 - (b) The Health Plan shall evaluate and annually submit these policies, procedures and monitoring plan, including social networking site content to BMHC each September 1st. However, if the policies, procedures or monitoring plan have been approved by BMHC within six (6) months prior to the annual evaluation/submission above, and are unchanged from the previous Contract year, the Health Plan shall submit an attestation to BMHC that the prior year's social networking policies, procedures and monitoring plan are still in place.

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- (2) The policies and procedures must include the requirement that, when using social networking applications, the protection of PHI and all HIPAA Privacy Rule-related information must be maintained and monitored. The Health Plan shall ensure that social networking records are maintained in accordance with this Contract, for the purposes of monitoring of this requirement.
 - (3) The social networking policies and procedures shall identify management resources, internal teams, external management resources (subcontractors) and human resources needed or used to monitor usage, analyze information trends and prepare responses for the public or private individuals/organizations.
 - (4) The social networking policies and procedures shall specify record retention requirements in accordance with this Contract, and include those records kept of each update and who is responsible for the update as it occurs, updates, communications or messages posted, with identifying handle or representative code in order to specify which Health Plan employee has issued the communication.
- c. The Health Plan shall develop and maintain a social networking matrix that identifies staff and subcontractors participating in social networking activities on behalf of the Health Plan. The Health Plan shall provide the Agency with unrestricted access to this matrix upon request. This matrix shall be updated within one (1) business day of any change and include the following information for each person:
- (1) The social networking application name; for example, MySpace, Twitter, facebook, Nixle.com, etc.;
 - (2) First and last name of the individual;
 - (3) Username (if applicable);
 - (4) Email address;
 - (5) Password; and
 - (6) Description of the social networking role, responsibility usage and control.
- d. The Health Plan shall provide to its employees instruction and training on this Contract and the Health Plan's social networking policies and procedures before using social networking applications on behalf of the Health Plan.
- e. The Health Plan is vicariously liable for any social networking violations of its employees, agents, vendors or subcontractors.
- (1) In addition to any other sanctions available in Attachment II, Section XIV, Sanctions, any violations of this section shall subject the Health Plan to administrative action by the Agency as determined by the Agency. The Health Plan may dispute any such administrative action pursuant to Attachment II, Section XVI, Terms and Conditions, Item I., Disputes.

- (2) The Health Plan shall report to BMHC any Health Plan staff who violates any requirements of the social networking policies and procedures or of this Contract within fifteen (15) calendar days of knowledge of such violation.
- f. The Health Plan shall comply with copyright and intellectual property law and shall reference or cite sources appropriately on all social networking sites.
- g. In addition to all other review and monitoring aspects of this Contract, the Agency reserves the right to monitor or review the Health Plan's monitoring of all social networking activity without notice.
- h. The Health Plan shall ensure its social networking applications and sites comply with the community outreach and marketing requirements specified in Attachment II, Section IV, Enrollee Services, Community Outreach and Marketing, Item B., Community Outreach and Marketing, of this Contract.

2. Social Networking Applications

- a. The following social networking applications or media communications are permitted by the Agency upon its written approval:
 - (1) Micro-blogging/Presence applications: Twitter, Plurk, Tumblr, Jaiku, fmylife;
 - (2) Social networking: Bebo, Facebook, LinkedIn, MySpace, Orkut, Skyrock, Hi5, Ning, Elgg;
 - (3) Social Network aggregation: NutshellMail, FriendFeed; and
 - (4) Events: Upcoming, Eventful, Meetup.com.
- b. Unless listed in a. above, the following Health Plan social networking sites or media are prohibited. Examples of prohibited social networking sites or media include but are not limited to:
 - (1) Collaboration
 - (a) Wikis: Wikipedia, PBwiki, wetpaint;
 - (b) Social bookmarking (or social tagging): Delicious, StumbleUpon, Google Reader, CiteULike;
 - (c) Social news: Digg, Mixx, Reddit, NowPublic; and
 - (d) Opinion sites: epinions, Yelp.
 - (2) Multimedia
 - (a) Photo sharing: Flickr, Zoomr, Photobucket, SmugMug, Picasa;
 - (b) Video sharing: YouTube, Vimeo, sevenload;
 - (c) Livcasting: Ustream.tv, Justin.tv, Stickam; and

- (d) Audio and Music sharing: imeem, The Hype Machine, Last.fm, ccMixer.
 - (3) Reviews and Opinions
 - (a) Product Reviews: epinions.com, MouthShut.com; and
 - (b) Community Q&A: Yahoo! Answers, WikiAnswers, Askville, Google Answers.
 - (4) Entertainment
 - (a) Media and Entertainment Platforms: Cisco Eos;
 - (b) Virtual worlds: Second Life, The Sims Online, Forterra; and
 - (c) Game sharing: Miniclip, Kongregate.
 - (5) Other
 - (a) Information aggregators: Netvibes, Twine (website);
 - (b) Platform providers: Huzu; and
 - (c) Blogs: Blogger, LiveJournal, Open Diary, TypePad, WordPress, Vox, Expression Engine.
- c. In any invitation, link or information about third party social networking applications or sites presented by the Health Plan that requires a user to have a membership, the Health Plan shall clearly advise users of the following:
- (1) That participation will require the user to become a member of the third party host;
 - (2) Disclaim the Health Plan's responsibility for the third party membership; and
 - (3) That the third party controls the membership, privacy, and data exchanged, and may use information for its own marketing purposes (or sell it.)

3. User Requirements

- a. The Health Plan's presence on such social networking sites shall include an avatar and/or a username that clearly indicates the Health Plan that is being represented and cannot use any Agency logo or State of Florida seal. When registering for social networking applications, the Health Plan shall use its email address. If the application requires a username, the following syntax shall be used: http://twitter.com/<Healthplan_identifier><username>
- b. The Health Plan shall personalize its interactions to include an identifying handle or representative code in order to specify which Health Plan employee has issued the communication. The Health Plan shall keep social networking records in accordance with social networking record retention requirements specified in Attachment II, Core Contract Provisions, Section XI, Information Management Systems, Item K., Social Networking, sub-item 1.b.(4).

- c. All Social Networking connections must be initiated by the external user and not the Health Plan.
- d. The Health Plan's social networking interactions with the public must either be general broadcast messages of information availability or responses to inquiry that contain only referral to authoritative resources such as the Health Plan or appropriate state or federal agency websites (including emergency public health advisories). The Health Plan shall not reference, cite, or publish information, views or ideas of any third party without the third party's written consent and only as permitted by the Agency for the purpose of conducting business in accordance with this Contract.
- e. The Health Plan may distribute updates, messages and reminders only to registered friends/followers who have chosen to receive these types of communication whether actively or passively (through a subscription initiated by the external user). Any subscription must be initiated by an opt-in from a user. Any communication resulting from such a subscription shall include a link/method to opt-out of the subscription.
- f. The Health Plan shall not conduct business relating to this Contract that involves the communication of personal identifying, confidential or sensitive information on a Health Plan social network application.
- g. The Health Plan shall place photographs on pages that are hosted on the site and not linked from outside web pages. The Health Plan shall not post information, photos, links/URLs or other items online that would reflect negatively on any individual(s), its enrollees, the Agency or the state.
- h. The Health Plan shall not place/embed video on its social networking sites.
- i. The Health Plan shall not tag photographic or video content and must remove all tags placed by others upon discovery.
- j. The Health Plan shall not allow advertising, whether targeted or general, on its social networking sites.
- k. The Health Plan shall not use affiliate/referral links or banners on its social networking sites. This includes links to other non-Medicaid lines of business in which the Health Plan or a parent company is engaged. The Health Plan shall ensure the following:
 - (1) Any site that automatically generates such linkage, recommendation, or endorsement on side bars or pop-ups must contain a message prominently displayed in the area under the Health Plan's control that such items, resources, and companies are NOT endorsed by the Health Plan or the Agency; and
 - (2) Any external links on any websites controlled by the Health Plan must be clearly identified as external links and must pop up a warning dialog when clicked on informing the user that they are leaving the Health Plan site.

4. Functionalities

a. The following functionalities are permitted:

- (1) Search – Finding information through keyword search;
- (2) Links – Guides to other related information; and
- (3) Signals – The use of syndication technology such as RSS to notify users of content changes.

b. The following functionalities are prohibited:

- (1) Authoring – The ability to create and update content leads to the collaborative work of many rather than just a few web authors. In wikis, users may extend, undo and redo each other’s work. In blogs, posts and the comments of individuals build up over time;
- (2) Tags – Categorization of content by users adding one-word descriptions to facilitate searching, without dependence on pre-made categories;
- (3) Extensions – Software that makes the Web and application platform as well as a document server; and
- (4) Forums – Sites hosted by a company that allow users to create topics (threads) and post comments, questions, etc., that are available for public conversation among all members in the forum.

5. Monitoring

The Health Plan shall include the following social networking areas in its monitoring:

- a. Social networking matrix of users as specified in Section K.1.c. of this section;
- b. Social networking content updates and posting;
- c. Social networking records retention; and
- d. Social networking permitted and prohibited activities and functionalities.

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21. Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, Item A., Health Plan Reporting Requirements, Table 1-A, Revised Summary of Reporting Requirements, is hereby deleted in its entirety and replaced with Table 1-B, Revised Summary of Reporting Requirements, as follows. All references in the Contract to Table 1-A shall hereinafter refer to Table 1-B.

TABLE 1-B
REVISED SUMMARY OF REPORTING REQUIREMENTS

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section II and Exhibit 2	Benefit Maximum Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC	Monthly , fifteen (15) calendar days after the end of the reporting month in which claims reach \$450,000 in enrollee costs	HSD Contract Manager once \$450,000 is reached, and to BMHC that initial month and monthly thereafter through the end of the Contract year
Section III and Exhibit 3	Newborn Enrollment Report	NR FFS PSN; Ref FFS PSN; CCC	Weekly , on Wednesday	Medicaid Area Office
Section III and Exhibit 3	Involuntary Disenrollment Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly , first Thursday of month	Choice Counseling Vendor
Section IV	Medicaid Redetermination Notice Summary Report	All Plans that participate per Attachment I	Quarterly , forty-five (45) calendar days after end of reporting quarter	BMHC
Section IV	Community Outreach Health Fairs/Public Events Notification	All Plans	Monthly, no later than 20 th calendar day of month before event month; amendments two (2) weeks before event	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section IV	Community Outreach Representative Report	All Plans	Two (2) weeks before activity Quarterly , forty-five (45) calendar days after end of reporting quarter	BMHC
Section V and Exhibit 4	Enhanced Benefits Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly , ten (10) calendar days after end of reporting month	BMHC
Section V, Exhibit 5	Customized Benefit Notifications Report	Ref HMO; Ref Cap PSN	Monthly , fifteen (15) calendar days after end of reporting month	BMHC
Section V	CHCUP (CMS-416) & FL 60% Screening (Child Health Check Up report)	All Plans	Annually , unaudited by January 15 th for prior federal fiscal year; Annually , audited report by October 1 st	BMHC
Section V	Inpatient Discharge Report	NR Ref HMO; NR Cap PSN; Ref HMO; Ref Cap PSN; HIV/AIDS	Quarterly , thirty (30) calendar days after end of reporting quarter	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section V	Hernandez Settlement Ombudsman Log	NR HMO; NR FFS PSN*; NR Cap PSN; Ref HMO; Ref FFS PSN*; Ref Cap PSN; CCC*; HIV/AIDS * If the FFS Health Plan has authorization requirements for prescribed dru services	Quarterly, fifteen (15) calendar days after end of reporting quarter	BMHC
Section V	Hernandez Settlement Agreement Survey	NR HMO; NR FFS PSN*; NR Cap PSN; Ref HMO; Ref FFS PSN*; Ref Cap PSN; CCC*; HIV/AIDS * If the FFS Health Plan has authorization requirements for prescribed drug services	Annually, on August 1 st	BMHC
Section V and Exhibit 6	Behavioral Health – Pharmacy Encounter Data Report	NR HMO; Ref HMO; Ref Cap PSN; HIV/AIDS	Quarterly, forty-five (45) calendar days after end of Reporting quarter	BMHC
Section V	Pharmacy Navigator Report	Ref HMO; Ref Cap PSN; HIV/AIDS	Annually, by December 1 st	Choice Counseling Vendor

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section VI, Exhibit 6	Behavioral Health Annual 80/20 Expenditure Report	NR HMO	Annually , by April 1 st ; Supplemental file due February 1st of the following year for plans that reported IBNR	BMHC
Section VI, Exhibit 6	Behavioral Health Critical Incident Report - Individual	NR HMO; Ref-HMO; Ref. FFS PSN; Ref Cap. PSN; CCC; HIV/AIDS	Immediately, no later than twenty-four (24) hours after occurrence or knowledge of incident	BMHC
Section VI, Exhibit 6	Behavioral Health Critical Incident Report - Summary	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly , by the 15 th	BMHC
Section VI, Exhibit 6	Behavioral Health - Required Staff/Providers Report	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Quarterly , forty-five (45) calendar days after end of reporting quarter for Health Plans operating less than one (1) year; Annually , by August 15 th , for all other Health Plans	BMHC
Section VI, Exhibit 6	Behavioral Health - FARS/CFARS	NR HMO Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Semi-Annually , August 15 th and February 15 th	BMHC
Section VI, Exhibit 6	Behavioral Health - Enrollee Satisfaction Survey Summary	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Annually by March 1 st	BMHC behavioral health analyst

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section VI, Exhibit 6	Behavioral Health - Stakeholders' Satisfaction Survey Summary	NR HMO; Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Annually, by March 1 st	BMHC
Section VI, Exhibit 6	Behavioral Health - Encounter Data Report	NR HMO; Ref HMO; Ref Cap PSN; HIV/AIDS	Quarterly, forty-five (45) calendar days after end of reporting quarter	BMHC
Section VII	Provider Network File	All Plans	Monthly, first Thursday of month (optional weekly submissions each Thursday for remainder of month)	AHCA Choice Counseling Vendor and Medicaid fiscal agent for Reform; For non-Reform, to Medicaid fiscal agent and BMHC
Section VII	Provider Termination and New Provider Notification Report	All Plans	Summary of new and terminated providers due monthly , by the fifteenth (15 th) calendar day of the month following the reporting month	BMHC
Section VII	PCP Wait Times Report	All Plans	Annually, by February 1 st	BMHC
Section VIII	Cultural Competency Plan (and Annual Evaluation)	All Plans	Annually, June 1 st	BMHC
Section VIII and Exhibit 5	Performance Measures	All Plans	Annually, on July 1 st	BMQM
Section IX	Complaints, Grievance, and Appeals Report	All Plans	Quarterly, fifteen (15) calendar days after end of quarter	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section X	MPI – Quarterly Fraud & Abuse Activity Report	All Plans	Quarterly , fifteen (15) calendar days after the end of reporting quarter	MPI
Section X	MPI – Annual Fraud & Abuse Activity Report	All Plans	Annually by September 1st .	MPI
Section X	MPI - Suspected/Confirmed Fraud & Abuse Reporting	All Plans	Within fifteen (15) calendar days of detection	MPI
Section X	Claims Aging Report & Supplemental Filing Report	All Plans	Quarterly , forty-five (45) calendar days after end of reporting quarter; Capitated Plans , optional supplemental filing – one-hundred and five (105) calendar days after end of reporting quarter	BMHC
Section XIII, Exhibit 13	Medicaid Reform Supplemental HIV/AIDS Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC; HIV/AIDS	Monthly , by second Thursday of month	BMHC
Section XIII, Exhibit 13	Catastrophic Component Threshold Report	Ref HMO; Ref FFS PSN; Ref Cap PSN; CCC per Attachment I	Monthly , fifteen (15) calendar days after end of reporting month	BMHC
Section XV, Exhibit 15	Insolvency Protection Multiple Signatures Agreement Form	NR HMO; NR Cap PSN; Ref HMO; Ref Cap PSN; HIV/AIDS	Annually , by April 1 st ; Thirty (30) calendar days after any change	BMHC

Contract Section	Report Name	Plan Type	Frequency	Submit To
Section XV	Audited Annual and Unaudited Quarterly Financial Reports	All Plans except CCC	Audited - Annually by April 1 st for calendar year; Unaudited – Quarterly, forty-five (45) calendar days after end of reporting quarter	BMHC

NR HMO = Non-Reform health maintenance organization, includes Health Plans covering Frail/Elderly Program services as specified in Attachment I

Ref HMO = Reform health maintenance organization

Ref Cap PSN = Reform capitated provider service network

Ref FFS PSN = Reform Fee-for-Service Provider Service Network

NR Cap PSN = Non-Reform Capitated Provider Service Network

NR FFS PSN = Non-Reform Fee-for-Service Provider Service Network

CCC = Specialty plan for children with chronic conditions

HIV/AIDS = Specialty plan for recipients living with HIV/AIDS

22. Attachment II, Core Contract Provisions, Section XII, Reporting Requirements, Item A., Health Plan Reporting Requirements, Table 2-B, Revised Summary of Submission Requirements, is hereby deleted in its entirety and replaced with Table 2-C, Revised Summary of Submission Requirements, as follows. All references in the Contract to Table 2-B shall hereinafter refer to Table 2-C.

TABLE 2-C

REVISED SUMMARY OF SUBMISSION REQUIREMENTS

Contract Section	Submission	Plan Type	Frequency	Submit To
Attachment I, Section B., Item 3.a.	Increase in enrollment levels	Capitated Health Plans; FFS PSNs; CCC	Before increases occur	BMHC and HSD
Attachment I, Section D., Item 3.b.	Changes to optional or expanded services	FFS PSNs; CCC	Annually, by June 15 th	HSD
Attachment I, Section D., Item 3.c.	Changes to optional or expanded services	Capitated Health Plans	Annually, by June 15 th	HSD
i. Subsequent references are to Attachment II and its Exhibits				

Contract Section	Submission	Plan Type	Frequency	Submit To
Section II, Item D.4.	Policies, procedures, model provider agreements & amendments, subcontracts, All materials related to Contract for distribution to enrollees, providers, public	All	Before beginning use; whenever changes occur	BMHC
Section II, Item D.4.a.	Written materials	All	Forty-five (45) calendar days before effective date	BMHC
Section II, Item D.4.b	Written notice of change to enrollees	All	Thirty (30) calendar days before effective date	Enrollees affected
Section II, Item D.6.	Enrollee materials, PDL, provider & enrollee handbooks	All	Available on Health Plan's website without log-in	Plan website
Section III, Item B.3.c.(1)	Enrollee pregnancy	All	Upon confirmation	DCF & MPI
Section III, Item B.3.c.(3)	Unborn activation notice	All	Presentation for delivery	DCF & MPI
Section III, Item B.3.d.	Birth information if no unborn activation	All	Upon delivery	DCF
Section III, Item C.4.b.	Involuntary disenrollment request	All	Forty-five (45) calendar days before effective date	BMHC
Section III, Item C.4.e.	Notice that Health Plan is requesting disenrollment in next Contract month	All	Before effective date	Enrollees affected

Contract Section	Submission	Plan Type	Frequency	Submit To
Section IV, Item A.1.e.	Notice of reinstatement	All	By 1 st calendar day of month after learning of reinstatement or within five (5) calendar days from receipt of enrollment file, whichever is later	Enrollee affected
Section IV, Item A.2.a. and Item A.6.a.(17); Section VIII, Item A.4.	How to get Health Plan information in alternative formats	All	Include in cultural competency plan and enrollee handbook, and upon request	Enrollees & potential enrollees
Section IV, Item A.2.c.	Right to get information about Health Plan	All	Annually	Enrollees
Section IV, Item A.7.c.	Provider directory online file	All	Update monthly & submit attestation	BMHC
Section IV, Item A.9.a.	Enrollee assessments	All	Within thirty (30) calendar days of enrollment notify about pregnancy screening	Enrollees
Section IV, Item A.9.c.	Enrollees more than 2 months behind in periodicity screening	All	Contact twice, if needed	Enrollees who meet criteria
Section IV, Item A.11.f.	Toll-free help line performance standards	All	Get approval before beginning operation	BMHC
Section IV, Item A.12. and Item A.,6.a.(17); Section VIII, Item A.4.	How to access translation services	All	Include in cultural competence plan and enrollee handbook	Enrollees
Section IV, Item A.14.a.	Incentive program	All	Get approval before offering	BMHC
Section IV, Item A.14.g.	Pre-natal care programs	All	Before implementation	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Section IV, Item A.17.c.	Notice of change in participation in redetermination notices	All	Annually, by June 1 st , if change in plan participation	BMHC
Section IV, Item A.17.c.(1)	Redetermination policies & procedures	All	When Health Plan agrees to participate	BMHC
Section IV, Item A.17.c.(1)(a)	Notice in writing to discontinue Medicaid redetermination date data use	All	Thirty (30) calendar days before stopping	BMHC
Section IV, Item B.3.c.	Member services phone script responding to community outreach calls and outreach materials	All	Before use	BMHC
Section IV, Item B.4.c.	In case of force majeure, notice of participation in health fair or other public event	All	By day of event	BMHC
Section IV, Item B.6.f.	Report of staff or community outreach rep. violations	All	Within fifteen (15) calendar days of knowledge	BMHC
Section V, Item C.1.	Written details of expanded services	All	Before implementation	HSD
Section V, Item F.	Decision to not offer a service on moral/religious grounds	All	One-hundred and twenty (120) calendar days before implementation Thirty (30) calendar days before implementation	BMHC Enrollees

Contract Section	Submission	Plan Type	Frequency	Submit To
Section V, Item H.10.b.2.	UNOS form & disenrollment request for specified transplants	All	When enrollee listed	BMHC
Section V, Item H.14.e.	Attestation that the Health Plan has advised providers to enroll in VFC program	All	Annually, by October 1 st	BMHC
Section V, Item H.16.a.(4)	PDL update	All	Annually, by October 1 st . Thirty (30) calendar days written notice of change.	BMHC and Bureau of Medicaid Pharmacy Services
Section VII, Item A.2.	Capacity to provide covered services	All	Before taking enrollment	BMHC
Section VII, Item C.1.	Request for initial or expansion review	All	When requesting initial enrollment or expansion into a county.	BMHC and HSD
Section VII, Item C.2.	Compliance with access requirements following significant changes in service area or new populations	All	Before expansion	BMHC and HSD
Section VII, Item C.3.	Significant network changes	All	Within seven (7) business days	BMHC
Section VII, Item C.5.	When PCP leaves network	All	Within fifteen (15) calendar days of knowledge. A copy of the enrollee notice for terminated providers is due no more than fifteen (15) calendar days after receipt of the PCP termination notice.	BMHC & affected enrollees

Contract Section	Submission	Plan Type	Frequency	Submit To
Section VII, Item D.2.jj.	Waiver of provider agreement indemnifying clause	All	Approval before use	BMHC
Section VII, Item E.3.	Notice of terminated providers due to imminent danger/impairment	All	Immediate	BMHC and Provider
Section VII, Item E.4.	Termination or suspension of providers; for “for cause” terminations, include reasons for termination	All	Sixty (60) calendar days before termination effective date	BMHC, affected enrollees, & provider
Section VII, Item H.8.	Notice of individuals with conditions giving rise to permissive or mandatory exclusions	All	Within ten (10) business days of learning of the health care-related criminal conviction; or Denial of credentialing for program integrity related reasons, or other required disclosure.	DHHS OIG With a copy to MPI
Section VIII, Item A.1.b.	Written Quality Improvement Plan	All	Within thirty (30) calendar days of initial Contract execution; Thereafter, Annually by April 1 st .	BMHC
Section VIII, Item A.3.a.(7)(a)	Proposal for each planned PIP	All	Ninety (90) calendar days after Contract execution.	BMHC
Section VIII, Item A.3.a.(7)(b)	Annual PIP proposal for each planned PIP	All	Thereafter, Annually by August 1	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Section VIII, Item A.3.c.(1)	Performance measure data and auditor certification	All	Annually by July 1 st	BMQM
Section VIII, Item A.3.c.(4)	Performance measure action plan	All	Within thirty (30) calendar days of determination of unacceptable performance	BMQM
Section VIII, Item A.3.e.(7)	Written strategies for medical record review	All	Before use	BMHC
Section VIII, Item B.1.a.(4)(a)	Service authorization protocols & any changes	All	Before use	BMHC
Section VIII, Item B.4.	Changes to UM component	All	Thirty (30) calendar days before effective date	BMHC
Section IX, Item A.8.	Complaint log	All	Upon request	BMHC
Section X, Item B.2.	Changes in staffing	All	Five (5) business days of any change	BMHC & HSD
Section X, Item B.2.b.	Full-Time Administrator	All	Before designating duties of any other position	BMHC
Section X, Item D.3.a.	Reform and non-Reform historical encounter data for all typical and atypical services	All	According to Agency-approved schedules and no later than 10/31/09	MEDS team & Agency Fiscal Agent
Section X, Item D.3.b.	Encounter data for all typical and atypical services	All	Within sixty (60) calendar days following end of month in which Health Plan paid claims for services, and as specified in MEDS Companion Guide	MEDS Team & Agency Fiscal Agent
Section X, Item E.3.b.	Subcontract for investigation of Fraud and Abuse	All	At least sixty (60) calendar days before anticipated subcontract execution date	MPI

Contract Section	Submission	Plan Type	Frequency	Submit To
Section X, Item E.3.c.	Executed Subcontract for investigation of Fraud and Abuse	All	Within thirty (30) calendar days after subcontract execution	MPI
Section X, Item E.3.d.	Corporate Integrity Agreements and/or Corporate Compliance Agreements	All	Within thirty (30) calendar days after execution	MPI
Section X, Item E.3.e.	Corrective Action Plans required by the Florida Department of Financial Services (DFS) and/or Federal governmental entities	All	Within thirty (30) calendar days after execution	MPI
Section X, Item E.5.	Compliance plan, anti-fraud plan, and related fraud and abuse policies & procedures	All	Within forty-five (45) calendar days after Agency contract execution; Upon initial implementation or revision; or As requested by MPI	MPI
Section X, Item E.5.b.	Anti-fraud plan annual submission	All	Annually on July 1 st , upon revision, or as requested by MPI.	MPI

Contract Section	Submission	Plan Type	Frequency	Submit To
Section X, Item E.11.	Notice of individuals with conditions giving rise to permissive or mandatory exclusions	All	Within ten (10) business days of learning of the health care-related criminal conviction; or Denial of credentialing for program integrity related reasons, or other required disclosure.	DHHS OIG With a copy to MPI
Section XI, Item D.4.a.	Any problem that threatens system performance	All	Within one (1) hour	Applicable Agency staff
Section XI, Item D.8.a.	Business Continuity-Disaster Recovery Plan	All	Before beginning operation. Ten (10) business days before change. Certification if plan is unchanged by April 30th, annually thereafter.	BMHC
Section XI, Item E.1.	System changes	All	Ninety (90) calendar days before change	HSD

Contract Section	Submission	Plan Type	Frequency	Submit To
Section XI, Item K.1.b.	Social Networking policies, procedures and monitoring plan	All	<p>Sixty (60) calendar days before beginning any new social networking application;</p> <p>Sixty (60) calendar days before change in policy, procedure or monitoring plan;</p> <p>Attestation if policies, procedures and monitoring plan are unchanged by September 1 of each Contract year.</p>	BMHC
Section XI, Item K.1.b.	Social networking content and intended use	All	<p>Sixty (60) calendar days before launch of any new social networking application or policy, procedure or monitoring plan;</p> <p>Sixty (60) calendar days before effective date of change in usage and/or content.</p>	BMHC
Section XIV, Item A.1.(a)	Corrective action plan	All	Within ten (10) business days of notice of violation or non-compliance with Contract	Agency Bureau sending violation notice
Section XIV, Item A.1.(b)	Performance measure action plan	All	Within thirty (30) calendar days of notice of failure to meet a performance standard	BMQM
Section XV, Item C.	Proof of working capital	All	Before enrollment	BMHC
Section XV, Item G.2.	Physician incentive plan	All	Written description before use	BMHC
Section XV, Item H.	Third party coverage identified	All	As soon as known	Medicaid Third Party Liability Vendor

Contract Section	Submission	Plan Type	Frequency	Submit To
Section XV, Item I.	Proof of fidelity bond coverage	All	Within sixty (60) calendar days of Contract execution & before delivering health care	HSD Contract manager
Section XVI, Item C.1.	Request for assignment or transfer of contract in approved merger/acquisition	All	Ninety (90) days before effective date	HSD
Section XVI, Item M.	Use of "Medicaid" or "AHCA"	All	Before use	BMHC
Section XVI, Item O.	All subcontracts for Agency approval	All	Before effective date	BMHC
Section XVI, Item O.1.f.	Subcontract monitoring schedule	All	Annually, by December 1 st	BMHC
Section XVI, Item V.1.	Ownership & management disclosure forms	All	With initial application; and then annually by September 1 st	HSD – for initial application; BMHC & HSD for annual
Section XVI, Item V.1.	Changes in ownership & control	All	Within five (5) calendar days of knowledge & sixty (60) days before effective date	BMHC & HSD
Section XVI, Item V.4.a.	Fingerprints for principals	All	Before Contract execution.	HSD
Section XVI, Item V.4.c.	Fingerprints of newly hired principals	All except CCC	Within thirty (30) calendar days of hire date	HSD
Section XVI, Item V.5.	Information about offenses listed in 435.04	All	Within five (5) business days of knowledge	HSD
Section XVI, Item V.6.	Corrective action plan related to principals committing offenses under 435.04	All	As prescribed by the Agency	HSD

Contract Section	Submission	Plan Type	Frequency	Submit To
Section XVI, Item Y.	General insurance policy declaration pages	All except CCC	Annually upon renewal	BMHC
Section XVI, Item Z.	Workers' compensation insurance declaration page	All except CCC	Annually upon renewal	BMHC
Section XVI, Item BB.	Emergency Management Plan	All	Before beginning operation and by May 31st annually thereafter	BMHC
Exhibit 2, Section II, Item D.4.c.	Policies & procedures for screening for clinical eligibility & any changes to them	CCC	Before implementation	BMHC
Exhibit 3, Section III, Item C.5.	Disenrollment notice	CCC	Get template approved before use At least two (2) months before anticipated effective date of involuntary disenrollment	BMHC Enrollee
Exhibit 5, Section V, Item A.6.	Letters about exhaustion of benefits under customized benefit package	Reform capitated Health Plans	Before use	BMHC
Exhibit 5, Section V, Item H.20.g.	Transportation subcontract	NR HMO offering transportation; Reform Health Plans	Before execution	BMHC
Exhibit 5, Section V, Item H.20.h.	Transportation policies & procedures	NR HMO offering transportation; Reform Health Plans	Before use	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Exhibit 5, Section V, Item H.20.i.	Transportation adverse incidents	NR HMO offering transportation; Reform Health Plans	Within two (2) business days of the occurrence	BMHC
Exhibit 5, Section V, Item H.20.i.	Transportation suspected fraud	NR HMO offering transportation; Reform Health Plans	Immediately upon identification	MPI
Exhibit 5, Section V, Item H.20.p.	Transportation performance measures	NR HMO offering transportation; Reform Health Plans	Annually report by July 1st	BMQM
Exhibit 5, Section V, Item H.20.q. & r.	Attestation that Health Plan complies with transportation policies & procedures & drivers pass background checks & meet qualifications	NR HMO offering transportation; Reform Health Plans	Annually by January 1st	BMHC
Exhibit 6, Item A.3.	Review & approval of behavioral health services staff & subcontractors for licensure compliance	Reform Health Plans & NR HMOs	Before providing services	BMHC
Exhibit 6, Item B.9.	Model agreement with community mental health centers	Reform Health Plans & NR HMOs	Before agreement is executed	BMHC
Exhibit 6, Item C.3.e.	Denied appeals from providers for emergency services claims	Plans covering behavioral health	Within ten (10) calendar days after Health Plan's final denial	BMHC

Contract Section	Submission	Plan Type	Frequency	Submit To
Exhibit 6, Item C.5.a.(3)	Medical necessity criteria for community mental health services	Plans covering behavioral health	Before use and before changes implemented	BMHC
Exhibit 6, Item L.2.	MBHO staff psychiatrist and model contracts for each specialty type	Plans covering behavioral health	Before execution	BMHC
Exhibit 6, Item M.	Optional services	Plans covering behavioral health	Before offering	BMHC
Exhibit 6, Item R.3.a.	Schedule for administrative and program monitoring and clinical record review	Plans covering behavioral health	Annually by July 1st	BMHC
Exhibit 8, Section VIII, Item B.5.	Substitute disease management initiatives	CCC	Within sixty (60) calendar days of Contract execution	BMHC
Exhibit 8, Section VIII, Item A.3.f.	Provider satisfaction survey plan & questions	All Reform Health Plans	By end of 8th month of Contract for approval	BMHC
Exhibit 8, Section VIII, Item A.3.f.	Provider satisfaction survey results	All Reform Health Plans	Four (4) months after the beginning of the 2nd year of Contract	BMHC
Exhibit 8, Section VIII, Item B.5.b.	Policies and procedures and program descriptions for each disease management program	All Reform Health Plans	Annually, by April 1st	BMHC
Exhibit 8, Section VIII, Item B.1.e. (5)	Caseload maximums for case managers	HIV/AIDS specialty plan	Before providing services	BMHC
Exhibit 10, Section X, Item C.5.a.	Discrepancies in ERV	FFS Health Plans; CCC	Within ten (10) business days of discovery	HSD analyst

Contract Section	Submission	Plan Type	Frequency	Submit To
Exhibit 15, Section XV, Item A.1.a.	Conversion application to capitated Health Plan	FFS PSNs; CCC	By September 1, 2012	HSD
Exhibit 15, Section XV, Item I.	Proof of coverage for any non-government subcontractor	CCC	Within sixty (60) calendar days of execution and before delivery of care	BMHC
Exhibit 16, Section XVI, Item V.4.c.	Fingerprints of newly hired principals	CCC	Within thirty (30) calendar days of hire date	Letter to HSD contract manager with list of hires and FDLE screening results

NR HMO = Non-Reform health maintenance organization, includes Health Plans covering Frail/Elderly Program services as specified in Attachment I

Ref HMO = Reform health maintenance organization

Ref Cap PSN = Reform capitated provider service network

Ref FFS PSN = Reform Fee-for-Service Provider Service Network

NR Cap PSN = Non-Reform Capitated Provider Service Network

NR FFS PSN = Non-Reform Fee-for-Service Provider Service Network

CCC = Specialty plan for children with chronic conditions

HIV/AIDS = Specialty plan for recipients living with HIV/AIDS

23. Attachment II, Core Contract Provisions, Section XIV, Sanctions, Item A., General Provisions, sub-item 1.(b) is hereby amended to now read as follows:
 - (b) If the Agency determines that the Health Plan has not met its performance standards, the Health Plan shall submit to the Bureau of Medicaid Quality Management (BMQM) a performance measure action plan (PMAP) within thirty (30) calendar days of receiving notice from the Agency.

24. Attachment II, Core Contract Provisions, Section XIV, Sanctions, Item E., Civil Monetary Penalties, is hereby amended to include sub-item 5. as follows:
 5. Notwithstanding the provisions of this Section, the Health Plan is subject to the fines set forth in s. 409.91212, F. S. See Attachment II, Section X, Administration and Management, Item E., Fraud and Abuse Prevention, of this Contract.

25. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item C., Assignment, is hereby amended to include sub-item 5. as follows:
 5. The entity requesting the assignment or transfer and the acquiring/merging entity must work with the Agency to develop and implement an Agency-approved transition plan, to include a timeline and appropriate notices to all enrollees and all providers as required by the Agency and to ensure a seamless transition for enrollees, particularly those requiring care coordination/case management.

26. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item O., Subcontracts, sub-item 1.c. is hereby amended to now read as follows:
- c. The Agency encourages use of minority business enterprise subcontractors. See Attachment II, Section VII, Provider Network, Item D., Provider Contract Requirements, for provisions and requirements specific to provider contracts. See Attachment II, Section XVI, Terms and Conditions, Item W., Minority Recruitment and Retention Plan, for other minority recruitment and retention plan requirements.
27. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item V., Ownership and Management Disclosure, sub-items 4., 5. and 6. are hereby deleted in their entirety and replaced as follows:
- 4. By September 1st of each Contract Year, the Health Plan shall conduct an annual background check with the Florida Department of Law Enforcement on all persons with five percent (5%) or more ownership interest in the Health Plan, or who have executive management responsibility for the Health Plan, or have the ability to exercise effective control of the Health Plan (see ss. 409.912 and 435.04, F.S.).
 - a. The Health Plan shall submit, prior to execution of this Contract, complete sets of fingerprints of principals of the Health Plan to HSD for the purpose of conducting a criminal history record check (see s. 409.907, F.S.).
 - b. Principals of the Health Plan shall be as defined in s. 409.907, F.S.
 - c. The Health Plan shall submit to the Agency Contract Manager complete sets of fingerprints of newly hired principals (officers, directors, agents, and managing employees) within thirty (30) calendar days of the hire date.
 - 5. The Health Plan shall submit to the Agency, within five (5) business days, any information on any officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Health Plan who has been found guilty of, regardless of adjudication, or who entered a plea of *nolo contendere* or guilty to, any of the offenses listed in s. 435.04, F.S. The Health Plan shall submit information to HSD for such persons who have a record of illegal conduct according to the background check. The Health Plan shall keep a record of all background checks to be available for Agency review upon request.
 - 6. The Agency shall not contract with a Health Plan that has an officer, director, agent, managing employee, or owner of stock or beneficial interest in excess of five percent (5%) of the Health Plan, who has committed any of the above listed offenses (see ss. 409.912 and 435.04, F.S.). In order to avoid termination, the Health Plan shall submit a corrective action plan, acceptable to the Agency, which ensures that such person is divested of all interest and/or control and has no role in the operation and/or management of the Health Plan.
28. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, Item W., Minority Recruitment and Retention Plan, the header row is hereby amended to now read as follows:

W. Minority Recruitment and Retention Plan

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29. Attachment II, Core Contract Provisions, Section XVI, Terms and Conditions, is hereby amended to include Items DD. through FF. as follows:

DD. Authority to Act

Any person executing this Contract or any documents, instruments or assurances, created, presented or reasonably necessary or appropriate to carry out the full intent and purpose of this Contract, in a representative capacity, hereby warrants to the Agency that it has implied, express or delegated authority to enter into, execute, attest or certify this Contract or aforementioned documents on behalf of such party which it represents. The Health Plan shall not raise the fact that a person executing a document, instrument or assurance as set forth herein lacks authority to bind the Health Plan for which it is representing as a defense to the enforcement of this Contract or other document executed in connection with this Contract.

EE. Proof of Execution by Electronic Copy or Facsimile.

For purposes of executing this Contract or any documents, instruments and assurances created, presented or reasonably necessary or appropriate to carry out the full intent and purpose of this Contract, a document signed or electronically signed and transmitted by facsimile, e-mail or other form of electronic transmission is to be treated as an original document. The signature or electronic signature of any party thereon, for purposes hereof, is to be considered as an original signature, and the document transmitted is to be considered to have the same binding effect as an original signature on an original document. At the request of the Agency, any document transmitted by facsimile, telecopy, e-mail or other form of electronic transmission is to be executed in original form by the Health Plan. The Health Plan shall not raise the fact that any signature was transmitted through the use of a facsimile, e-mail or other form of electronic transmission as a defense to the enforcement of this Contract or other document executed in connection with this Contract.

FF. Remedies Cumulative

Except as otherwise expressly provided herein, all rights, powers and privileges conferred hereunder upon the Health Plan are cumulative and not restrictive of those given by law. No remedy herein conferred is exclusive of any other available remedy; but each and every such remedy is cumulative and is in addition to every other remedy given by Contract or now or hereafter existing at law, in equity or by statute.

30. Attachment II, Core Contract Provisions, Exhibit 5, Covered Services, Item 2., Non-Reform Health Plans covering dental as an optional service and Reform Health Plans, Section V, Covered Services, Item H., Coverage Provisions, sub-item 3., Dental Services, is hereby deleted in its entirety and replaced with the following:

Dental services are defined in the Medicaid Dental Services Coverage and Limitations Handbook.

- a. For enrollees under age 21, the Health Plan shall cover diagnostic services, preventive treatment, CHCUP dental screening (including a direct referral to a dentist for enrollees beginning at three (3) years of age or earlier as indicated); restorative treatment, endodontic treatment, periodontal treatment, surgical procedures and/or extractions, orthodontic treatment, complete and partial dentures, complete and partial denture relines and repairs, and adjunctive and emergency services. Fluoride varnish application in a physician's office under CHCUP is limited to children up to three and one half (3 ½) years (42 months) of age. The Health Plan shall ensure the following for active orthodontia:

- (1) The Health Plan shall ensure continuity of care for active orthodontia until completion of care, regardless of provider network affiliation;
 - (2) The Health Plan shall ensure reimbursement to providers for active orthodontia until completion of care, regardless of provider network affiliation;
 - (3) The Health Plan shall ensure maintenance of written case management continuity of care protocol(s) that include the following minimum functions:
 - (a) Appropriate referral of and scheduling assistance for enrollees needing specialty dental care.
 - (b) Documentation of referral services in enrollees' dental records, including results.
 - (c) Monitoring enrollees with on-going dental conditions and coordination of services for high users such that the following functions are addressed as appropriate: acting as a liaison between the member and providers, ensuring the member is receiving routine dental care, ensuring that the member has adequate support at home, and assisting enrollees who are unable to access necessary care due to their medical or emotional conditions or who do not have adequate community resources to comply with their care.
 - (4) Documentation in dental records of member emergency encounters with appropriate indicated follow-up.
- b. Adult services include adult full and partial denture services and medically necessary emergency dental procedures to alleviate pain or infection. Emergency dental care shall be limited to emergency oral examinations, necessary x-rays, extractions, and incision and drainage of abscess.
31. Attachment II, Core Contract Provisions, Exhibit 6, HMOs & Reform Health Plans, Behavioral Health Care, Item 1., Reform Health Plans and Non-Reform HMOs, sub-item A., General Provisions, sub-item 5., is hereby amended to now read as follows:
5. The Health Plan shall provide the following services as described in the Mental Health Targeted Case Management Coverage & Limitations Handbook and the Community Behavioral Health Services Coverage & Limitations Handbook (the Handbooks). The Health Plan shall not alter the amount, duration and scope of such services from that specified in the Handbooks. The Health Plan shall not establish service limitations that are lower than, or inconsistent with, the Handbooks.
 - a. Inpatient hospital services for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
 - b. Outpatient hospital services for psychiatric conditions (ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);

- c. Psychiatric physician services (for psychiatric specialty codes 42, 43, 44 and ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9);
 - d. Community mental health services (ICD-9-CM codes 290 through 290.43, 290.8, 290.9, 293.0 through 298.9, 300 through 301.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9); and for these procedure codes H0031; H0031HO; H0031HN; H0031TS; H0032; H0032TS; H0046; H2000; H2000HO; H2000HP; H2010HO; H2010HE; H2010HQ; H2012; H2017; H2019; H2019HM; H2019HN; H2019HO; H2019HQ; H2019HR; T1015; T1015HE; or T1023HE;
 - e. Community substance abuse services when the appropriate ICD-9 CM diagnosis code (290 through 290.43, 293 through 298.9, 302.7, 306.51 through 312.4 and 312.81 through 314.9, 315.3, 315.31, 315.5, 315.8, and 315.9) has been documented: H0001, H0001HN; H0001HO, H0001TS, H0047, H2010HF, H2012HF, T1007, T1007TS, T1015HF or T1023HF;
 - f. Mental Health Targeted Case Management (Children: T1017HA; Adults: T1017); and
 - g. Mental Health Intensive Targeted Case Management (Adults: T1017HK).
32. Attachment II, Core Contract Provisions, Exhibit 6, HMOs & Reform Health Plans, Behavioral Health Care, Item 1., Reform Health Plans and Non-Reform HMOs, sub-item C., Service Requirements, sub-item 3., Emergency Services – Behavioral Health Services is hereby deleted in its entirety and replaced with the following:

3. Emergency Services – Behavioral Health Services

The Health Plans shall provide emergency behavioral health services pursuant, but not limited, to s. 394.463, F.S.; s. 641.513, F.S.; and Title 42 CFR Chapter IV.

a. Crisis Intervention Mental Health Services and Post-Stabilization Care Services

- (1) Crisis intervention services include intervention activities of less than twenty-four (24) hour duration (within a twenty-four (24) hour period) designed to stabilize an enrollee in a psychiatric emergency.
 - (2) Post-stabilization care services include any of the mandatory services that a treating physician views as medically necessary, that are provided after an enrollee is stabilized from an emergency mental health condition in order to maintain the stabilized condition, or under the circumstances described in 42 CFR 438.114(e) to improve or resolve the enrollee's condition.
- b. Emergency service providers shall make a reasonable attempt to notify the Health Plan within twenty-four (24) hours of the enrollee's presenting for emergency behavioral health services. In cases in which the enrollee has no identification, or is unable to orally identify himself/herself when presenting for behavioral health services, the provider shall notify the Health Plan within twenty-four (24) hours of learning the enrollee's identity.

- c. The emergency service provider shall notify the Health Plan as soon as possible prior to discharge of the enrollee from the emergency care area or notify the Health Plan within twenty-four (24) hours or on the next business day after the enrollee's inpatient admission.
 - d. The Health Plan shall process all out-of-plan emergency behavioral health service claims within the time frames specified for emergency claims payment in Attachment II, Section V, Covered Services, Item H., Coverage Provisions, sub-item 7., Emergency Services.
 - e. The Health Plan shall submit to BMHC within ten (10) calendar days after the Health Plan's final appeal determination for review and final determination all denied appeals from behavioral health care providers and out-of-plan, non-participating behavioral health care providers for denied emergency behavioral health service claims.
 - f. The Health Plan shall not deny emergency services for enrollees presenting at receiving facilities for involuntary examination under the Baker Act.
 - (1) The receiving facility will make every effort to notify the Health Plan within twenty-four (24) hours of receiving the enrollee.
 - (2) The Health Plan shall begin coordinating the enrollee's care upon notification by the receiving facility.
 - (3) A stabilized condition is determined when the physician treating the enrollee decides when the enrollee may be considered stabilized for transfer or discharge, and that decision is binding on the Health Plan (42 CFR 438.114(d)(3)).
 - g. Fee-for-service Health Plans shall follow provisions of subparagraph f. above for receiving facilities that are not CSUs.
33. Attachment II, Core Contract Provisions, Exhibit 6, HMOs and Reform Health Plans, Behavioral Health Care, Item 1., Reform Health Plans and Non-Reform HMOs, sub-item D., Transition Plan, sub-item 2., the second sentence is hereby amended to now read as follows:

For enrollees who have received behavioral health services for at least six (6) months from a behavioral health care provider, whether the provider is in the Health Plan's network or not, the Health Plan shall continue to authorize all valid claims until the Health Plan has:

Unless otherwise stated, this amendment is effective upon execution.

All provisions not in conflict with this amendment are still in effect and are to be performed at the level specified in the Contract.

This amendment, and all its attachments, are hereby made part of the Contract.

This amendment cannot be executed unless all previous amendments to this Contract have been fully executed.

AHCA Contract No. FA905, Amendment No. 5, Page 44 of 45

IN WITNESS WHEREOF, the Parties hereto have caused this forty-five (45) page amendment (including all attachments) to be executed by their officials thereunto duly authorized.

HEALTHEASE OF FLORIDA, INC.

STATE OF FLORIDA, AGENCY FOR HEALTH CARE ADMINISTRATION

BY: /s/ Christina Cooper

BY: /s/ Elizabeth Dudek

NAME: Christina Cooper

NAME: Elizabeth Dudek

TITLE: President FL & HI Division

TITLE: Secretary

DATE: 3/27/11

DATE: 3/31/11

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AHCA Contract No. FA905, Amendment No. 5, Page 45 of 45

CERTIFICATION

I, Alec Cunningham, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of WellCare Health Plans, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 6, 2011

/s/ Alec Cunningham
Alec Cunningham, Chief Executive Officer
(Principal Executive Officer)

CERTIFICATION

I, Thomas L. Tran, certify that:

1. I have reviewed this Quarterly Report on Form 10-Q of WellCare Health Plans, Inc.;
2. Based on my knowledge, this report does not contain any untrue statement of a material fact or omit to state a material fact necessary to make the statements made, in light of the circumstances under which such statements were made, not misleading with respect to the period covered by this report;
3. Based on my knowledge, the financial statements, and other financial information included in this report, fairly present in all material respects the financial condition, results of operations and cash flows of the registrant as of, and for, the periods presented in this report;
4. The registrant's other certifying officer and I are responsible for establishing and maintaining disclosure controls and procedures (as defined in Exchange Act Rules 13a-15(e) and 15d-15(e)) and internal control over financial reporting (as defined in Exchange Act Rules 13a-15(f) and 15d-15(f)) for the registrant and have:
 - a) Designed such disclosure controls and procedures, or caused such disclosure controls and procedures to be designed under our supervision, to ensure that material information relating to the registrant, including its consolidated subsidiaries, is made known to us by others within those entities, particularly during the period in which this report is being prepared;
 - b) Designed such internal control over financial reporting, or caused such internal control over financial reporting to be designed under our supervision, to provide reasonable assurance regarding the reliability of financial reporting and the preparation of financial statements for external purposes in accordance with generally accepted accounting principles;
 - c) Evaluated the effectiveness of the registrant's disclosure controls and procedures and presented in this report our conclusions about the effectiveness of the disclosure controls and procedures, as of the end of the period covered by this report based on such evaluation; and
 - d) Disclosed in this report any change in the registrant's internal control over financial reporting that occurred during the registrant's most recent fiscal quarter (the registrant's fourth fiscal quarter in the case of an annual report) that has materially affected, or is reasonably likely to materially affect, the registrant's internal control over financial reporting; and
5. The registrant's other certifying officer and I have disclosed, based on our most recent evaluation of internal control over financial reporting, to the registrant's auditors and the audit committee of the registrant's board of directors (or persons performing the equivalent functions):
 - a) All significant deficiencies and material weaknesses in the design or operation of internal control over financial reporting which are reasonably likely to adversely affect the registrant's ability to record, process, summarize and report financial information; and
 - b) Any fraud, whether or not material, that involves management or other employees who have a significant role in the registrant's internal control over financial reporting.

Date: May 6, 2011

/s/ Thomas L. Tran

Thomas L. Tran
Senior Vice President and Chief Financial Officer
(Principal Financial Officer)

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO SECTION 906
OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of WellCare Health Plans, Inc. (the "Company") for the fiscal quarter ended March 31, 2011 as filed with the Securities and Exchange Commission on the date hereof (the "Form 10-Q"), I, Alec Cunningham, Chief Executive Officer of the Company, hereby certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Form 10-Q fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: May 6, 2011

/s/ Alec Cunningham
Alec Cunningham, Chief Executive Officer
(Principal Executive Officer)

CERTIFICATION PURSUANT TO
18 U.S.C. SECTION 1350,
AS ADOPTED PURSUANT TO SECTION 906
OF THE SARBANES-OXLEY ACT OF 2002

In connection with the Quarterly Report on Form 10-Q of WellCare Health Plans, Inc. (the "Company") for the fiscal quarter ended March 31, 2011 as filed with the Securities and Exchange Commission on the date hereof (the "Form 10-Q"), I, Thomas L. Tran, Senior Vice President and Chief Financial Officer of the Company, hereby certify, pursuant to 18 U.S.C. Section 1350, as adopted pursuant to Section 906 of the Sarbanes-Oxley Act of 2002, that:

- (1) The Form 10-Q fully complies with the requirements of Section 13(a) or 15(d) of the Securities Exchange Act of 1934; and
- (2) The information contained in the Form 10-Q fairly presents, in all material respects, the financial condition and results of operations of the Company.

Date: May 6, 2011

/s/ Thomas L. Tran

Thomas L. Tran
Senior Vice President and Chief Financial Officer
(Principal Financial Officer)

Document And Entity Information

Document And Entity Information (USD \$)	3 Months Ended 03/31/2011	05/04/2011
Entity Registrant Name	WELLCARE HEALTH PLANS, INC.	
Entity Central Index Key	0001279363	
Current Fiscal Year End Date	--12-31	
Entity Well-known Seasoned Issuer	Yes	
Entity Voluntary Filers	No	
Entity Current Reporting Status	Yes	
Entity Filer Category	Large Accelerated Filer	
Entity Common Stock, Shares Outstanding		42,561,287
Document Fiscal Year Focus	2,011	
Document Fiscal Period Focus	Q1	
Document Type	10-Q	
Amendment Flag	false	
Document Period End Date	2011-03-31	

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS (Unaudited)

CONDENSED CONSOLIDATED STATEMENTS OF OPERATIONS (Unaudited) (USD \$) (in Thousands except Per Share Data)	3 Months Ended 03/31/2011	3 Months Ended 03/31/2010
Revenues:		
Premium (see Note 1)	\$ 1,472,416	\$ 1,353,458
Investment and other income	2,326	2,495
Total revenues	<u>1,474,742</u>	<u>1,355,953</u>
Expenses:		
Medical benefits	1,245,040	1,165,972
Selling, general and administrative	169,243	163,593
Medicaid premium taxes (see Note 1)	18,864	9,744
Depreciation and amortization	6,475	5,756
Interest	77	10
Total expenses	<u>1,439,699</u>	<u>1,345,075</u>
Income before income taxes	<u>35,043</u>	<u>10,878</u>
Income tax expense	13,713	4,460
Net income	<u>\$ 21,330</u>	<u>\$ 6,418</u>
Net income per common share (see Note 1):		
Basic (in dollars per share)	\$ 0.50	\$ 0.15
Diluted (in dollars per share)	\$ 0.50	\$ 0.15

CONDENSED CONSOLIDATED BALANCE SHEET (Unaudited)

CONDENSED CONSOLIDATED BALANCE SHEET (Unaudited) (USD \$) (in Thousands)	3 Months Ended 03/31/2011	12 Months Ended 12/31/2010
Assets		
Current Assets:		
Cash and cash equivalents	\$ 1,232,918	\$ 1,359,548
Investments	201,894	108,788
Premium receivables, net	190,182	127,796
Funds held for the benefit of members	0	33,182
Income taxes receivable	16,838	9,973
Prepaid expenses and other current assets, net	117,815	114,492
Deferred income tax asset	42,963	61,392
Total current assets	<u>1,802,610</u>	<u>1,815,171</u>
Property, equipment and capitalized software, net	75,980	76,825
Goodwill	111,131	111,131
Other intangible assets, net	11,045	11,428
Long-term investments	83,717	62,931
Restricted investments	105,812	107,569
Deferred income tax asset	55,188	58,340
Other assets	3,726	3,898
Total Assets	<u>2,249,209</u>	<u>2,247,293</u>
Liabilities and Stockholders' Equity		
Current Liabilities:		
Medical benefits payable	790,624	742,990
Unearned premiums	84,532	67,383
Accounts payable	7,629	8,284
Other accrued expenses and liabilities	152,348	199,033
Current portion of amounts accrued related to investigation resolution	68,799	121,406
Other payables to government partners	52,179	46,605
Funds held for the benefit of members	<u>4,624</u>	<u>0</u>
Total current liabilities	<u>1,160,735</u>	<u>1,185,701</u>
Amounts accrued related to investigation resolution	218,274	216,136
Other liabilities	12,546	13,410
Total liabilities	<u>1,391,555</u>	<u>1,415,247</u>
Commitments and contingencies (see Note 6)		
Stockholders' Equity:		
Preferred stock, \$0.01 par value (20,000,000 authorized, no shares issued or outstanding)	0	0
Common stock, \$0.01 par value (100,000,000 authorized, 42,557,404 and 42,541,725 shares issued and outstanding at March 31, 2011 and December 31, 2010, respectively)	426	425
Paid-in capital	432,810	428,818
Retained earnings	426,442	405,112
Accumulated other comprehensive loss	(2,024)	(2,309)
Total stockholders' equity	<u>857,654</u>	<u>832,046</u>
Total Liabilities and Stockholders' Equity	<u>\$ 2,249,209</u>	<u>\$ 2,247,293</u>

CONDENSED CONSOLIDATED BALANCE SHEET (Unaudited) Parenthetical

CONDENSED CONSOLIDATED BALANCE SHEET (Unaudited) Parenthetical (USD \$)	03/31/2011	12/31/2010
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Stockholders' Equity:

Preferred stock, par value (in dollars per share)	\$ 0.01	\$ 0.01
Preferred stock, authorized (in shares)	20,000,000	20,000,000
Preferred stock, issued (in shares)	0	0
Preferred stock, outstanding (in shares)	0	0
Common stock, par value (in dollars per share)	\$ 0.01	\$ 0.01
Common stock, authorized (in shares)	100,000,000	100,000,000
Common stock, issued (in shares)	42,557,404	42,541,725
Common stock, outstanding (in shares)	42,557,404	42,541,725

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS (Unaudited)

CONDENSED CONSOLIDATED STATEMENTS OF CASH FLOWS (Unaudited) (USD \$) (in Thousands)	3 Months Ended 03/31/2011	3 Months Ended 03/31/2010
Cash from (used in) operating activities:		
Net income	\$ 21,330	\$ 6,418
Adjustments to reconcile net income to net cash used in operating activities:		
Depreciation and amortization	6,475	5,756
Equity-based compensation expense	4,849	1,142
Deferred taxes, net	21,581	16,721
Changes in operating accounts:		
Premium receivables, net	(62,386)	23,781
Prepaid expenses and other current assets, net	(3,323)	(2,985)
Medical benefits payable	47,634	(95,690)
Unearned premiums	17,149	(90,353)
Accounts payables and other accrued expenses	(43,475)	(18,466)
Other payables to government partners	5,574	4,547
Amounts accrued related to investigation resolution	(50,469)	511
Income taxes, net	(8,012)	(14,401)
Other, net	(869)	(7,525)
Net cash used in operating activities	<u>(43,942)</u>	<u>(170,544)</u>
Cash from (used in) investing activities:		
Purchases of investments	(198,305)	(117)
Proceeds from sale and maturities of investments	85,043	12,322
Purchases of restricted investments	(4,012)	(289)
Proceeds from maturities of restricted investments	5,601	368
Additions to property, equipment and capitalized software, net	(8,715)	(4,235)
Net cash (used in) provided by investing activities	<u>(120,388)</u>	<u>8,049</u>
Cash from (used in) financing activities:		
Proceeds from option exercises and other	1,034	770
Purchase of treasury stock	(744)	(3,030)
Payments on capital leases	(396)	(58)
Funds held for the benefit of members	37,806	34,019
Net cash provided by financing activities	<u>37,700</u>	<u>31,701</u>
Cash and cash equivalents:		
Decrease during period	<u>(126,630)</u>	<u>(130,794)</u>
Balance at beginning of year	1,359,548	1,158,131
Balance at end of period	1,232,918	1,027,337
SUPPLEMENTAL DISCLOSURES OF CASH FLOW INFORMATION:		
Cash paid for taxes	446	8,161
Cash paid for interest	74	7
Equipment acquired through capital leases	\$ 0	\$ 8,411

ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES
(USD \$)

3 Months Ended
03/31/2011

ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

1. ORGANIZATION, BASIS OF PRESENTATION AND SIGNIFICANT ACCOUNTING POLICIES

WellCare Health Plans, Inc., a Delaware corporation (the "Company," "we," "us," or "our"), provides managed care services exclusively to government-sponsored health care programs, serving approximately 2,383,000 members as of March 31, 2011. Through our licensed subsidiaries, as of March 31, 2011, we operate our Medicaid health plans in Florida, Georgia, Hawaii, Illinois, Missouri, New York and Ohio, and our Medicare Advantage ("MA") coordinated care plans ("CCPs") in Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Missouri, New Jersey, New York, Ohio and Texas. We also operate a stand-alone Medicare prescription drug plan ("PDP") in 49 states and the District of Columbia. We exited the Medicare private fee-for-service ("PFFS") program on December 31, 2009.

Basis of Presentation & Use of Estimates

The accompanying unaudited condensed consolidated interim financial statements should be read in conjunction with the consolidated financial statements and notes thereto for the fiscal year ended December 31, 2010 included in our Annual Report on Form 10-K ("2010 Form 10-K"), filed with the United States Securities and Exchange Commission (the "SEC") in February 2011. In the opinion of management, the interim financial statements reflect all normal recurring adjustments that we consider necessary for the fair presentation of our financial position, results of operations and cash flows for the interim periods presented. The interim financial statements included herein have been prepared in accordance with accounting principles generally accepted in the United States of America ("GAAP") and with the instructions to Form 10-Q and Article 10 of Regulation S-X. Accordingly, certain information and footnote disclosures normally included in financial statements prepared in accordance with GAAP have been condensed or omitted. The preparation of financial statements in conformity with GAAP requires management to make estimates and assumptions that affect the amounts reported in the condensed consolidated financial statements and accompanying notes. These estimates are based on knowledge of current events and anticipated future events and accordingly, actual results may differ from those estimates. Results for the interim periods presented are not necessarily indicative of results that may be expected for the entire year or any other interim period. Certain items in our financial statements have been reclassified from their prior year classifications to conform to our current year presentation. We have evaluated all material events subsequent to the date of these financial statements.

Significant Accounting Policies

Net Income per Share

We compute basic net income per common share on the basis of the weighted-average number of unrestricted common shares outstanding. Diluted net income per common share is computed on the basis of the weighted-average number of unrestricted common shares outstanding plus the dilutive effect of outstanding stock options, restricted shares and restricted stock units using the treasury stock method. The following table presents the calculation of net income per common share - basic and diluted:

	Three Months Ended March 31,	
	2011	2010
Numerator:		
Net income	\$ 21,330	\$ 6,418
Denominator:		
Weighted-average common shares outstanding - basic	42,621,908	42,193,662
Dilutive effect of:		
Unvested restricted stock, restricted stock units and performance stock units	280,073	360,043
Stock options	138,548	153,536
Weighted-average common shares outstanding - diluted	43,040,529	42,707,241
Net income per common share:		
Basic	\$ 0.50	\$ 0.15
Diluted	\$ 0.50	\$ 0.15

For the three months ended March 31, 2011 and 2010, certain options to purchase common stock were not included in the calculation of diluted net income per common share because their exercise prices were greater than the average market price of our common stock for the period and, therefore, the effect would be anti-dilutive. For the three months ended March 31, 2011, 142,153 restricted equity awards and 294,626 options with exercise prices ranging from \$28.27 to \$90.52 were excluded from diluted weighted-average common shares outstanding. For the three months ended March 31, 2010, approximately 119,356 restricted equity awards as well as 1,165,606 options with exercise prices ranging from \$24.17 to \$91.64 per share were excluded from diluted weighted-average common shares outstanding.

Premium Revenue Recognition

We receive premiums from state and federal agencies for the members that are assigned to, or have selected, us to provide health care services under Medicaid and Medicare. The premiums we receive for each member vary according to the specific government program and are generally determined at the beginning of the contract period. These premiums

are subject to adjustment throughout the term of the contract by CMS and the states, although such adjustments are typically made at the commencement of each new contract renewal period.

Our Medicaid contracts with state governments are generally multi-year contracts subject to annual renewal provisions. Our Medicare Advantage and PDP contracts with the Centers for Medicare & Medicaid Services (“CMS”) generally have terms of one year.

In most cases we receive premiums in advance of providing services, and we recognize premium revenues in the period in which we are obligated to provide services to our members. We are paid generally in the month in which we provide services. Premiums are billed monthly for coverage in the following month and are recognized as revenue in the month for which insurance coverage is provided. Premiums collected in advance of the period in which we are obligated to provide services to our members are deferred and reported as Unearned premiums in the accompanying Condensed Consolidated Balance Sheets and amounts that have not been received by the end of the period remain on the Condensed Consolidated Balance Sheets classified as Premium receivables, net.

We routinely monitor the collectability of specific accounts, the aging of receivables and historical retroactivity trends, as well as prevailing and anticipated economic conditions, and reflect any required adjustments in current operations. We estimate, on an ongoing basis, the amount of member billings that may not be fully collectible or that will be returned based on historical collection experience, retroactive membership adjustments, anticipated or actual, compliance with requirements for certain contracts to expend a minimum percentage of premiums on eligible medical expense, and other factors. An allowance is established for the estimated amount that may not be collectible and a liability is established for premium expected to be returned. The allowance has not been significant to premium revenue.

Premium payments that we receive are based upon eligibility lists produced by the government. We verify these lists to determine whether we have been paid for the correct premium category and program. From time to time, the states or CMS require us to reimburse them for premiums that we received based on an eligibility list that a state, CMS or we later discover, through our audits or otherwise, contains individuals who were not eligible for any government-sponsored program or belong to a different plan other than ours. The verification and subsequent membership changes may result in additional amounts due to us or we may owe premiums back to the government. The amounts receivable or payable identified by us through reconciliation and verification of agency eligibility lists relate to current and prior periods. The amounts receivable from government agencies for reconciling items were \$11,925 and \$270 at March 31, 2011 and

December 31, 2010, respectively, and are included in Premium receivables, net, on our Condensed Consolidated Balance Sheets. The amounts due to government agencies for reconciling items were \$48,645 and \$63,289 at March 31, 2011 and December 31, 2010, respectively, and are included in Other accrued expenses and liabilities on our Condensed Consolidated Balance Sheets. We record adjustments to revenues based on member retroactivity. These adjustments reflect changes in the number and eligibility status of enrollees subsequent to when revenue was billed. We estimate the amount of outstanding retroactivity adjustments each period and adjust premium revenue accordingly; if appropriate, the estimates of retroactivity adjustments are based on historical trends, premiums billed, the volume of member and contract renewal activity and other information. Changes in member retroactivity adjustment estimates had a minimal impact on premiums recorded during the periods presented. Our government contracts establish monthly rates per member that may be adjusted based on member demographics such as age, working status or medical history.

Risk-Adjusted Premiums

CMS employs a risk-adjustment model to determine the premium amount it pays for each member. This model apportions premiums paid to all MA plans according to the health status of each beneficiary enrolled. As a result, our CMS monthly premium payments per member may change materially, either favorably or unfavorably. The CMS risk-adjustment model pays more for Medicare members with predictably higher costs. Diagnosis data from inpatient and ambulatory treatment settings are used to calculate the risk-adjusted premiums we receive. We collect claims and encounter data and submit the necessary diagnosis data to CMS within prescribed deadlines. After reviewing the respective submissions, CMS establishes the premium payments to MA plans generally at the beginning of the calendar year, and then adjusts premium levels on two separate occasions on a retroactive basis. The first retroactive adjustment for a given fiscal year generally occurs during the third quarter of such fiscal year. This initial settlement (the "Initial CMS Settlement") represents the updating of risk scores for the current year based on the severity of claims incurred in the prior fiscal year. CMS then issues a final retroactive risk-adjusted premium settlement for that fiscal year in the following year (the "Final CMS Settlement"). We reassess the estimates of the Initial CMS Settlement and the Final CMS Settlement each reporting period and any resulting adjustments are made to MA premium revenue.

We develop our estimates for risk-adjusted premiums utilizing historical experience and predictive models as sufficient member risk score data becomes available over the course of each CMS plan year. Our models are populated with available risk score data on our members. Risk premium adjustments are based on member risk score data from the previous year. Risk score data for members who entered our plans during the current plan year,

however, is not available for use in our models; therefore, we make assumptions regarding the risk scores of this subset of our member population. All such estimated amounts are periodically updated as additional diagnosis code information is reported to CMS and adjusted to actual amounts when the ultimate adjustment settlements are either received from CMS or we receive notification from CMS of such settlement amounts.

As a result of the variability of factors that determine such estimates, including plan risk scores, the actual amount of CMS retroactive payment could be materially more or less than our estimates. Consequently, our estimate of our plans' risk scores for any period, and any resulting change in our accrual of MA premium revenues related thereto, could have a material adverse effect on our results of operations, financial position and cash flows. Historically, we have not experienced significant differences between the amounts that we have recorded and the revenues that we ultimately receive. The data provided to CMS to determine the risk score is subject to audit by CMS even after the annual settlements occur. These audits may result in the refund of premiums to CMS previously received by us. While our experience to date has not resulted in a material refund, this refund could be significant in the future, which would reduce our premium revenue in the year that CMS determines repayment is required.

Medical Benefits Payable and Expense

The cost of medical benefits is recognized in the period in which services are provided and includes an estimate of the cost of incurred but not reported ("IBNR") medical benefits. Medical benefits payable has two main components: direct medical expenses and medically-related administrative costs. Direct medical expenses include amounts paid or payable to hospitals, physicians and providers of ancillary services, such as laboratories and pharmacies. Medically-related administrative costs include items such as case and disease management, utilization review services, quality assurance and on-call nurses, which are recorded in Selling, general, and administrative expense. Medical benefits payable on our Consolidated Balance Sheets represents amounts for claims fully adjudicated awaiting payment disbursement and estimates for IBNR claims. The following table provides a reconciliation of the total medical benefits payable balances as of March 31, 2011 and December 31, 2010:

	March 31, 2011	% of Total	December 31, 2010	% of Total
	(in millions)		(in millions)	
Claims adjudicated, but not yet paid	\$ 78,067	10%	\$ 50,879	7%
IBNR	<u>712,557</u>	90%	<u>692,111</u>	93%
Total	\$ 790,624		\$ 742,990	

The medical benefits payable estimate has been, and continues to be, our most significant estimate included in our financial statements. We historically have used and continue to use a consistent methodology for estimating our medical benefits expense and medical benefits payable. Our policy is to record management's best estimate of medical benefits payable based on the experience and information available to us at the time. This estimate is determined utilizing standard actuarial methodologies based upon historical experience and key assumptions consisting of trend factors and completion factors using an assumption of moderately adverse conditions, which vary by business segment. These standard actuarial methodologies include using, among other factors, contractual requirements, historic utilization trends, the interval between the date services are rendered and the date claims are paid, denied claims activity, disputed claims activity, benefits changes, expected health care cost inflation, seasonality patterns, maturity of lines of business and changes in membership.

Changes in medical benefits payable estimates are primarily the result of obtaining more complete claims information and medical expense trend data over time. Volatility in members' needs for medical services, provider claims submissions and our payment processes result in identifiable patterns emerging several months after the causes of deviations from assumed trends occur. Since our estimates are based upon per-member per-month ("PMPM") claims experience, changes cannot typically be explained by any single factor, but are the result of a number of interrelated variables, all of which influence the resulting medical cost trend. Differences in our financial statements between actual experience and estimates used to establish the liability, which we refer to as prior period developments, are recorded in the period when such differences become known and have the effect of increasing or decreasing the reported medical benefits expense in such periods.

Medical benefits expense for the three months ended March 31, 2011, was impacted by approximately \$51,038 of net favorable development related to prior years. For the three months ended March 31, 2010, medical benefits expense was impacted by approximately \$4,592 of net favorable development related to prior years. The net favorable prior year development in 2011 results primarily from the difference between actual medical utilization compared to original assumptions and prior year claims estimates being settled for amounts that are different than originally anticipated. The net amount of prior period developments in the 2010 was primarily attributable to the reduction of the provision for moderately adverse conditions resulting from the exit of the PFFS product on December 31, 2009. The factors impacting the changes in the determination of medical benefits payable discussed above were not discernable in advance. The impact became clearer over time as claim payments were processed and more complete claims information was

obtained.

Medicaid Premium Taxes

Certain state agencies place an assessment or tax on Medicaid premiums, which is included in the premium rates established in the Medicaid contracts with each state agency and recorded as a component of revenue, as well as administrative expense, when incurred.

In October 2009, the State of Georgia stopped assessing taxes on Medicaid premiums remitted to us, which resulted in an equal reduction to Premium revenues and Medicaid premium taxes. However, effective July 1, 2010, the State of Georgia began assessing premium taxes again on Medicaid premiums. Therefore, from July 1, 2010 through March 31, 2011, we were assessed and remitted taxes on premiums in Georgia, Hawaii, Missouri, New York and Ohio. Medicaid premium taxes incurred were \$18,864 and \$9,744 for the three months ended March 31, 2011 and 2010, respectively.

Income Taxes

On a quarterly basis, our tax liability is estimated based on enacted tax rates, estimates of book-to-tax differences in income, and projections of income that will be earned in each taxing jurisdiction. Deferred tax assets and liabilities are recognized for the estimated future tax consequences attributable to differences between the financial statement carrying amounts of existing assets and liabilities and their respective tax basis. Deferred tax assets and liabilities are measured using tax rates expected to apply to taxable income in the years in which those temporary differences are expected to be recovered or settled. A valuation allowance is recognized when, based on available evidence, it is more likely than not that the deferred tax assets may not be realized. After tax returns for the applicable year are filed, the estimated tax liability is adjusted to the actual liability per the filed state and Federal tax returns. Historically, we have not experienced significant differences between our estimates of tax liability and our actual tax liability.

We sometimes face challenges from state and Federal tax authorities regarding the amount of taxes due. Positions taken on the tax returns are evaluated and benefits are recognized only if it is more likely than not that the position will be sustained on audit. Based on our evaluation of tax positions, we believe that potential tax exposures have been recorded appropriately. In addition, we are periodically audited by state and Federal taxing authorities and these audits can result in proposed assessments. We believe that our tax positions comply with applicable tax law and, as such, will vigorously defend our positions on audit. We believe that we have adequately provided for any reasonable foreseeable outcome related to these matters. Although the ultimate resolution of these audits may require additional tax payments, it is not anticipated that any additional tax payments would have a material impact to our results of operations or cash flows.

Goodwill and Intangible Assets

We review goodwill and intangible assets for impairment at least annually, or more frequently if events or changes in our business climate occur that may potentially affect the estimated useful life or the recoverability of the remaining balance of goodwill or intangible assets. Events or changes in circumstances would include significant changes in membership, state funding, medical contracts and provider networks. We select the second quarter of each year for our annual impairment test, which generally coincides with the finalization of federal and state contract negotiations and our initial budgeting process, and complete our impairment testing during the third quarter of each year. As of our last testing date in 2010, we assessed the book value of goodwill and other intangible assets and determined that the fair value of these assets exceeds its carrying value and noted no indications that would require additional impairment testing as of March 31, 2011.

Recently Issued Accounting Standards

In December 2010, the Financial Accounting Standards Board (the "FASB") issued new guidance on business combinations to clarify that if a public entity presents comparative financial statements, the entity should disclose revenue and earnings of the combined entity as though the business combination that occurred during the current year had occurred as of the beginning of the prior annual reporting period and to include a description of the nature and amount of material, nonrecurring pro forma adjustments directly attributable to the business combination included in the reported pro forma revenue and earnings. This new guidance is effective prospectively for business combinations for which the acquisition date is on, or after, the beginning of the first annual reporting period beginning on or after December 15, 2010. Any future business combinations will be accounted for under this guidance. The adoption of this topic is not expected to have a material effect on our consolidated financial statements.

In December 2010, the FASB issued accounting guidance clarifying the requirement to test for goodwill impairment when the carrying amount of a reporting unit exceeds its fair value. Under this guidance, if the carrying amount of a reporting unit is zero or negative, an entity must assess whether any adverse qualitative factors exist that would indicate that goodwill impairment, more likely than not, exists. If it is determined that goodwill impairment would, more likely than not, be triggered, additional testing to determine whether goodwill has actually been impaired would be required and the amount of such impairment, if any, would accordingly be determined. This guidance is effective for fiscal years, and interim periods within those years, beginning after December 15, 2010. The adoption of this topic is not expected to have a material effect on our consolidated financial statements.

We have reviewed all other recently issued accounting standards in order to determine their

effects, if any, on our results of operations, financial position and cash flows. Based on that review, none of these pronouncements are expected to have a significant affect on our financial statements.

SEGMENT REPORTING

SEGMENT REPORTING
(USD \$)

3 Months Ended
03/31/2011

SEGMENT REPORTING **2. SEGMENT REPORTING**

Reportable operating segments are defined as components of an enterprise for which discrete financial information is available and evaluated on a regular basis by the chief operating decision-maker to determine how resources should be allocated to an individual segment and to assess performance of those segments. Accordingly, we have three reportable segments within our two main business lines: Medicaid, MA and PDP. The PFFS product that we exited on December 31, 2009 is reported within the MA segment.

Medicaid

Medicaid was established to provide medical assistance to low-income and disabled persons. It is state operated and implemented, although it is funded and regulated by both the state and federal governments. Our Medicaid segment includes plans for beneficiaries of Temporary Assistance for Needy Families ("TANF"), Supplemental Security Income ("SSI"), Aged Blind and Disabled ("ABD") and state-based programs that are not part of the Medicaid program, such as Children's Health Insurance Programs ("CHIPs") and Family Health Plus ("FHP") for qualifying families who are not eligible for Medicaid because they exceed the applicable income thresholds. TANF generally provides assistance to low-income families with children; ABD and SSI generally provide assistance to low-income aged, blind or disabled individuals.

Medicare

Medicare is a federal program that provides eligible persons age 65 and over and some disabled persons with a variety of hospital, medical insurance and prescription drug benefits.

Medicare Advantage

Our MA segment consists of MA plans, which, following our exit from the PFFS product on December 31, 2009, is comprised of CCPs. MA is Medicare's managed care alternative to original Medicare fee-for-service ("Original Medicare"), which provides individuals standard Medicare benefits directly through CMS. CCPs are administered through health maintenance organizations ("HMOs") and generally require members to seek health care services and select a primary care physician from a network of health care providers. In addition, we offer Medicare Part D coverage, which provides prescription drug benefits, as a component of our MA plans.

As part of our MA segment, we continue to administer our expired PFFS plans, which include processing claims payments as well as providing member and provider services, for health care services provided prior to our exit from the PFFS program on December 31, 2009. As of March 31, 2011, the remaining medical benefits payable related to the PFFS program is not material relative to the total Medical benefits payable.

Prescription Drug Plans

We offer stand-alone Medicare Part D coverage to Medicare-eligible beneficiaries in our PDP segment. The Medicare Part D prescription drug benefit is supported by risk sharing with the federal government through risk corridors designed to limit the losses and gains of the drug plans and by reinsurance for catastrophic drug costs. The government subsidy is based on the national weighted average monthly bid for this coverage, adjusted for risk factor payments. Additional subsidies are provided for dual-eligible beneficiaries and specified low-income beneficiaries. The Part D program offers national in-network prescription drug coverage that is subject to limitations in certain circumstances.

We allocate goodwill, but no other assets or liabilities, or investment and other income, or any other expenses to our reportable operating segments. A summary of financial information for our reportable operating segments as well as a reconciliation to Income before income taxes is presented in the table below.

	Three Months Ended	
	March 31,	
	2011	2010
Premium revenue:		
Medicaid	\$ 855,843	\$ 809,033
Medicare Advantage	354,645	351,083
PDP	261,928	193,342
Total premium revenue	<u>1,472,416</u>	<u>1,353,458</u>

Medical benefits expense:			
Medicaid	703,710		701,779
Medicare Advantage	277,029		276,175
PDP	264,301		188,018
Total medical benefits expense	1,245,040		1,165,972
Gross margin:			
Medicaid	152,133		107,254
Medicare Advantage	77,616		74,908
PDP	(2,373)		5,324
Total gross margin	227,376		187,486
Investment and other income	2,326		2,495
Other expenses	(194,659)		(179,103)
Income before income taxes	\$ 35,043	\$	10,878

EQUITY-BASED COMPENSATION

EQUITY-BASED COMPENSATION
(USD \$)

3 Months Ended
03/31/2011

EQUITY-BASED COMPENSATION

3. EQUITY-BASED COMPENSATION

Equity-based compensation expense is calculated based on awards ultimately expected to vest. The compensation expense recorded related to our equity-based compensation awards, which correspondingly also increased Paid-in capital, for the three months ended March 31, 2011 and 2010 was \$4,849 and \$1,142, respectively.

Under the 2004 Equity Incentive Plan, we granted a performance share award to a former executive, of which the vesting and the amount of shares to be awarded were contingent upon achievement of an earnings per share target over three- and five-year performance periods. The earnings per share target for the first performance period was achieved. However, in accordance with the separation agreement between the former executive and us, issuance of those shares was subject to certain conditions that we have determined have not been, and are unlikely to be, met. Accordingly, the previously recorded expense of \$4,683 was reversed against equity-based compensation during the first quarter of 2010, which is included in Selling, general and administrative expense for the three months ended March 31, 2010.

A summary of our restricted stock, restricted stock unit (“RSU”) and stock option activity for the three months ended March 31, 2011 is presented in the table below.

	<u>Restricted Stock and RSU</u>	<u>Weighted Average Grant-Date Fair Value</u>	<u>Options</u>	<u>Weighted Average Exercise Price</u>
Outstanding as of January 1, 2011	718,009	\$ 28.69	1,008,757	\$ 30.02
Granted	118,131	39.68	-	-
Exercised	-	-	(46,356)	22.62
Vested	(75,386)	32.25	-	-
Forfeited and expired	(16,019)	30.51	(48,437)	56.39
Outstanding at March 31, 2011	<u>744,735</u>	30.04	<u>913,964</u>	28.99
Exercisable at March 31, 2011			<u>721,880</u>	28.86
Vested and expected to vest as of March 31, 2011			<u>855,346</u>	28.94

As of March 31, 2011, there was \$22,920 of unrecognized compensation cost related to non-vested equity-based compensation arrangements that is expected to be recognized over a weighted-average period of 1.5 years.

Performance Stock Units

The Compensation Committee awards performance stock unit awards (“PSUs”) under our long-term incentive program (“LTI Program”). PSUs are scheduled to cliff-vest three years from the grant date and are subject to adjustment in the target range of 0% to 150%, based on the achievement of certain financial and quality-based performance goals set by the Compensation Committee over the performance period and conditioned on the employee's continued service through the vest date. The actual number of PSUs that vest will be determined by the Compensation Committee at its sole discretion. As a result of the subjective nature of the PSUs, we have determined that, for accounting purposes, a mutual understanding of the key terms and conditions does not exist; and accordingly, these awards do not have an accounting grant date. The PSUs ultimately expected to vest will be recognized as expense over the requisite service period based on the estimated progress made towards the achievement of the pre-determined performance measures, as well as subsequent changes in the market price of our common stock since the awards do not have an accounting grant date. The compensation expense related to our PSUs granted assume that targets will be met and was \$755 for the three months ended March 31, 2011. As of March 31, 2011, there was \$9,351 of unrecognized compensation cost related to non-vested PSUs that is expected to be recognized over a weighted-average period of 2.6 years.

A summary of our PSU activity for the three months ended March 31, 2011 is presented in the table below.

	PSUs	Weighted Average Grant-Date Fair Value
Outstanding as of January 1, 2011	144,801	\$ 29.58
Granted	203,309	39.75
Exercised	-	-
Vested	-	-
Forfeited and expired	(5,604)	30.97
Outstanding at March 31, 2011	342,506	35.59

FAIR VALUE MEASUREMENTS

FAIR VALUE MEASUREMENTS
(USD \$)

3 Months Ended
03/31/2011

FAIR VALUE MEASUREMENTS 4. FAIR VALUE MEASUREMENTS

Fair value measurements apply to all financial assets and financial liabilities that are being measured and reported on a fair value basis. Accounting standards require that fair value measurements be classified and disclosed in one of the following three categories: Level 1, defined as observable inputs such as quoted prices in active markets; Level 2, defined as inputs other than quoted prices in active markets that are either directly or indirectly observable; and Level 3, defined as unobservable inputs in which little or no market data exists, therefore requiring an entity to develop its own assumptions.

Our Condensed Consolidated Balance Sheets include the following financial instruments: cash and cash equivalents, receivables, investments, accounts payable and amounts accrued related to the investigation resolution discussed in Note 6 of these Condensed Consolidated Financial Statements. The carrying amounts of current assets and liabilities approximate their fair value because of the relatively short period of time between the origination of these instruments and their expected realization.

Our Long-term investments include \$46,150 of municipal note investments with an auction reset feature ("auction rate securities"), at par value, as of both March 31, 2011 and December 31, 2010. Liquidity for these auction rate securities is typically provided by an auction process which allows holders to sell their notes and resets the applicable interest rate at pre-determined intervals, usually every seven, 14, 28 or 35 days. Auctions for these auction rate securities continued to fail during the three months ended March 31, 2011. An auction failure means that the parties wishing to sell their securities could not be matched with an adequate volume of buyers. As a result, our ability to liquidate and fully recover the carrying value of our remaining auction rate securities in the near term may be limited or non-existent. However, when there is a failed auction, the indenture governing the security requires the issuer to pay interest at a contractually defined rate that is generally above market rates for other types of similar instruments. We continue to receive interest payments on the auction rate securities we hold. Based on our analysis of anticipated cash flows, we have determined that it is more likely than not that we will be able to hold these securities until maturity or until market stability is restored. Additionally, there are government guarantees or municipal bond insurance in place and we have the ability and the present intent to hold these securities until maturity or market stability is restored. Accordingly, we do not believe our auction rate securities are impaired and as a result, we have not recorded any impairment losses for our auction rate securities. However, as these securities are believed to be in an inactive market, we have estimated the fair value of these securities using a discounted cash flow model and update these estimates on a quarterly basis. Our analysis considered, among other things, the collateralization underlying the securities, the creditworthiness of the counterparty, the timing of expected future cash flows and the capital adequacy and expected cash flows of the subsidiaries that hold the securities. The estimated values of these securities were also compared, when possible, to valuation data with respect to similar securities held by other parties.

Our assets measured at fair value on a recurring basis subject to the disclosure requirements of fair value accounting guidance were as follows:

Description	Fair Value Measurements at March 31, 2011:			
	March 31, 2011	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Available-for-sale securities				
Municipal variable rate bonds	\$ 89,870	\$ 89,870	\$ -	\$ -
Variable rate bond fund	50,000	50,000	-	-
Auction rate securities	42,703	-	-	42,703
Money market funds	41,720	41,720	-	-
Corporate debt and other	37,227	37,227	-	-

securities					
Certificates of deposit	21,128	21,128	-	-	
U.S. Government					
securities	2,963	2,963	-	-	
Total investments	\$ 285,611	\$ 242,908	\$ -	\$ 42,703	
Restricted investments:					
Available-for-sale securities					
Money market funds	\$ 54,677	\$ 54,677	\$ -	\$ -	
Cash and cash					
equivalents	27,577	27,577	-	-	
U.S. Government					
securities	22,504	22,504	-	-	
Certificates of deposit	1,054	1,054	-	-	
Total restricted investments	\$ 105,812	\$ 105,812	\$ -	\$ -	
Amounts accrued related to investigation resolution(1)					
	\$ 287,073	\$ -	\$ 287,073	\$ -	

Description	Fair Value Measurements at December 31, 2010:			
	December 31, 2010	Quoted Prices in Active Markets for Identical Assets (Level 1)	Significant Other Observable Inputs (Level 2)	Significant Unobservable Inputs (Level 3)
Investments:				
Available-for-sale securities				
Certificates of deposit	\$ 52,309	\$ 52,309	\$ -	\$ -
Auction rate securities	42,245	-	-	42,245
Municipal variable rate bonds	29,120	29,120	-	-
Corporate debt and other securities	23,100	23,100	-	-
Variable rate bond fund	24,945	24,945	-	-
Total investments	\$ 171,719	\$ 129,474	\$ -	\$ 42,245
Restricted investments:				
Available-for-sale securities				
Money market funds	\$ 54,908	\$ 54,908	\$ -	\$ -
Cash and cash				
equivalents	27,581	27,581	-	-
U.S. Government				
securities	24,027	24,027	-	-
Certificates of deposit	1,053	1,053	-	-
Total restricted investments	\$ 107,569	\$ 107,569	\$ -	\$ -
Amounts accrued related to investigation resolution(1)				
	\$ 337,542	\$ -	\$ 337,542	\$ -

(1) These amounts are included in the short- and long-term portions of amounts accrued related to investigation resolution line items in our Condensed Consolidated Balance Sheets as of March 31, 2011 and December 31, 2010, respectively.

The following tables present our auction rate securities measured at fair value on a recurring basis using significant unobservable inputs (i.e., Level 3 data) as of March 31, 2011 and 2010, respectively.

	Fair Value Measurements Using Significant Unobservable Inputs (Level 3)	
	2011	2010
Beginning balance at January 1	\$ 42,245	\$ 51,710
Realized gains (losses) in earnings (or changes in net assets)	-	-

Unrealized gains (losses) in other comprehensive income(a)	458	230
Purchases, sales and redemptions(b)	-	(6,300)
Transfers in and/or out of Level 3	-	-
Ending balance at March 31	\$ 42,703	\$ 45,640

(a) As a result of the increase in the fair value of our investments in auction rate securities, we recorded a net unrealized gain of \$458 and \$230 to Accumulated other comprehensive loss during the three months ended March 31, 2011 and 2010, respectively. The increase in unrealized gain was driven by the continued stabilization and improvement within the municipal bond market.

(b) A \$6,300 auction rate security tranche was redeemed by the issuer at par in March 2010. Accordingly, we recorded an adjustment to the fair market valuation of the issuer's auction rate securities during the first quarter of 2010.

INCOME TAXES

INCOME TAXES
(USD \$)

3 Months Ended
03/31/2011

INCOME TAXES **5. INCOME TAXES**

As discussed in Note 6, we made a \$52,500 payment in March 2011 that was required in connection with an agreement to resolve certain class action complaints. Settlement payments are generally deductible when paid; therefore the payment had the effect of increasing Income taxes receivable and decreasing the current portion of Deferred income tax assets as of March 31, 2011. There was no impact to the effective income tax rate since the settlement was included in the determination of taxable income in prior periods. There has been no material change in the estimated non-deductible amounts associated with amounts accrued for investigation resolution during the three month period ended March 31, 2011.

Our effective income tax rate was 39.1% for the three months ended March 31, 2011 compared to 41.0% for the same three month period in the prior year. The decrease in the effective tax rate was primarily due to the lower non-deductible executive compensation costs in 2011 and higher Income before income taxes. The effective tax rate for the three months ended March 31, 2011 and 2010 was higher when compared to the statutory rate and was primarily attributable to certain non-deductible executive compensation costs.

COMMITMENTS AND CONTINGENCIES

COMMITMENTS AND CONTINGENCIES
(USD \$)

3 Months Ended
03/31/2011

COMMITMENTS AND CONTINGENCIES

6. COMMITMENTS AND CONTINGENCIES

Government Investigations

Deferred Prosecution Agreement

As previously disclosed, in May 2009, we entered into a Deferred Prosecution Agreement (the "DPA") with the United States Attorney's Office for the Middle District of Florida (the "USAO") and the Florida Attorney General's Office, resolving previously disclosed investigations by those offices.

Under the one-count criminal information (the "Information") filed with the United States District Court for the Middle District of Florida (the "Federal Court") by the USAO pursuant to the DPA, we were charged with one count of conspiracy to commit health care fraud against the Florida Medicaid Program in connection with reporting of expenditures under certain community behavioral health contracts, and against the Florida Healthy Kids programs, under certain contracts, in violation of 18 U.S.C. Section 1349. The USAO recommended to the Federal Court that the prosecution be deferred for the duration of the DPA. Within five days of the expiration of the DPA the USAO will seek dismissal with prejudice of the Information, provided we have complied with the DPA.

The term of the DPA is thirty-six months, but such term may be reduced by the USAO to twenty-four months upon consideration of certain factors set forth in the DPA, including our continued remedial actions and compliance with all federal and state health care laws and regulations.

In accordance with the DPA, the USAO has filed, with the Federal Court, a statement of facts relating to this matter. As a part of the DPA, we retained an independent monitor (the "Monitor") for a period of 18 months from August 19, 2009 to February 18, 2011. The Monitor was selected by the USAO after consultation with us and was retained at our expense. In addition, we agreed to continue undertaking remedial measures to ensure full compliance with all federal and state health care laws. Among other things, the Monitor reviewed and evaluated our compliance with the DPA and all applicable federal and state health care laws, regulations and programs. The Monitor also reviewed, evaluated and, as necessary, made written recommendations concerning certain of our policies and procedures.

The DPA does not, nor should it be construed to, operate as a settlement or release of any civil or administrative claims for monetary, injunctive or other relief against us, whether under federal, state or local statutes, regulations or common law. Furthermore, the DPA does not operate, nor should it be construed, as a concession that we are entitled to any limitation of our potential federal, state or local civil or administrative liability. Pursuant to the terms of the DPA, we have paid the USAO a total of \$80,000.

Civil Division of the United States Department of Justice

In October 2008, the Civil Division of the United States Department of Justice (the "Civil Division") informed us that as part of its pending civil inquiry, it was investigating four *qui tam* complaints filed by relators against us under the whistleblower provisions of the False Claims Act, 31 U.S.C. sections 3729-3733. The seal in those cases was partially lifted for the purpose of authorizing the Civil Division to disclose to us the existence of the *qui tam* complaints. In May 2010, as part of the ongoing resolution discussions with the Civil Division, we were provided with a copy of the *qui tam* complaints, in response to our request, which otherwise remained under seal as required by 31 U.S.C. section 3730(b)(3).

As previously disclosed, we also learned from a docket search that a former employee filed a *qui tam* action on October 25, 2007 in state court for Leon County, Florida against several defendants, including us and one of our subsidiaries (the "Leon County *qui tam* suit"). As part of our discussions to resolve pending *qui tam* and related civil investigations discussed above, we were informed that the Leon County *qui tam* suit was filed by one of the federal *qui tam* relators and contains allegations similar to those alleged in one of the recently unsealed *qui tam* complaints.

On June 24, 2010, (i) the United States government filed its Notice of Election to Intervene in three of the *qui tam* matters, and (ii) we announced that we reached a preliminary agreement with the Civil Division, the Civil Division of the USAO, and the Civil Division of the United States Attorney's Office for the District of Connecticut to settle their pending inquiries. On June 25, 2010, the Federal Court lifted the seal in the three *qui tam* complaints in which the government had intervened (the "Florida Federal *qui tam* Actions"). Those complaints are now publicly available.

On April 26, 2011, we entered into certain settlement agreements, described below, which will resolve the pending inquiries of the Civil Division, the USAO and the United States Attorney's Office for the District of Connecticut (the "USAO Connecticut"). These settlement agreements are related to the Florida Federal *qui tam* Actions as well as another federal *qui tam* action that had been filed in the District of Connecticut (the "Connecticut Federal *qui tam* Action") and the Leon County *qui tam* Action. In connection with the execution of these settlement agreements, the Connecticut Federal *qui tam* Action and the Leon County *qui tam* Action were recently unsealed on April 29, 2011, and April 28, 2011, respectively.

The settlement agreements are with (a) the United States, with signatories from the Civil Division, the Office of Inspector General of the Department of Health and Human Services ("OIG-HHS") and the Civil Divisions of the USAO and the USAO Connecticut (the "Federal Settlement Agreement") and (b) the following states (collectively, the "Settling States"): Connecticut, Florida, Georgia, Hawaii, Illinois, Indiana, Missouri, New York and Ohio (collectively, the "State Settlement Agreements"). The material terms of the Federal Settlement Agreement and the State Settlement Agreements are, collectively, substantively the same as the terms of the previously disclosed preliminary settlement with the Civil Division, the USAO and the USAO Connecticut. We have agreed, among other things, to pay the Civil Division a total of \$137,500 (the "Settlement Amount"), which is to be paid in installments over a period of up to 36 months after the date of the Federal Settlement Agreement (the "Payment Period") plus interest at the rate of 3.125% per year. The settlement includes an acceleration clause that would require immediate payment of the remaining balance of the Settlement Amount in the event that the Company is acquired or otherwise experiences a change in control during the Payment Period. In addition, the settlement provides for a contingent payment of an additional \$35,000 in the event that the Company is acquired or otherwise experiences a change in control within three years of the execution of the Federal Settlement Agreement and provided that the change in control transaction exceeds certain minimum transaction value thresholds as specified in the Federal Settlement Agreement.

In exchange for the payment of the Settlement Amount, the United States and the Settling States agree to release us from any civil or administrative monetary claim under the False Claims Act and certain other legal theories for certain conduct that was at issue in their inquiries and the *qui tam* complaints. Likewise, in consideration of the obligations in the Federal Settlement Agreement and the Corporate Integrity Agreement (as described below under *United States Department of Health and Human Services*), OIG-HHS agrees to release and refrain from instituting, directing or maintaining any administrative action seeking to exclude us from Medicare, Medicaid and other federal health care programs.

The Federal Settlement Agreement has not been executed by one of the relators. Under its terms, this failure to timely execute is deemed to be an objection to the Federal Settlement Agreement. In the case of an objection, the Federal Court is required to conduct a hearing (a "Fairness Hearing") to determine whether the proposed settlement is fair, adequate and reasonable under all the circumstances. The Federal Settlement Agreement and the State Settlement Agreements will not be effective until the earlier of (a) the execution of the Federal Settlement Agreement by the objecting relator or (b) entry by the Federal Court of a final order determining that the settlement is fair, adequate and reasonable under all the circumstances.

We can make no assurances that the objecting relator will execute the Federal Settlement Agreement or that the Federal Court will approve the settlement at a Fairness Hearing and the actual outcome of these matters may differ materially from the terms of the settlement.

We have discounted the total liability of \$137,500 for the resolution of these matters and accrued this amount at its estimated fair value, which amounted to approximately \$136,259 at March 31, 2011. In addition to the Settlement Amount, another \$5,000 for estimated *qui tam* relators attorneys' fees to be paid was accrued in 2010. Approximately \$31,848 and \$104,411 has been included in the current and long-term portions, respectively, of Amounts accrued related to the investigation resolution in our Condensed Consolidated Balance Sheet as of March 31, 2011. There can be no assurance that the Federal Settlement

Agreement and the State Settlement Agreements will become effective and the actual outcome of these matters may differ materially from the terms of these settlements as described above.

United States Department of Health and Human Services

On April 26, 2011, the Company entered into a Corporate Integrity Agreement (the "Corporate Integrity Agreement") with OIG-HHS. The Corporate Integrity Agreement has a term of five years and concludes the previously disclosed matters relating to the Company under review by OIG-HHS.

The Corporate Integrity Agreement formalizes various aspects of the Company's ethics and compliance program and contains other requirements designed to help ensure the Company's ongoing compliance with federal health care program requirements. The terms of the Corporate Integrity Agreement include certain organizational structure requirements, internal monitoring requirements, compliance training, screening processes for new employees, reporting requirements to OIG-HHS, and the engagement of an independent review organization to review and prepare written reports regarding, among other things, the Company's reporting practices and bid submissions to federal health care programs.

Class Action Complaints

Putative class action complaints were filed in October 2007 and in November 2007. These putative class actions, entitled *Eastwood Enterprises, L.L.C. v. Farha, et al.* and *Hutton v. WellCare Health Plans, Inc. et al.*, respectively, were filed in Federal Court against us, Todd Farha, our former chairman and chief executive officer, and Paul Behrens, our former senior vice president and chief financial officer. Messrs. Farha and Behrens were also officers of various subsidiaries of ours. The *Eastwood Enterprises* complaint alleged that the defendants materially misstated our reported financial condition by, among other things, purportedly overstating revenue and understating expenses in amounts unspecified in the pleading in violation of the Securities Exchange Act of 1934, as amended ("Exchange Act"). The *Hutton* complaint alleged that various public statements supposedly issued by the defendants were materially misleading because they failed to disclose that we were purportedly operating our business in a potentially illegal and improper manner in violation of applicable federal guidelines and regulations. The complaint asserted claims under the Exchange Act. Both complaints sought, among other things, certification as a class action and damages. The two actions were consolidated, and various parties and law firms filed motions seeking to be designated as Lead Plaintiff and Lead Counsel. In an Order issued in March 2008, the Federal Court appointed a group of five public pension funds from New Mexico, Louisiana and Chicago (the "Public Pension Fund Group") as Lead Plaintiffs. In October 2008, an amended consolidated complaint was filed in this class action asserting claims against us, Messrs. Farha and Behrens, and adding Thaddeus Bereday, our former senior vice president and general counsel, as a defendant.

In January 2009, we and certain other defendants filed a joint motion to dismiss the amended consolidated complaint, arguing, among other things, that the complaint failed to allege a material misstatement by defendants with respect to our compliance with marketing and other health care regulations and failed to plead facts raising a strong inference of scienter with respect to all aspects of the purported fraud claim. The Federal Court denied the motion in September 2009 and we and the other defendants filed our answer to the amended consolidated complaint in November 2009. In April 2010, the Lead Plaintiffs filed their motion for class certification. On June 18, 2010, the USAO filed motions seeking to intervene and for a temporary stay of discovery of this matter. Discovery was stayed through March 17, 2011.

In August 2010, we reached agreement with the Lead Plaintiffs on the material terms of a settlement to resolve these matters. In December 2010, the terms of the settlement were documented in a formal settlement agreement (the "Stipulation Agreement") that was subject to approval by the Federal Court following notice to all class members. On February 9, 2011, the Federal Court entered an order preliminarily approving the settlement and scheduled the final settlement hearing for May 4, 2011.

On May 4, 2011, the Federal Court entered an order (the "Approval Order") approving the Stipulation Agreement. As required by the Stipulation Agreement, in March 2011 the Company paid \$52,500 into an escrow account for the benefit of the class. The Stipulation Agreement also provides, among other things, that the Company will make an additional cash payment to the class of \$35,000 by July 31, 2011 (the "July 2011 Payment"). It also requires, among other things, that the Company issue to the class tradable unsecured subordinated notes having an aggregate face value of \$112,500, with a fixed coupon of 6% and a maturity date of

December 31, 2016. Additionally, the Company will be required to pay to the class an additional \$25,000 if the Company experiences a change in control at a share price of \$30 or more within three years of the date of the Stipulation Agreement.

With respect to the July 2011 Payment and as required by the Stipulation Agreement, by May 9, 2011, the Company is required to deliver to the escrow agent for the class a non-negotiable promissory note in the principal amount of \$35,000 (the "Note"). The Note is due and payable in full on July 31, 2011. The unpaid principal amount of the Note will accelerate and become immediately due and payable in the event of the Company's insolvency, a general assignment for the benefit of creditors, or the commencement by or against the Company of any action seeking reorganization, liquidation, dissolution, or similar treatment of the Company's debts under any law relating to bankruptcy, relief of debtors or similar laws. The unpaid principal will also accelerate in the event the Company or any third party seeks the appointment of a receiver or other similar official for the Company or its assets which, in the case of involuntary proceedings, has not been withdrawn or dismissed within 60 days after the filing of such proceeding. If the Company fails to pay the Note in full by July 31, 2011, then interest on the unpaid balance shall accrue at the rate and pursuant to the method set forth in 28 USC §1961 until all sums due are paid. In the event the payment is accelerated as described in the previous paragraph, then such interest will begin to accrue upon such acceleration.

As a result of this settlement having been reached, our estimate for the remaining resolution amount of this matter is \$147,500. We have discounted the \$147,500 liability for the resolution of this matter and accrued this amount at its estimated fair value, which amounted to approximately \$145,814 at March 31, 2011. Approximately \$31,951 and \$113,863 have been included in the current and long-term portions, respectively, of Amounts accrued related to investigation resolution in our Condensed Consolidated Balance Sheet as of March 31, 2011.

Derivative Lawsuits

As previously disclosed, in connection with our government investigations, five putative stockholder derivative actions were filed between October and November 2007. Four of these actions were asserted against directors Kevin Hickey and Christian Michalik, our current directors who were directors prior to 2007, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, and former director and officer Todd Farha. These actions also named us as a nominal defendant. Two of these actions were filed in the Federal Court and two actions were filed in the Circuit Court for Hillsborough County, Florida (the "State Court"). The fifth action, filed in the Federal Court, asserts claims against directors Robert Graham, Kevin Hickey and Christian Michalik, our current directors who were directors at the time the action was filed, and against former directors Regina Herzlinger, Alif Hourani, Ruben King-Shaw and Neal Moszkowski, former director and officer Todd Farha, and former officers Paul Behrens and Thaddeus Bereday. A sixth derivative action was filed in January 2008 in the Federal Court and asserted claims against all of these defendants except Robert Graham. All six of these actions contended, among other things, that the defendants allegedly allowed or caused us to misrepresent our reported financial results, in amounts unspecified in the pleadings, and seek damages and equitable relief for, among other things, the defendants' supposed breach of fiduciary duty, waste and unjust enrichment. In April 2009, upon the recommendation of the Nominating and Corporate Governance Committee of the Board, the Board formed a Special Litigation Committee, comprised of a newly-appointed independent director, to investigate the facts and circumstances underlying the claims asserted in the derivative cases and to take such action with respect to these claims as the Special Litigation Committee determines to be in our best interests. In November 2009, the Special Litigation Committee filed a report with the Federal Court determining, among other things, that we should pursue an action against three of our former officers. In December 2009, the Special Litigation Committee filed a motion to dismiss the claims against the director defendants and to realign us as a plaintiff for purposes of pursuing claims against former officers Messrs. Farha, Behrens and Bereday.

In March 2010, a Stipulation of Partial Settlement ("Stipulation I") was filed in the Federal Court. Under the terms of Stipulation I, the plaintiffs in the federal action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. The plaintiffs in the consolidated federal putative stockholder derivative action also agreed to dismiss their claims against Messrs. Farha, Behrens and Bereday. In turn, we paid to plaintiffs' counsel in the federal action attorneys' fees in the amount of \$1,688. In April 2010, the Federal Court entered an order preliminarily

approving Stipulation I and directing us to provide notice to our stockholders. The Federal Court also approved Stipulation I and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in July 2010. The case is now styled *WellCare v. Farha, et al.* In August 2010, Messrs. Farha, Behrens and Bereday filed a notice of appeal in the United States Court of Appeals for the Eleventh Circuit (the "Court of Appeals"), which is pending. In April 2011, the Federal Court stayed this action pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

In April 2010, a second Stipulation of Partial Settlement ("Stipulation II") was filed in the State Court. Under the terms of Stipulation II, the plaintiffs in the state action agreed that the Special Litigation Committee's motion to dismiss the director defendants and to realign us as a plaintiff should be granted in its entirety. In turn, we paid to plaintiffs' counsel in the state action attorneys' fees in the amount of \$563. The State Court approved Stipulation II and granted our motion to dismiss the director defendants and realigned us as the plaintiff in this action in June 2010. In July 2010, Mr. Farha filed a notice of appeal in this matter, which remains pending. In April 2011, the State Court stayed this action pending the conclusion of parallel federal criminal proceedings against Messrs. Farha, Behrens and Bereday.

In October 2010, we filed a motion for leave to file an amended complaint against Mr. Farha in the State Court action and a new lawsuit in Federal Court against Messrs. Behrens and Bereday, stating claims for breach of contract and breach of their fiduciary duties.

Risk Adjustment Data Validation Audits

CMS has performed and continues to perform Risk Adjustment Data Validation ("RADV") audits of selected MA plans to validate the provider coding practices under the risk adjustment model used to calculate the premium paid for each MA member. Our Florida MA plan was selected by CMS for audit for the 2007 contract year and we anticipate that CMS will conduct additional audits of other plans and contract years on an ongoing basis. The CMS audit process selects a sample of 201 enrollees for medical record review from each contract selected. We have responded to CMS's audit requests by retrieving and submitting all available medical records and provider attestations to substantiate CMS-sampled diagnosis codes. CMS will use this documentation to calculate a payment error rate for our Florida MA plan 2007 premiums. CMS has not indicated a schedule for processing or otherwise responding to our submissions.

CMS has indicated that payment adjustments resulting from its RADV audits will not be limited to risk scores for the specific beneficiaries for which errors are found, but will be extrapolated to the relevant plan population. In late December 2010, CMS issued a draft audit sampling and payment error calculation methodology that it proposes to use in conducting these audits. CMS invited public comment on the proposed audit methodology and announced in early February 2011 that it will revise its proposed approach based on the comments received. CMS has not given a specific timetable for issuing a final version of the audit sampling and payment error calculation methodology. Given that the RADV audit methodology is new and is subject to modification, there is substantial uncertainty as to how it will be applied to MA organizations like our Florida MA plan. At this time, we do not know whether CMS will require retroactive or subsequent payment adjustments to be made using an audit methodology that may not compare the coding of our providers to the coding of Original Medicare and other MA plan providers, or whether any of our other plans will be randomly selected or targeted for a similar audit by CMS. We are also unable to determine whether any conclusions that CMS may make, based on the audit of our plan and others, will cause us to change our revenue estimation process. Because of this lack of clarity from CMS, we are unable to estimate with any reasonable confidence a coding or payment error rate or predict the impact of extrapolating an applicable error rate to our Florida MA plan 2007 premiums and as a result, have not accrued a liability for the potential outcome. However, it is likely that a payment adjustment will occur as a result of these audits, and that any such adjustment could have a material adverse effect on our results of operations, financial position, and cash flows, possibly in 2011 and beyond.

Other Lawsuits and Claims

Separate and apart from the legal matters described above, we are also involved in other legal actions that are in the normal course of our business, including, without limitation, provider disputes regarding payment of claims and disputes relating to the performance of contractual obligations with state agencies, some of which seek monetary damages, including claims for punitive damages, which are not covered by insurance. We currently believe that none of these actions, when finally concluded and determined, will have a material adverse

effect on our financial position, results of operations or cash flows.

