CENTENE CORP
Form 10-K
February 22, 2010

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

Form 10-K

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

For the fiscal year ended December 31, 2009

or

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

For the transition period from to

Commission file number: 001-31826

Centene Corporation
(Exact name of registrant as specified in its charter)

Delaware	42-1406317
(State or other jurisdiction of incorporation or organization)	(I.R.S. Employer Identification Number)
7711 Carondelet Avenue St. Louis, Missouri	63105
(Address of principal executive offices)	(Zip Code)

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

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

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

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

Indicate by check mark if the registrant is a well-known seasoned issuer, as defined in Rule 405 of the Securities Act.

Yes T No £

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

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

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

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

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

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

The aggregate market value of the voting and non-voting common equity held by non-affiliates of the registrant, based upon the last reported sale price of the common stock on the New York Stock Exchange on June 30, 2009, was $843.5 million.

As of February 5, 2010, the registrant had 51,372,683 shares of common stock outstanding.

DOCUMENTS INCORPORATED BY REFERENCE

Portions of the Proxy Statement for the registrant's 2010 annual meeting of stockholders are incorporated by reference in Part III, Items 10, 11, 12, 13 and 14.

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CAUTIONARY STATEMENT ON FORWARD-LOOKING STATEMENTS

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

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

- our ability to accurately predict and effectively manage health benefits and other operating expenses;
- competition;
- changes in healthcare practices;
- changes in federal or state laws or regulations;
- inflation;
- provider contract changes;
- new technologies;
- reduction in provider payments by governmental payors;
- major epidemics;
- disasters and numerous other factors affecting the delivery and cost of healthcare;
- the expiration, cancellation or suspension of our Medicaid managed care contracts by state governments;
- availability of debt and equity financing, on terms that are favorable to us; and
- general economic and market conditions.

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

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PART I

Item 1. Business

OVERVIEW

We are a multi-line healthcare enterprise operating in two segments: Medicaid Managed Care and Specialty Services. Our Medicaid Managed Care segment provides Medicaid and Medicaid-related health plan coverage to individuals through government subsidized programs, including Medicaid, the State Children's Health Insurance Program, or CHIP, Foster Care, Medicare Special Needs Plans and the Supplemental Security Income Program, also known as the Aged, Blind or Disabled Program, or collectively ABD. Our health plans in Florida, Georgia, Indiana, Ohio, South Carolina, Texas and Wisconsin are included in the Medicaid Managed Care segment. As of December 31, 2009, Medicaid accounted for 74% of our at-risk membership, while CHIP (also including Foster Care) and ABD (also including Medicare) accounted for 18% and 6%, respectively. Other state programs in Massachusetts represent the remaining 2% at-risk membership. Our Specialty Services segment provides specialty services, including behavioral health, individual health insurance, life and health management, long-term care programs, managed vision, telehealth services, and pharmacy benefits management to state programs, healthcare organizations, employer groups and other commercial organizations, as well as to our own subsidiaries. Our health plans in Arizona, which is operated by our long-term care company, and Massachusetts, which is operated by our individual health insurance provider, are included in the Specialty Services segment. Our Specialty Services segment also provides a full range of healthcare solutions for the rising number of uninsured Americans.

We expect to complete the sale of certain assets of University Health Plans, Inc., or UHP, our New Jersey health plan, during the first quarter of 2010. This sale is discussed in detail under the caption "Discontinued Operations" under "Item 7. Management's Discussion and Analysis of Financial Condition and Results of Operations." Accordingly, our New Jersey health plan operations are reported as discontinued operations for all periods presented in our consolidated financial statements. The following discussion and analysis is presented primarily in the context of continuing operations unless otherwise identified.

Our at-risk managed care membership totaled approximately 1.5 million as of December 31, 2009. For the year ended December 31, 2009, our revenues and net earnings from continuing operations were $4.1 billion and $86.1 million, respectively, and our total cash flow from operations was $248.2 million.

In November 2009, the Mississippi Division of Medicaid selected Centene as one of two organizations to participate in the Mississippi Coordinated Access Network, a program for Mississippi Medicaid beneficiaries. We are continuing to work with Mississippi to execute a contract in which we will serve eligible members throughout the state, as Magnolia Health Plan, and expect to execute the contract and begin managing care for ABD members in Mississippi in 2010.

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

Our initial health plan commenced operations in Wisconsin in 1984. We were organized in Wisconsin in 1993 as a holding company for our initial health plan and reincorporated in Delaware in 2001. Our corporate office is located at 7711 Carondelet Avenue, St. Louis, Missouri 63105, and our telephone number is (314) 725-4477. Our stock is publicly traded on the New York Stock Exchange under the ticker symbol "CNC."

INDUSTRY

We provide our services to the uninsured primarily through Medicaid, CHIP, Foster Care, ABD, Medicare and other state programs for the uninsured. The federal Centers for Medicare and Medicaid Services, or CMS, estimated the total Medicaid market was approximately $329 billion in 2007, and estimate the market will grow to $800 billion by 2018. According to the most recent information provided by the Kaiser Commission on Medicaid and the Uninsured, Medicaid spending increased by 7.9% in fiscal 2009 and states appropriated an increase of 6.3% for Medicaid in fiscal 2010 budgets.

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

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

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

A portion of Medicaid beneficiaries are dual eligibles, low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare. According to the Kaiser Commission on Medicaid and the Uninsured, there were approximately 8.8 million dual eligible enrollees in 2009. These dual eligibles may receive assistance from Medicaid for Medicaid benefits, such as nursing home care and/or assistance with Medicare premiums and cost sharing. Dual eligibles also use more services due to their tendency to have more chronic health issues. We serve dual eligibles through our ABD and long-term care programs, and beginning in 2008, through Special Needs Plans.

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

Since the early 1980s, increasing healthcare costs, combined with significant growth in the number of Medicaid recipients, have led many states to establish Medicaid managed care initiatives. Additionally, a number of states are designing programs to cover the rising number of uninsured Americans. The Kaiser Commission on Medicaid and the Uninsured estimated there were over 46 million Americans in 2008 that lacked health insurance. We expect that continued pressure on states' Medicaid budgets will cause public policy to recognize the value of managed care as a means of delivering quality healthcare and effectively controlling costs. A growing number of states have mandated that their Medicaid recipients enroll in managed care plans. Other states are considering moving to a mandated managed care approach. As a result, a significant market opportunity exists for managed care organizations with operations and programs focused on the distinct socio-economic, cultural and healthcare needs of the uninsured population and the Medicaid, CHIP, Foster Care and ABD populations. We believe our approach and strategy enable us to be a growing participant in this market.

OUR COMPETITIVE STRENGTHS

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

- Strong Historic Operating Performance. We have increased revenues as we have grown in existing markets, expanded into new markets and broadened our product offerings. We entered the Wisconsin market in 1984, the Indiana market in 1995, the Texas market in 1999, the Arizona market in 2003, the Ohio market in 2004, the Georgia market in 2006, the South Carolina market in 2007 and the Florida and Massachusetts markets in 2009. We have increased our membership through participation in new programs in existing states. For example, in 2008, we began operations in the Texas Foster Care program and began serving Acute Care members in Yavapai county of Arizona. We have also increased membership by acquiring Medicaid businesses, contracts and other related assets from competitors in existing markets, most recently in Florida and South Carolina in 2009. Our at-risk membership totaled approximately 1.5 million as of December 31, 2009. For the year ended December 31, 2009, we had revenues of $4.1 billion, representing a 39% Compound Annual Growth Rate, or CAGR, since the year ended December 31, 2005. We generated total cash flow from operations of $248.2 million and net earnings of $86.1 million for the year ended December 31, 2009.

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- Medicaid Expertise. Over the last 25 years, we have developed a specialized Medicaid expertise that has helped us establish and maintain relationships with members, providers and state governments. We have implemented programs developed to achieve savings for state governments and improve medical outcomes for members by reducing inappropriate emergency room use, inpatient days and high cost interventions, as well as by managing care of chronic illnesses. Our experience in working with state regulators helps us implement and deliver programs and services efficiently and affords us opportunities to provide input regarding Medicaid industry practices and policies in the states in which we operate. We work with state agencies on redefining benefits, eligibility requirements and provider fee schedules in order to maximize the number of uninsured individuals covered through Medicaid, CHIP, Foster Care and ABD and expand these types of benefits offered. Our approach is to accomplish this while maintaining adequate levels of provider compensation and protecting our profitability.

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

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

- Specialized and Scalable Systems and Technology. Through our specialized information systems, we work to strengthen relationships with providers and states which help us grow our membership base. We continue to develop our specialized information systems which allow us to support our core processing functions under a set of integrated databases, designed to be both replicable and scalable. Physicians can use claims, utilization and membership data to manage their practices more efficiently, and they also benefit from our timely payments. State agencies can use data from our information systems to demonstrate that their Medicaid populations receive quality healthcare in an efficient manner. These systems also help identify needs for new healthcare and specialty programs. We have the ability to leverage our platform for one state configuration into new states or for health plan acquisitions. Our ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner.

OUR BUSINESS STRATEGY

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

- Increase Penetration of Existing State Markets. We seek to continue to increase our Medicaid membership in states in which we currently operate through alliances with key providers, outreach efforts, development and

implementation of community-specific products and acquisitions. In 2006, we were awarded two regions in connection with Ohio's statewide restructuring of its Medicaid managed care program, expanding the number of counties we serve from three to 27. We also were awarded a Medicaid ABD contract in Ohio. In Texas, we expanded our operations to the Corpus Christi market in 2006, began managing care for ABD recipients in February 2007 and began operations in the Foster Care program in April 2008. In Arizona, we began serving members of a long-term care plan in 2006 and within an acute care plan in 2008. In 2008, we began serving Medicare members within Special Needs Plans in Arizona, Ohio, Texas and Wisconsin. We may also increase membership by acquiring Medicaid businesses, contracts and other related assets from our competitors in our existing markets or by enlisting additional providers. For example, in 2009, we acquired certain Medicaid-related assets in Florida and South Carolina.

- Diversify Business Lines. We seek to broaden our business lines into areas that complement our existing business to enable us to grow and diversify our revenue. We are constantly evaluating new opportunities for expansion both domestically and abroad. For instance, in July 2008, we completed the acquisition of Celtic Insurance Company, a national individual health insurance provider, in October 2006, we commenced operations under our managed care program contracts to provide long-term care services in Arizona, and in January 2006, we completed the acquisition of US Script, a pharmacy benefits manager. We are also considering other premium based or fee-for-service lines of business that would provide additional diversity. We employ a disciplined acquisition strategy that is based on defined criteria including internal rate of return, accretion to earnings per share, market leadership and compatibility with our information systems. We engage our executives in the relevant operational units or functional areas to ensure consistency between the diligence and integration process.

- Address Emerging State Needs. We work to assist the states in which we operate in addressing the operating challenges they face. We seek to assist the states in balancing premium rates, benefit levels, member eligibility, policies and practices, and provider compensation. For example, in 2008, we began operating under a contract with the Texas Health and Human Services Commission for Comprehensive Health Care for Children in Foster Care, a new statewide program providing managed care services to participants in the Texas Foster Care program. By helping states structure an appropriate level and range of Medicaid, CHIP and specialty services, we seek to ensure that we are able to continue to provide those services on terms that achieve targeted gross margins, provide an acceptable return and grow our business.

- Develop and Acquire Additional State Markets. We continue to leverage our experience to identify and develop new markets by seeking both to acquire existing business and to build our own operations. We expect to focus expansion in states where Medicaid recipients are mandated to enroll in managed care organizations, because we believe member enrollment levels are more predictable in these states. In addition, we focus on states where managed care programs can help address states' financial needs. For example, effective June 1, 2006, we began managing care for Medicaid and CHIP members in Georgia. In 2007, we entered the South Carolina market and we participated in the state's conversion to at-risk managed care. In February 2009, we began managed care operations in Florida through conversion of members in certain counties from Access Health Solutions to at-risk managed care in Sunshine State Health Plan, through our new state contract. In July 2009, we began operating under our contract in Massachusetts to manage healthcare services operating as CeltiCare Health Plan of Massachusetts. In 2010, we expect to begin managing care for ABD members in Mississippi.

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

- Maintain Operational Discipline. We monitor our cost trends, operating performance, regulatory relationships and the Medicaid political environment in our existing markets. We seek to operate in markets that allow us to meet our

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

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

State	Local Health Plan Name	First Year of Operations Under the Company	Counties Served at December 31, 2009	Market Share (1)	At-risk Managed Care Membership at December 31, 2009
Arizona	Bridgeway Health Solutions (2)	2008	4	1.5%	18,100
Florida	Sunshine State Health Plan	2009	9	9.9%	102,600
Georgia	Peach State Health Plan	2006	90	28.0%	309,700
Indiana	Managed Health Services	1995	92	31.9%	208,100
Ohio	Buckeye Community Health Plan	2004	43	10.1%	150,800
Massachusetts	CeltiCare Health Plan	2009	14	(3)	27,800
South Carolina	Absolute Total Care	2007	42	10.4%	48,600
Texas	Superior HealthPlan	1999	239	22.2%	455,100
Wisconsin	Managed Health Services	1984	33	21.0%	134,800
			566		1,455,600

(1) Represents Medicaid and CHIP membership as of December 31, 2009 as a percentage of total eligible Medicaid and CHIP members in each state. ABD programs are excluded.

(2) Represents the acute care and Medicare business under Bridgeway Health Solutions.

(3) CeltiCare Health Plan manages members under the state Commonwealth Care Bridge program and Commonwealth Care program with market share of 100% and less than 0.1% , respectively.

All of our revenue is derived from operations within the United States and its territories. We generally receive a fixed premium per member per month pursuant to our state contracts. Our medical costs have a seasonality component due to cyclical illness, for example cold and flu season, resulting in higher medical expenses beginning in the fourth quarter and continuing throughout the first quarter of each year. Our managed care subsidiaries in Georgia, Ohio, and Texas had revenues from their respective state governments that each exceeded 10% of our consolidated total revenues in 2009. Other financial information about our segments is found in Note 21, Segment Information, of our Notes to Consolidated Financial Statements and “Management’s Discussion and Analysis of Financial Condition and Results of Operations” included elsewhere in this Annual Report on Form 10-K.

MEDICAID MANAGED CARE

Benefits to States

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

- Significant cost savings compared to state paid reimbursement for services. We bring bottom-line management experience to our health plans. On the administrative and management side, we bring experience including quality of care improvement methods, utilization management procedures, an efficient claims payment system, and provider performance reporting, as well as managers and staff experienced in using these key elements to improve the quality of and access to care.

- Data-driven approaches to balance cost and verify eligibility. Our Medicaid health plans have conducted enrollment processing and activities for state programs since 1984. We seek to ensure effective enrollment procedures that move members into the plan, then educate them and ensure they receive needed services as quickly as possible. Our IT department has created mapping/translation programs for loading membership and linking membership eligibility status to all of Centene's subsystems.

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

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

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

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

- Cost saving outreach and specialty programs. Our health plans have adopted a physician-driven approach where network providers are actively engaged in developing and implementing healthcare delivery policies and strategies. This approach is designed to eliminate unnecessary costs, improve services to members and simplify the administrative burdens placed on providers.

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

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

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

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Member Programs and Services

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

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

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

- Fluvention is an outreach program aimed at educating members on preventing the transmission of the influenza virus by encouraging members to get the seasonal influenza vaccines and take everyday precautions to prevent illness. We use an integrated communications approach including direct mail, phone calls, providing information via health plan websites and posting information in provider offices. The health plans also conduct general community awareness through public service announcements on television and radio. During 2009, we targeted education efforts related to health hygiene, preventative care and the benefits of obtaining appropriate care of their condition, for groups that are at higher-risk for contracting the H1N1 influenza virus, including pregnant women, children from six months old up to 24-year-old adults, as well as adults with chronic health conditions. Incentives in the form of gift cards were given to members who received both flu vaccines.

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

- Connections Plus is a cell phone program developed for high-risk members who have limited or no access to a safe, reliable telephone. The program puts free, preprogrammed cell phones into the hands of eligible members. This program seeks to eliminate lack of safe, reliable access to a telephone as a barrier to coordinating care, thus reducing avoidable adverse events such as inappropriate emergency room utilization, hospital admissions and premature birth. Members are identified through case management activities or through a referral. Connections Plus is available to high-risk members in all Centene health plans. Connections Plus has been recognized as a URAC Best Practice 2009 Silver Medalist and is included in the NCQA Quality Profiles Manual for 2009.

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Start Smart For Your Baby is a prenatal and infant health program designed to increase the percentage of pregnant women receiving early prenatal care, reduce the incidence of low birth weight babies, identify high risk pregnancies, increase participation in the federal Women, Infant and Children program, prevent hospital admissions in the first year of life and increase well-child visits. The program includes risk assessments, education through face-to-face meetings and materials, behavior modification plans, assistance in selecting a provider for the infant and scheduling newborn follow-up visits. Start Smart was named a 2009 NCQA Best Practice.

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

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

Ÿ The Kids' Club is aimed at educating child members on a variety of health topics. Our health plans are reaching out directly to children with newsletters, contests and other innovative events, such as readings with the author of "The Adventures of Thumbs Up Johnnie." The Kids' Club is initially focusing on the childhood obesity epidemic - obesity rates for children doubled in the past two decades and tripled for adolescents during the same period - with educational information encouraging proper eating and exercise habits. We have sponsored the creation of a book with Michelle Bain titled "Thumbs Up Johnnie & the SUPER Centeam 5- Adventures Through FITROPOLIS!" which is intended to educate children on the importance of living an active and healthy life.

Providers

For each of our service areas, we establish a provider network consisting of primary and specialty care physicians, hospitals and ancillary providers. As of December 31, 2009, the health plans we currently operate contracted with the following number of physicians and hospitals:

	Primary Care Physicians	Specialty Care Physicians	Hospitals
Arizona	303	2,170	8
Florida	922	2,032	57
Georgia	2,992	9,569	123
Indiana	1,016	4,087	93
Massachusetts	1,083	4,132	31
Ohio	2,359	9,262	140
South Carolina	1,172	2,933	37
Texas	8,243	20,786	395
Wisconsin	2,103	5,770	64
Total	20,193	60,741	948

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

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

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

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

- Under risk-sharing arrangements, physicians are paid under a capitated or fee-for-service arrangement. The arrangement, however, contains provisions for additional bonus to the physicians or reimbursement from the physicians based upon cost and quality factors. We often refer to these arrangements as Model 1 contracts.

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

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

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

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

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

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

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

Quality Management

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

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

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

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

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

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Information Technology

The ability to access data and translate it into meaningful information is essential to operating across a multi-state service area in a cost-effective manner. Our centralized information systems, which are located in St. Louis, Missouri, support our core processing functions under a set of integrated databases and are designed to be both replicable and scalable to accommodate organic growth and growth from acquisitions. We continue to enhance our systems in order to leverage the platform we have developed for our existing states for configuration into new states or health plan acquisitions.

Our predictive modeling technology enables the medical management operations to proactively case and disease manage specific high risk members. It can recommend medical care opportunities using a mix of company defined algorithms and evidence based medical guidelines. Interventions are determined by the clinical indicators, the ability to improve health outcomes, and the risk profile of members.

Our integrated approach helps to assure that consistent sources of claim and member information are provided across all of our health plans. Our membership and claims processing system is capable of expanding to support additional members in an efficient manner. We have a disaster recovery and business resumption plan developed and implemented in conjunction with a third party. This plan allows us complete access to the business resumption centers and hot-site facilities provided under the business resumption plan.

SPECIALTY COMPANIES

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

Ÿ Behavioral Health. Cenpatico Behavioral Health, or Cenpatico, manages behavioral healthcare for members via a contracted network of providers. Cenpatico works with providers to determine the best services to help people overcome mental illness and lead productive lives. Our networks feature a full range of services and levels of care to help people with mental illness reach their recovery and wellness goals. We also run school-based programs in Arizona that focus on students with special needs including speech therapy services. We acquired Cenpatico in 2003.

Ÿ Individual and State Sponsored Health Insurance. Celtic Insurance Company, or Celtic, is a national healthcare provider licensed in 49 states offering high-quality, affordable health insurance to individual customers and their families. Sold online and through independent insurance agents nationwide, Celtic's portfolio of major medical plans is designed to meet the diverse needs of the uninsured at all budget and benefit levels. Celtic also offers a standalone guaranteed-issue medical conversion program to self-funded employer groups, stop-loss and fully-insured group carriers, managed care plans, and HMO reinsurers. We acquired Celtic in July 2008. In 2009, CeltiCare of Massachusetts was formed to provide state sponsored health insurance to the uninsured who do not qualify for Medicaid.

Ÿ Life and Health Management. Nurtur Health specializes in implementing life and health management programs that encourage healthy behaviors, promote healthier workplaces, improve productivity and reduce healthcare costs. Health risk appraisals, biometric screenings, online and telephonic wellness programs, disease management and work-life services are areas of focus. Nurtur Health uses telephonic health coaching, in-home and online interaction and informatics processes to deliver effective clinical results, enhanced patient-provider satisfaction and cost reductions in its health management operations. Nurtur Health was formed in December 2007 through the

combination of three entities we acquired from July 2005 through November 2007.

Ÿ Long-term Care and Acute Care. Bridgeway Health Solutions, or Bridgeway, provides long-term care services to the elderly and people with disabilities that meet income and resources requirements who are at risk of being or are institutionalized. Bridgeway has long-term members in the Maricopa, Yuma and La Paz counties of Arizona. Bridgeway participates with community groups to address situations that might be barriers to quality care and independent living. Bridgeway commenced long-term care operations in 2006. Bridgeway also provides acute care services to members in the Yavapai county of Arizona. These services include emergency and physician services, limited dental and rehabilitative services and other maternal and child health services. Bridgeway commenced acute care operations in October 2008.

Ÿ Managed Vision. OptiCare manages vision benefits for members via a contracted network of providers. OptiCare offers a variety of vision plan designs to help meet the needs of is members and clinics. OptiCare provides a range of products and services so that clients can implement a vision plan to fit their needs and patients can be treated at appropriate levels of care. We acquired the managed vision business of OptiCare Health Systems, Inc. in 2006.

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- Telehealth Services. NurseWise and Nurse Response provide a toll-free nurse triage line 24 hours per day, 7 days per week, 52 weeks per year. Our members call one number and reach bilingual customer service representatives and nursing staff who provide health education, triage advice and offer continuous access to health plan functions. Additionally, our representatives verify eligibility, confirm primary care provider assignments and provide benefit and network referral coordination for members and providers after business hours. Our staff can arrange for urgent pharmacy refills, transportation and qualified behavioral health professionals for crisis stabilization assessments. Call volume is based on membership levels and seasonal variation. NurseWise commenced operations in 1998.

- Pharmacy Benefits Management. US Script is a pharmacy benefits manager that administers pharmacy benefits and processes pharmacy claims via its proprietary claims processing software. US Script has developed and administers a contracted national network of retail pharmacies. We acquired US Script in 2006.

CORPORATE COMPLIANCE

Our Corporate Ethics and Compliance Program was first established in 1998 and provides methods by which we further enhance operations, safeguard against fraud and abuse, improve access to quality care and help assure that our values are reflected in everything we do.

The two primary standards by which corporate compliance programs in the healthcare industry are measured are the 1991 Federal Organizational Sentencing Guidelines and the "Compliance Program Guidance" series issued by the Office of the Inspector General, or OIG, of the Department of Health and Human Services. Our program contains each of the seven elements suggested by the Sentencing Guidelines and the OIG guidance. These key components are:

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

Our internal Corporate Compliance website, accessible by all employees, contains our Business Ethics and Conduct Policy, our Mission, Values and Philosophies and Compliance Programs, a company-wide policy and procedure database and our toll-free hotline to allow employees or other persons to report suspected incidents of fraud, abuse or other violations. The audit committee and the board of directors review a compliance report on a quarterly basis.

COMPETITION

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

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

- Medicaid Managed Care Organizations focus on providing healthcare services to Medicaid recipients. These organizations consist of national and regional organizations, as well as smaller organizations that operate in one city

or state and are owned by providers, primarily hospitals.

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

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

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

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

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

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REGULATION

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

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

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

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

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

State Contracts

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

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

- Ÿ eligibility, enrollment and disenrollment processes;
- Ÿ covered services;
- Ÿ eligible providers;
- Ÿ subcontractors;
- Ÿ record-keeping and record retention;
- Ÿ health education and wellness and prevention programs;
- Ÿ timeliness of claims payment;
- Ÿ financial standards;
- Ÿ safeguarding of member information;
- Ÿ fraud and abuse detection and reporting;

- Ÿ periodic financial and informational reporting;
- Ÿ quality assurance;
- Ÿ grievance procedures; and
- Ÿ organization and administrative systems.

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

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The table below sets forth the term of our state contracts and provides details regarding related renewal or extension and termination provisions as of December 31, 2009.

State Contract	Expiration Date	Renewal or Extension by the State	Termination by the State
Arizona – Acute Care	September 30, 2011	May be extended for up to two additional one-year terms.	May be terminated for convenience or an event of default.
Arizona – Behavioral Health	June 30, 2010	Renewable through the state's reprocurement process.1	May be terminated for convenience or an event of default.
Arizona – Long-term Care	September 30, 2010	May be extended for up to one additional year.	May be terminated for convenience, an event of default or lack of funding.
Arizona – Special Needs Plan (Medicare)	December 31, 2010	Renewable annually for successive 12-month periods.	May be terminated by an event of default.
Florida – Medicaid & ABD	August 31, 2012	Renewable through the state's recertification process.	May be terminated for an event of default or lack of federal funding.
Georgia – Medicaid & CHIP	June 30, 2010	Renewable for two additional one-year terms.	May be terminated for an event of default or significant changes in circumstances.
Indiana – Medicaid & CHIP	December 31, 2010	Renewable through the state's recertification process. 2	May be terminated for convenience or an event of default.
Kansas – Behavioral Health	June 30, 2010	May be extended for up to two additional one-year terms.	May be terminated for cause, or without cause for lack of funding.
Massachusetts – Commonwealth Care	June 30, 2010	Renewable through the state's recertification process.	May be terminated for convenience or an event of default.
Massachusetts – Commonwealth Care Bridge	June 30, 2010	Renewable through the state's recertification process.	May be terminated for convenience or an event of default.
Ohio – Medicaid & CHIP	June 30, 2010	Renewable annually for successive 12-month periods.	May be terminated for an event of default.

Ohio – Aged, Blind or Disabled (ABD)	June 30, 2010	Renewable annually for successive 12-month periods.	May be terminated for an event of default.
Ohio – Special Needs Plan (Medicare)	December 31, 2010	Renewable annually for successive 12-month periods.	May be terminated by an event of default.
South Carolina – Medicaid & ABD	March 31, 2010	Renewable for successive 24-month periods.	May be terminated for convenience or an event of default.
South Carolina – CHIP	March 31, 2010	Renewable through the state's recertification process.	May be terminated for convenience, an event of default or lack of federal funding.
Texas – Medicaid, CHIP & ABD	August 31, 2010	May be extended for up to four additional years.	May be terminated for convenience, an event of default or lack of federal funding.
Texas – Exclusive Provider Organization (CHIP)	August 31, 2010	Coverage for the CHIP members continues under the new CHIP Rural Service Area contract discussed below. 3	May be terminated upon any event of default or in the event of lack of state or federal funding.
Texas – CHIP Rural Service Area	August 31, 2013	May be extended for up to five additional years. 3	May be terminated upon any event of default or in the event of lack of state or federal funding.
Texas – Foster Care	August 31, 2010	May be extended for up to four and a half additional years.	May be terminated for convenience, an event of default, or non-appropriation of funds.
Texas – Special Needs Plan (Medicare)	December 31, 2010	Renewable annually for successive 12-month periods.	May be terminated by an event of default.
Wisconsin – Medicaid, CHIP & ABD 4	December 31, 2011	Renewable through the state's recertification process. 4	May be terminated if a change in state or federal laws, rules or regulations materially affects either party's right or responsibilities or for an event of default or lack of funding.

Wisconsin – Medicaid & CHIP 5	July 31, 2010 5	Subject to the state's reprocurement process. 5	Subject to the state's reprocurement process. 5
Wisconsin – Network Health Plan Subcontract	December 31, 2011	Renews automatically for successive five-year terms.	May be terminated upon two-years notice prior to the end of the then current term or if a change in state or federal laws, rules or regulations materially affects either party's rights or responsibilities under the contract, or if Network Health Plan's contract with the State is terminated.
Wisconsin – Special Needs Plan (Medicare)	December 31, 2010	Renewable annually for successive 12-month periods.	May be terminated by an event of default.

1 The Arizona Behavioral Health contract renewal is currently in process under the state's reprocurement process.
2 The Indiana Medicaid and CHIP contract is subject to a reprocurement process with a contract effective date of January 1, 2011.
3 The Texas CHIP Rural Service Area (RSA) contract covers CHIP members previously included under the Exclusive Provider Organization (EPO) contract. The CHIP RSA contract has a start date of September 1, 2010. Under the previous EPO contract, we were the sole provider of services. Under the new RSA contract, members have the option to select either our plan or the new alternate plan provided by another carrier.
4 The current contract excludes coverage for Medicaid and CHIP members in six counties (Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha). The state has not yet determined the process for renewal and if it will require requalification or a complete reprocurement submission.
5 The contract covers six counties carved out by the state for Medicaid and CHIP members (Kenosha, Milwaukee, Ozaukee, Racine, Washington and Waukesha). This contract extension is in place to cover members in these counties until the later of July 31, 2010 or at a date which the state has awarded membership under the reprocurement currently in process.

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HIPAA and HITECH

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

The Privacy Rule and HITECH regulations establish requirements to protect the privacy of medical records and other personal health information maintained and used by healthcare providers, health plans, healthcare clearinghouses, and their business associates. Among numerous other requirements, the privacy regulations:

- limit certain uses and disclosures of private health information, and require patient authorizations for such uses and disclosures of private health information;
- guarantee patients the right to access their medical records and to know who else has accessed them;
- limit most disclosure of health information to the minimum needed for the intended purpose;
- establish procedures to ensure the protection of private health information;
- authorize access to records by researchers and others;
- establish requirements for breach notification; and
- impose criminal and civil sanctions for improper uses or disclosures of health information.

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

The requirements of the Transactions Standards apply to certain healthcare related transactions conducted using "electronic media." Since "electronic media" is defined broadly to include "transmissions that are physically moved from one location to another using magnetic tape, disk or compact disk media," many communications are considered to be electronically transmitted. Under HIPAA, health plans are required to have the capacity to accept and send all covered transactions in a standardized electronic format. Penalties can be imposed for failure to comply with these requirements.

The preemption provisions of HIPAA provide that the federal standards will not preempt state laws that are more stringent than the related federal requirements. In addition, the Secretary of HHS may grant exceptions allowing state laws to prevail if one or more of a number of conditions are met, including but not limited to the following:

- the state law is necessary to prevent fraud and abuse associated with the provision of and payment for healthcare;
- the state law is necessary to ensure appropriate state regulation of insurance and health plans;

- the state law is necessary for state reporting on healthcare delivery or costs; or
- the state law addresses controlled substances.

We have implemented processes, policies and procedures to comply with HIPAA and HITECH, including administrative, technical and physical safeguards to prevent against electronic data breach, education and training for employees in specific practices designed to help ensure against unauthorized use or access to personal health information, and training on procedures for reporting a suspected breach. In addition, our corporate privacy officer and health plan privacy officials serve as resources to employees to address any questions or concerns they may have.

Patients' Rights Legislation

Although no federal legislation has been enacted, patients' rights legislation is frequently proposed in Congress. If enacted, this type of legislation could expand our potential exposure to lawsuits and increase our regulatory compliance costs. Depending on the final form of any enacted patients' rights legislation, such legislation could, among other things, expose us to liability for economic and punitive damages for making determinations that deny benefits or delay beneficiaries' receipt of benefits as a result of our medical necessity or other coverage determinations. We cannot predict when or whether patients' rights legislation will be enacted into law or, if enacted, what final form such legislation might take.

Other Fraud and Abuse Laws

Investigating and prosecuting healthcare fraud and abuse became a top priority for law enforcement entities in the last decade. The focus of these efforts has been directed at participants in public government healthcare programs such as Medicaid. The laws and regulations relating to Medicaid fraud and abuse and the contractual requirements applicable to health plans participating in these programs are complex and changing and may require substantial resources.

EMPLOYEES

As of December 31, 2009, we had approximately 3,900 employees. None of our employees are represented by a union. We believe our relationships with our employees are good.

EXECUTIVE OFFICERS OF THE REGISTRANT

The following table sets forth information regarding our executive officers, including their ages, at January 31, 2010:

Name	Age	Position
Michael F. Neidorff	67	Chairman and Chief Executive Officer
Mark W. Eggert	48	Executive Vice President, Health Plan Business Unit
Carol E. Goldman	52	Executive Vice President and Chief Administrative Officer
Jason M. Harrold	40	Senior Vice President, Specialty Business Unit
Jesse N. Hunter	34	Executive Vice President, Corporate Development
Donald G. Imholz	57	Executive Vice President and Chief Information Officer
Edmund E. Kroll	50	Senior Vice President, Finance and Investor Relations

Frederick J. Manning	62	Executive Vice President, Celtic Insurance Company
William N. Scheffel	56	Executive Vice President, Chief Financial Officer and Treasurer
Jeffrey A. Schwaneke	34	Vice President, Corporate Controller and Chief Accounting Officer
Toni Simonetti	53	Senior Vice President, Public Affairs
Keith H. Williamson	57	Senior Vice President, General Counsel and Secretary

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

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

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

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

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

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

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

Frederick J. Manning. Mr. Manning has served as our Executive Vice President, Celtic Insurance Company since July 2008. From 1978 to July 2008, Mr. Manning served as Chief Executive Officer and Chairman of the Board of Celtic Insurance Company.

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

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

Corporation, from March 2004 to December 2004 and Director of Financial Reporting from November 2002 to February 2004.

Toni Simonetti. Ms. Simonetti has served as our Senior Vice President, Public Affairs since December 2009. She previously served as Vice President, Global Communications at GMAC Financial Services from July 2004 to June 2009. From December 1999 to September 2006, Ms. Simonetti served as Executive Director, Financial Communications and Global Media Relations at General Motors Corporation.

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

Available Information

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

Item 1A. Risk Factors

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

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

Risks Related to Being a Regulated Entity

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

Most of our revenues come from Medicaid, CHIP and ABD premiums. The base premium rate paid by each state differs, depending on a combination of factors such as defined upper payment limits, a member's health status, age, gender, county or region, benefit mix and member eligibility categories. Future levels of Medicaid, CHIP and ABD funding and premium rates may be affected by continuing government efforts to contain healthcare costs and may further be affected by state and federal budgetary constraints. Additionally, state and federal entities may make changes to the design of their Medicaid programs resulting in the cancellation or modification of these programs.

For example, in August 2007, the Centers for Medicare & Medicaid Services, or CMS, published a final rule regarding the estimation and recovery of improper payments made under Medicaid and CHIP. This rule requires a CMS contractor to sample selected states each year to estimate improper payments in Medicaid and CHIP and create

national and state specific error rates. States must provide information to measure improper payments in Medicaid and CHIP for managed care and fee-for-service. Each state will be selected for review once every three years for each program. States are required to repay CMS the federal share of any overpayments identified. CMS published a proposed rule on July 15, 2009 that would make certain changes to the previously published rule. Among other things, the proposed changes establish a process for appealing error determinations. The changes will not become effective until the final rule is published. We cannot predict whether a final rule will become effective and if it does, what impact it will have on the states with which we have contracts.

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The American Reinvestment and Recovery Act of 2009, which was signed into law on February 17, 2009, provides $87 billion in additional federal Medicaid funding for states' Medicaid expenditures between October 1, 2008 and December 31, 2010. Under this Act, states meeting certain eligibility requirements will temporarily receive additional money in the form of an increase in the federal medical assistance percentage (FMAP). Thus, for a limited period of time, the share of Medicaid costs that are paid for by the federal government will go up, and each state's share will go down. We cannot predict whether states are, or will remain, eligible to receive the additional federal Medicaid funding, or whether the states will have sufficient funds for their Medicaid programs.

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

Changes to Medicaid, CHIP, Foster Care and ABD programs could reduce the number of persons enrolled in or eligible for these programs, reduce the amount of reimbursement or payment levels, or increase our administrative or healthcare costs under these programs, all of which could have a negative impact on our business. We believe that reductions in Medicaid, CHIP, Foster Care and ABD payments could substantially reduce our profitability. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds.

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

Federal support for CHIP has been authorized through 2013. We cannot be certain that CHIP will be reauthorized when current funding expires in 2013, and if it is, what changes might be made to the program following reauthorization. Thus, we cannot predict the impact that reauthorization will have on our business.

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

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

We provide managed care programs and selected services to individuals receiving benefits under federal assistance programs, including Medicaid, CHIP and ABD. We provide those healthcare services under contracts with regulatory entities in the areas in which we operate. Our contracts with various states are generally intended to run for one or two years and may be extended for one or two additional years if the state or its agent elects to do so. Our current contracts are set to expire or renew between March 31, 2010 and August 31, 2013. When our contracts expire, they may be opened for bidding by competing healthcare providers. There is no guarantee that our contracts will be renewed or extended. For example, on August 25, 2006, we received notification from the Kansas Health Policy Authority that FirstGuard Health Plan Kansas, Inc.'s contract with the State would not be renewed or extended, and as a result, our contract ended on December 31, 2006. Further, our contracts with the states are subject to cancellation by the state after a short notice period in the event of unavailability of state funds. For example, the Indiana contract under which we operate can be terminated by the State without cause. Our contracts could also be terminated if we fail to perform in accordance with the standards set by state regulatory agencies. If any of our contracts are terminated, not renewed,

renewed on less favorable terms, or not renewed on a timely basis, our business will suffer, and our financial position, results of operations or cash flows may be materially affected.

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

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

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

Our business is extensively regulated by the states in which we operate and by the federal government. The applicable laws and regulations are subject to frequent change and generally are intended to benefit and protect the financial interests of health plan providers and members rather than investors. The enactment of new laws and rules or changes to existing laws and rules or the interpretation of such laws and rules could, among other things:
• force us to restructure our relationships with providers within our network;
• require us to implement additional or different programs and systems;
• mandate minimum medical expense levels as a percentage of premium revenues;
• restrict revenue and enrollment growth;
• require us to develop plans to guard against the financial insolvency of our providers;
• increase our healthcare and administrative costs;
• impose additional capital and reserve requirements; and
• increase or change our liability to members in the event of malpractice by our providers.

For example, Congress is currently considering health care reform legislation. We cannot predict the impact of any such legislation, if adopted, on our business.

The pending health care reform legislation could harm our business.

Congress is currently considering legislation that could significantly reform the U.S. health care system. We cannot predict whether any legislation will be passed and if it is, what impact it will have on our business. If any reforms are implemented that reduce Medicaid or CHIP spending or the payments we receive from states or increase taxes on HMOs or MCOs, our business could suffer.

Regulations may decrease the profitability of our health plans.

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

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

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

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

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

Federal and state governments have enacted fraud and abuse laws and other laws to protect patients' privacy and access to healthcare. In some states, we may be subject to regulation by more than one governmental authority, which may impose overlapping or inconsistent regulations. Violation of these and other laws or regulations governing our operations or the operations of our providers could result in the imposition of civil or criminal penalties, the cancellation of